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An Ontological Analysis of Mainstream Addiction Theories:

Exploring Relational Alternatives

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A dissertation submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

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ABSTRACT

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Exploring Relational Alternatives

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Doctor of Philosophy

Individuals and societies have long struggled to understand and confront, by constructive means, the nemesis of addiction. No other human ill has provoked more concern, accounted for more suffering, or elicited greater consequence than addiction in all its diverse forms. Although alcoholism and drug abuse symbolize the traditional essence of addiction; compulsive sexuality, pathological gambling, eating disorders, tobacco use, etc., are also believed to have addictive properties according to contemporary concepts. Numerous commendable theories and therapies have been offered down through history to explain and mediate addiction's conceptually enigmatic and therapeutically resistant nature. As this paper will clarify, many of these time-honored conceptions and resultant treatments of addiction have been inclined to proceed from a particular philosophical perspective known as abstractionism. The first purpose of this dissertation, therefore, is to explore and analyze the influence of abstractionist ideologies in addiction theory and therapy. Further on, this paper will suggest an alternate theory of addiction that derives its meaning and significance from a philosophical basis known as relationality. A relational perspective of addiction theory and treatment will be proposed along with a number of therapeutic suggestions.

Keywords: Ontology, abstractionism, relationality, addiction

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An Ontological Analysis of Mainstream Addiction Theories: Exploring Relational Alternatives

Chapter 1: Introduction

There can be little doubt about three realities relating to the subject of addiction. First, addiction by all accounts is one of the most destructive of human phenomenon (Miller & Brown, 1997). Second, at present the recovery rate of individuals who maintain abstinent from harmful addictions is shockingly low (Hunt & Belpalec, 1974; Myers, 2000; Vormer & Davis, 2003; White, 1998). And third, the proliferation of theories to explain the phenomenon of addiction is at an all time high (Shaffer, 1997, 2007).

The Significance and Toll of Addiction

The cost of addiction. The quandary of addiction, with its attendant negative consequences, has been an unrelenting feature of humanity for millennia, and at present constitutes a pernicious and growing threat to the welfare and order of societies (Cohen, 1969; Fields, 1998; Kinney, 2003; Walters, 2007). In fact, addiction's burden on health care in the United States is so excessive that it exerts a disproportionate influence on the overall economy (National Institute on Drug Abuse, 2007). For example, of the $666 billion spent for health care in the U.S. in 1993, 25% or $167 billion was spent on addiction-related problems (American Medical Association, 2003; Kinney, 2003). Figures of this magnitude confirm that addiction, especially substance abuse, constitutes a medical and economic crisis (Boji & Ruan, 2004; Virage, Cox, & Rachel, 1988). However, monetary figures alone will never fully capture the full costs of addiction.

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Other dilemmas. Addiction's aftermath is not limited to the personal and financial consequences of poor health. The reach and multiplicity of addiction extends well beyond the implications of illness and economic hardships. Of the 11 million victims of violent crime committed each year in the U.S., nearly 3 million reported that the offender had been drinking prior to the crime, further evidence that abuse of substances carries extensive repercussions (Greenfield, 1998). Addiction to drugs and alcohol is the most prevalent form of mental health disorder, indicating the widespread psychological harm related to addiction (American Psychological Association, 2007; Miller & Brown, 1997; Williams, 1996). Although other alarming varieties of addiction, such as gambling, eating, and sexual compulsivity, are not as conspicuous or well-known as substance abuse, they are nonetheless devastating in their own right (Beck & Beck, 1990; Carnes, 1989; Caton, 1990; Dickerson & O'Conner, 2001; Sheppard, 1993). Despite a monumental and well-meaning effort by governments, institutions, and the sciences, addiction in all its various manifestation persists as a destructive and demoralizing aspect of modern life (Cushman, 1995; Putnam, 2000; Schumaker, 2001; White, 1998).

The Twofold Problem of Confronting Addiction

Introduction. Given the considerable long term effort to address the problem of addiction, what has prevented us from solving it? Why are these problems and consequences continuing? This dissertation begins (in chapters 2 and 3) by identifying the twofold nature of the problems confronting those who address addiction: 1. definitional confusion (Shaffer et al, 1997, 2004; Valliant, 1995; White, 1998) and 2. treatment ineffectiveness (Shaffer, 2004; Fields, 1998; White, 1998).

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Definitional confusion. At present addiction theories and treatments are so prolific and diverse that the field is in a near total state of confusion (Shaffer et al, 1997, 2004; Valliant, 1995; White, 1998). Regrettably, this confusion is so profound that Howard Shaffer (2008), the Director of the Harvard Medical School's Division on Addictions, has referred to it as "Conceptual chaos…a crisis of concepts and explanatory categories in the addictions…[and] The most important unresolved issue in the addictions" (p. 1573).

Addiction has been studied and defined from seemingly every conceivable theoretical perspective (Andreasen, 1984; Shaffer et al, 1997; White, 1998). For example, early conceptualizations theorized that alcoholism was the result of *fluid imbalances* e.g., "... morbid excitemaent caused by capillary tension" which resulted in an aberration of character within the individual (White, 1998, p. 3). Therapies from this approach ranged from harmless and non-invasive "water cures" to deadly and dehumanizing lobotomies and sterilization (Armstrong & Armstrong, 1991; Kellogg, 1898; Valenstein, 1986; White, 1998).

Contemporary methods that profess to treat a wide variety of disorders may be somewhat safer but are no less divergent. Modern approaches for a variety of addictive disorders include cognitive behavioral, cognitive developmental, transtheoretical, motivational interviewing, and pharmacological intervention, just to name a few (Kinney, 2003; Prentiss, 2005; Miller & Rollnick, 2002; Ray & Ksir, 2004; Velasquez, Maurer, Crouch, & DiClemente, 2001; White, 1998; Wilkerson, 1966). The profusion of approaches, whether conventional or unorthodox, has no doubt contributed to our overall knowledge of addiction and how to deal with it (Flores, 1997; Ray & Ksir, 2004; White,

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1998). However, the one thing that apparently none of them has done is to quell the chaos and controversy surrounding the study and treatment of addiction (Brodie & Redfield, 2002; Santrock, 2006; Shaffer, 1997).

Treatment ineffectiveness. In view of the abundance and diversity of treatment options, it is also discouraging to find that therapeutic interventions for addiction are seemingly ineffective (Dawson, Grant, Stinson, & Chou, 2006). For instance, large population analyses indicate relapse rates following treatment of alcohol dependence disorders to be between 70 % and 90% and success in treating illicit drugs is even more discouraging with recidivism rates exceeding 90% in many demographics (Apsler, 2004; Dawson, Grant, Stinson & Chou, 2006; National Institute on Drug Abuse, 2005).

William L. White (1998) noted author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* states:

> With our two centuries of accumulated knowledge and the best available treatments, there still exist no cure for addiction, and only a minority of addicted clients achieves sustained recovery following our intervention in their lives. In 200 years of addiction treatment history, the most significant breakthroughs have existed alongside the most ill-conceived. Some of the most passionately claimed truths and best championed interventions have proven wrong, ineffective, and at times harmful (p.342).

The overall ineffectiveness in confronting addiction has not emerged due to a lack of interest or genuine effort on the part of concerned groups (Flores, 1995; Ray & Ksir, 2004; White, 1998). For example, science's prodigious inquiry into addiction has perhaps generated the most optimism due to its invaluable breakthroughs in other areas of

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public concern. Progress in such issues as sanitation, epidemiology, emergency medicine, and drug therapies has instilled hope that addition could also be effectively treated with persistent and heroic efforts (Hoffman & Goldfrank, 1990; Maxmen & Ward, 1995; O'Brian, 1997).

Unfortunately, these achievements have not been duplicated with regards to addiction. In fact, so ineffective is treatment that *relapse* and *loss of control* related to substance abuse are now commonly recognized as the defining features of addiction (Fields, 1998; Ray and Ksir, 2004; White, 1998). What's more, recovery rates are so low that legislative policies, such as *harm reduction*, are beginning to reflect an overall mood of resignation and even retreat in the face of this intractable condition (Peele, 2002; Stoil, 1993; Yuile, 2008). Regrettably, temperance movements, faith initiatives, prohibition, and the "war on drugs" have likewise fallen short in producing widespread and encouraging results (Bork, 1996; Cushman, 1995; Kilpatrick, 1992; Peele, 1985; Schumaker, 1995).

In summary, the present state of confronting addiction presents a twofold problem. First, the abundance of theories and treatments seems to have resulted not in cohesion but confusion (Shaffer, 1997). And, second, notwithstanding the abundance and diversity of theoretical and therapeutic approaches to addiction, both scholars and practitioners acknowledge the ineffectiveness of current interventions (Armstrong & Armstrong, 1991; Levine, 1978; Shorter, 1991).

A twofold proposal. In view of the twofold nature of these problems, I will propose a twofold tentative "solution." In proposing a "solution" to the conceptual confusion and inadequate treatment of addiction, I do not want to overstate what I am

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able to provide. Still, the following proposal may help decipher some of the current confusion surrounding addiction and also present a view as yet unexplored in traditional conceptions: First, I will suggest that the conceptual confusion surrounding addiction is more apparent than real, that there is in fact, a shared unity at the ontological level; Second, if it is true that most conceptions share a similar ontological basis, then perhaps an alternative ontological viewpoint could offer a fresh approach to addiction and conceivably lead to greater treatment effectiveness.

Unity in diversity. Addiction conceptions, over the last two hundred years, are seemingly as diverse as the individuals who propose them (Shaffer, 2007; White, 1998). However, a significant portion of this dissertation investigates the possibility that most traditional approaches to addiction share a similar foundational philosophy.

The term "ontology" can have several meanings but as used here *ontology* simply means our assumptions of what is ultimately real and fundamental (Slife & Richardson, 2008). Ontology is, therefore, a philosophical framework in which the most fundamental aspects of reality are depicted. In the context of this dissertation ontology will be used as an investigational framework to determine the most basic assumptions underlying various addiction theories. In essence, an ontological analysis will ask the critical questions: What are the most basic and influential assumptions that undergird a particular concept of addiction. And, how do those assumptions impact the way in which addiction is confronted (Gruber, 1993; Slife, 2005)? The purpose therefore of an ontological analysis of addiction concepts is to test for the possibility that the majority of mainstream addiction conceptions share similar ontological perspectives. In order to validly conduct

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this test, it is vital that I remain open to the possibility that many addiction conceptions are ontologically distinct.

As philosophers and theoretical psychologists have long established, all ideas have ontological roots or assumptions, whether or not the authors of these ideas realize these roots (Bishop, 2007; Polkinghorn, 2004; Schick, 2000; Slife, 2005). In this sense, all scientific conceptions, including approaches to addiction, begin with certain ontological foundations. Addiction conceptions and treatments likewise begin with certain philosophical assumptions, which set the initial direction and character of the concept (Slife, 2003; Richardson, 2002; Bohman, 1993). In the case of addiction, these early assumptions may have gone unnoticed and therefore unchallenged once methods began to be employed to treat the disorder (Shaffer, 1986).

For instance, Ribes-Inesta (2003) has commented "…that psychologist have paid little attention to the nature of concepts they use, to the assumptions that underlie their theories, and the ways such concepts are applied in the study of behavior" (p.147). Slife & Richardson (in press) have further noted that within the social sciences there exists a "prominence and even dominance…in our professional culture [psychology]" of various ontological viewpoints which in turn serve as hidden assumptions (p. 3). Addiction conceptions and ensuing treatments may likewise have been influenced by various prominent ontological perspectives that have been taken for granted.

For instance, the three main addiction frameworks are the *disease model*, the *life-process model*, and the *biopsychosocial model*. On the surface these models seem dramatically diverse and theoretically conflicted (Flores, 1997; Paris, 1998; Santrock, 2006; Sarafino, 2001; White, 1998). I will explore the possibility, however, that despite

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what appears to be dissimilar at the surface is distinctly similar when analyzed from an ontological viewpoint. Ontological similarities in theoretical foundations are not the exception but the rule in the "hard" and social sciences (Bishop, 2007; Slife & Richardson, 2008). Lindberg (1992) identifies this unity by noting that:

> "Science has a particular content (not a special methodology or epistemology, but a special ontology so to speak); that is to say a particular set of propositions about nature [e.g., human behavior] reflected in disciplines such as physics, chemistry, biology, geography, [psychology] and so forth" (p.11).

In like manner, addiction science, along with its multitude of concepts may resemble many other scientific disciplines that share a common philosophical basis, regardless of what appears to be divergent on the surface.

An alternative perspective. If it is true that most addiction theories share particular ontological fundamentals; then perhaps an alternative ontological philosophy will allow addiction to be considered in perhaps a unique way. I will explore the prospect that perspectives of addiction from alternate ontologies have received little attention in comparison to dominant ontological perspectives. Therefore, there exists the opportunity that addiction can be theorized from a radically different ontological frame of reference than what presently constitutes the prevailing approach.

Such an approach may offer not only a fresh conceptual framework for addiction but also a therapeutic philosophy that matches more closely the most basic realities of the disorder. In this sense, a perspective of addiction derived from this ontological alternative could possibly offer unique insights into addiction and perhaps even contribute to more effective treatments.

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Synopsis of Subsequent Chapters

Chapter 2: Two ontologies in the social sciences. Chapter 2 will contain a description of the two main ontological categories of the social sciences, abstractionism and relationality (Bishop, 2007; Jackson, 2005; Slife, 2005). I will compare the two on a variety of important issues for addiction. Each ontology has been used in a wide range of applications to describe the most basic and fundamental aspects of human behavior (Bishop, 2007; Slife & Richardson, 2007). Given that addiction is considered a very basic element of human behavior (Brodie & Redfield, 2002; Flores, 1997) perhaps these investigational tools will help us to more fully understand addiction and clarify our present theoretical approaches to the disorder.

Chapter 3: An ontological analysis of addiction conceptions. Chapter 3 reviews the three most prominent frameworks in mainstream addiction theory and therapy to discover their ontological basis. The disease model, the life-process model, and compound models, such as the biopsychosocial model, will be the focus of this ontological assessment. Most addiction researchers agree that these three general frameworks encompass the full spectrum of theories past and present (Campbell, 1996; Jay & Jay, 2000; Santrock, 2007; Shaffer et al, 2004). Therefore, examples from each of these three perspectives will be analyzed from an ontological viewpoint to discover their most basic frame of reference concerning addiction.

Chapter 4: An alternative ontological approach to addiction. If Chapter 3 reveals the domination of a particular ontology in mainstream addiction concepts, then the final chapter will focus on an ontological alternative to addiction conceptualization. Chapter 4 would present an alternate ontology that may provide a fresh and provocative

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approach to addiction. Perhaps the introduction of new perspectives would be a timely and welcome addition to existing efforts to unravel the enigma of addiction. At present, there are many in the social sciences who are proposing non-traditional perspectives to complex and difficult issues in human behavior (Gantt, 2005; Gergen, 1987; Reber & Osbeck, 2005; Richardson, 2005; Slife, 2005). Concurrently, there is also a substantial undercurrent in the study of addiction indicating that the time may be right for diverse approaches to be considered (Jay & Jay, 2000; Prentiss, 2005; Shaffer, 1995, 2004, 2007; White, 1998). Additionally, a radical departure from conventional ontologies may be necessary to stimulate further discussion and research for a condition as intractable as addiction (Kuhn, 1970; McMurray, 1999; Richardson & Frost, 2006; Rorty, 1999; Slife, 2005).

Relevance and justification. It is no doubt abundantly clear to those who work in the field of social science that addiction, manifested through any number of diverse presentations, represents one of the most serious dilemmas societies face (Flores, 1997; Fields, 1998; Shaffer, 2007). Additionally, it is also apparent, that sustained progress, as of late, is sorely lacking in specific demographics and generally unacceptable in the overall mitigation of addiction (Behrens & Satterfield, 2007; Bennett, 1999; Comfort, 2000; Marcenko, Kemp, & Larson, 2000).Therefore, an in-depth analysis of addiction theory's fundamental assumptions is not only warranted but also seems to be justifiable in light of the seeming conceptual disagreements, even though there is agreement at a level of ontological assumptions (Shaffer, 1985, 1986, 1997). Dewey (1938) stresses "[that] any theory and set of practices is dogmatic which is not based upon critical examination of its own underlying principles." (p. 22).

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It is hoped that the critical analysis and the subsequent perspectives voiced in this dissertation will add a modest amount of practical knowledge to the professional field of addiction conceptualization and treatment. Perhaps it will add somewhat to the tradition carried on by numerous "counselors, physicians, nurses, outreach workers, and case managers working on the front lines of addiction treatment." (White, 1998, p. *xi*).

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Chapter 2: Two Ontologies in the Social Sciences

The research and study of addiction, over the last two hundred years, has presented an almost unmanageable surplus of theories and treatments (Flores, 1997; Schaffer, 1987). The way in which I propose to sort through this tangle of "conceptual chaos" (Shaffer, 1997, p. 1573) is to subject the more important and mainstream concepts to an ontological analysis.

Chapter 2 Rationale and Overview

Rationale. The purpose of Chapter 2 is to introduce the notion of ontology and in particular the two ontologies of the social sciences, abstractionism and relationality. These two specific ontologies will be described and their relevance to this paper established. Ontological frameworks have often been used to find the underlying assumptions of theoretical perspectives in the social sciences (Slife, 2005). Since addiction has been conceptualized in a multitude of diverse ways, an ontological analysis may be helpful in finding the most primary assumptions of mainstream addiction theories.

Ontology: A framework for conceptual analysis. The concept and application of ontological frameworks in the social sciences is somewhat ill-defined. However, for this particular application ontology means what is ultimately real and fundamental (Slife & Richardson, 2008). Ontological language has long been used to classify the ultimate and fundamental reality of the world and to articulate questions pertaining to the fundamental assumptions of concepts (Bishop, 2007; Honderich, 2005; Slife, 2007). Williams (2005) has noted that declarative language found in ontology, provides the organization, structure, and comparative criteria needed to analyze conceptual

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assumptions. Such assumptions underlie all concepts of the social sciences (Slife, 2003) including concepts of addiction.

The use of an ontological analysis is not widely recognized in the social sciences. However, it may have value in answering a number of pertinent questions relative to the conceptualization and subsequent treatment of addiction. For example, how different at the level of foundational assumptions are the various theoretical approaches to addiction? How are addiction theories affected by their ontological assumptions? And, what are the therapeutic implications of different ontological perspectives for the understanding and treatment of addiction?

All branches of the social sciences, including addictionology, approach their subjects from a foundation of basic but often hidden assumptions (Bishop, 2007; Gantt, 2005; Polkinghorn, 2004). Slife (2005) has pointed out that ontology helps to discover and identify which basic assumptions are valued more than others in scientific research. For instance, some ontological approaches would suggest that "observables" are more fundamental than "non-observables" and therefore of greater value in understanding human behavior, including addictive behavior. Additionally, Bishop (2007) asserts that an ontological mode of investigation helps to recognize which theoretical viewpoints are either "value-laden" or "value-free" in their approach to scientific inquiry, theory, and practice. Ontological analysis has also proven useful in investigating a wide variety of subjects ranging from therapeutic practices in counseling to positive psychology (Slife & Richardson, 2008).

An ontological analysis may prove helpful in answering three basic questions concerning the issue of addiction and how we approach it. First, are mainstream

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approaches to addiction as diverse and seemingly contradictory at the assumptive level as they appear to be at the applied level? Second, if mainstream approaches share a theoretical unity at an assumptive level, how does this influence affect the way in which we understand and treat addiction? And third, can an alternative ontological perspective provide greater clarity and effectiveness when dealing with such a complex issue as addiction?

Ontological Abstractionism and Relationality-A General Comparison

Introduction. There are basically two ontological perspectives which have been adopted in the social sciences, sometimes labeled *abstractionism* and *relationality* (Bishop, 2007; Richardson, 2005; Slife, 2005). The abstractionist perspective was adopted from the natural sciences as the most basic way in which to study and comprehend the world and human behavior (Bishop, 2007; Richardson, Fowers, & Guignon, 1999; Slife, 2005). Relationality on the other hand is a more recent approach that appears to be motivated by a desire to broaden the way in which we conceive of the world and our experience in it (Slife, 2005; Slife, Harris, Wiggins, & Zenger, 2005). However, of the two, scholars have argued that ontological abstractionism seems to play the more dominant role in defining what is most basic and fundamental in studying human behavior (Bella, 1985; Cushman, 1995; Richardson, 2002; Slife, 2007).

Ontological abstractionism. Ontological abstractionism is a philosophy or world view that defines or considers all that is real as self-contained and isolated (Slife & Richardson, 2008). Abstractionism therefore regards things as best understood when detached from other things and especially from the context in which the thing occurs. Bishop (2007) states "The key idea [behind abstractionism] is to isolate the properties in

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question from the rest of the environment and analyze them in as context free a manner as possible" (Bishop, 2007, p. 114). Humans and their behaviors, from an abstractionist perspective, are therefore assumed to be more accurately understood when detached from their surroundings (Slife & Richardson, 2008). Ontological abstractionism would thus "assume that all things, including the self [including addiction and addicted individuals], are the most real and best understood when they are separated from the situations in which they occur" (Slife, 2007, p.3). For example, studying pathogens in a laboratory is just one way in which contexts is minimized through separation. This separation theoretically yields more invariable and "law like connections between causes and effects" (Bishop, p. 115, 2007).

Addiction concepts from the abstractionist perspective would therefore only accept a contextless and individualist approach as the most fundamental way in which to understand and treat the disorder (Fields, 1998; Polkinghorne, 2004; Prentiss, 2005; Richardson, 2002; Slife, 2005; White, 1998). For example, an abstractionist approach to addiction would conceive of factors associated with addiction as individual or autonomous components in order to capture the ultimate reality of the condition.

Abstractionism does not preclude these components from converging or being combined in some manner; it just assumes that they begin as separate and self-contained entities before their combination, much as chemical combinations are assumed to originate from separate elements. From this perspective, each factor of addiction, e.g., genetics or environment is conceived of as being detached from other factors and also detached from the context in which the factors occur as well. This ontology implies that

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the ultimate realities of addiction are to be found in self-contained or isolatable factors considered to be basically unchanged and or at least similar from context to context.

This inference of essential unchangeableness or similarity would imply that the diagnosis of addiction itself is self-contained and remains basically unchanged from context to context. There are a number of contemporary conceptions of addiction that reflect this particular principle of unchangeableness (Flores, 1997; White, 1998). For example, addiction to alcohol is frequently considered to be still be "within" the individual even if they are abstinent for many years and basically symptom free (Flores, 1997; Menninger, 1938; Valliant, 1982, 1985). Thus the factors of addiction and indeed addiction itself, from the abstractionist position, are viewed as being similar and consistent regardless of the context in which the individual is found.

Ontological relationality. Ontological relationality, by contrast, is a philosophy that asserts individuals and their behaviors can only be understood in relation to the contexts in which the individual exists or the behavior occurs. For example, Slife & Richardson (2008) offer the illustration of a hammer in one context as being best understood as nail driver but in different contexts being best understood as a paper weight or even a weapon. Relationality recognizes and notes the similarities of the hammer from context to context but it also argues that a fuller meaning requires relations of differences that are often found in the hammer's contexts. Additionally, language, such as the word *hammer*, fails to convey the fuller meanings present in a more detailed context (Slife, 2005). Thus, to conceive of the hammer as only a nail driver across all contexts would, according to a relational ontology, minimize the fuller meaning of the hammer as it exists in a variety of settings.

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Addiction from a relational perspective would likewise not only value the similarities evident from context to context, but would also acknowledge the influence[1] of contexts and relationships on the most basic meanings of addiction. Furthermore, factors associated with addiction would be conceived of not as self-contained or autonomous but as inter-related and *mutually constitutive* of other pertinent factors. Mutually constitutive refers to how each factor never exists as a self-contained entity but only in relationship to other factors. Pertinent factors are thus necessary for addiction to occur but not sufficient in and of themselves to account for the disorder. This suggests that factors of addiction, e.g., genetics, environment, and the contexts in which they occur, are not sufficient or "the cause" in and of themselves because they are not self-contained and do not remain fixed from context to context. This would also imply that aspects of addiction and indeed the very meaning of addiction are subject to contextual influences and alteration. In short, a relational approach would view contexts and relationships as indispensable when trying to comprehend, conceptualize, and therefore treat addiction.

Strong and weak ontological relations. To further explicate the philosophical framework of ontology I will endeavor to point out a few nuances present when comparing abstractionism and relationality. Both abstractionism and relationality, as they relate to the social sciences, assume that relationships are a widespread reality in a variety of human behaviors. However, one viewpoint assumes a relationship based on weak relations while the other assumes relationships are more strongly connected. As Slife

[1] . It is important for the reader to note that the word *influence*—when used in conjunction with a relational ontology—does not imply an efficient causality or a sufficient condition. Rather, influence, in this case, denotes a formal or final cause meaning that influence of certain factors is a necessary but not sufficient condition.

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(2005) points out:

> From this weak relational perspective [abstractionism], persons, places, and things begin and end as self-contained individualities... Relationships... in this weak sense are reciprocal exchanges of information among essentially self-contained organisms [or entities]. The term "interaction" often connotes this weak form of relationality because members of the interaction "act on" each other... In all cases, the identity of these entities stems from what is ultimately "inside" and within them, even if some of what is inside might have originated from the outside... Strong relationality, by contrast, is an ontological relationality. Relationships are not just the interactions of what was originally nonrelational; relationships are relational "all the way down". Things are not first self-contained entities and then interactive. Each thing, [including addiction], is first and always a nexus of relations. (p. 3-4).

We will find a helpful application of these distinctive differences near the end of Chapter 3 when the biopsychosocial model of addiction is analyzed.

Comparing and Contrasting Overlapping Ontological Issues

Context. There are several distinguishing features of ontology that will need to be developed at length in view of their critical relevance to an ontological analysis of addiction. The first of these is the important issue of context. *Context* has been described as the set of factors and circumstances that surround and give meaning to situations and behaviors (Bishop, 2007; Miller & Rollnick, 2002; Slife, 2005). The subject of context has an especially important bearing on both ontological abstractionism and ontological relationality. For instance, the central ideal of ontological abstractionism is that things,

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such as behaviors, are best understood when decontextualized from adjacent factors, e.g., their surroundings, histories, or the cultures in which they take place. This ontological belief is, of course, the reason for laboratories. Referring to science's predisposition for abstractionism, Bishop (2007) states "The process of abstraction has become an indispensable element of scientific practice for those disciplines dealing with impersonal properties of reality" (p. 114).

One such example of this contextual detachment can be seen in contemporary conceptions of addiction where certain features of the disorder are prioritized over others. These "select" factors are viewed abstractly as the most fundamental feature of addiction regardless of accompanying features and context. For instance, the developmental influences of environment are often noted in contemporary addiction literature as a fundamental and initial step in the etiology of addiction (Fields, 1998; Peele, 1985; Phelps & Nourse, 1986; Ray & Ksir, 2004). Environmental conditions, such as low SES, absence of a father in the home, and aversive cultural norms are often cited as essential "gateways" to addiction. This implies that regardless of other contextual interactions within the environment e.g., a supportive network of personal relationships or spiritual influences, individuals in a disadvantaged environment are likely to succumb to addiction.

This is not to say that contemporary psychological conceptions do not assume the interaction and influence of multiple factors in the etiology of various disorders. The *diathesis stress* model, for instance, draws attention to the interface between genetics and the environment as co-occurring factors that may combine to increase an individual's vulnerability of a disorder (Liberman & Yager, 1994; Zubin & Spring, 1977). Such

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nature/nurture conceptions accept, up to a point, the importance of interactions or syntheses in the etiology of disorders. Nevertheless, these multiple factors are assumed to stem from individual and separate sources prior to their interaction within a given context.

Decontextualized approaches to addiction demonstrate the capacity of isolated and select factors of addiction to override or negate every other contextual interaction present. These select factors are thus thought of as predominant and therefore of greater impact than other factors, such as the context in which the select factors occur. For instance, addiction is widely known to manifest itself over an extremely broad socioeconomic stratum, from the very affluent to the very impoverished (Fields, 1998; Prentiss, 2005; Valliant, 1995). One popular hypothesis for this peculiarity is that specific neurological deficits confer an overriding influence and are therefore capable of superseding even the most advantageous of environmental circumstances (Heyman, 1995; Valenstein, 1996; Volkow, Fowler, & Wang, 1996; Young, 2004). Consequently, addiction theories that isolate, distinguish, or elevate one or a few factors over other factors or contexts as the most basic reality of the disorder, sufficient or causal in itself, can be regarded as abstractionist.

Relationality, on the other hand, approaches context from a completely different perspective than that of abstractionism. Relationality asserts that contextual influences such as, history, culture, and physical settings are all relevant and indispensable clues to understanding human behavior (Slife & Richardson, 2008). This implies that addiction cannot originate in or be defined according to one or even a combination of factors, such as specifics within the individual or their environment. Nor can addiction exist in a

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contextual vacuum according to relationality. Each relevant factor of addiction is significantly associated with and mutually constitutive of other factors.

For example, according to relationality, each contextual or relational factor is never sufficient to fully account for addiction but exists only as a necessary component of the whole. Addiction in this sense is not explained by separate factors that somehow merge to form a disorder but rather by factors whose qualities are mutually formed by their relationship to other factors. Thus in a relational approach to addiction, each relevant factor is not only an indispensable part of the whole but also derives its qualities from its relationship to other factors. Slife (2005) employs a simple "stick figure" to illustrate how relationships among factors confer meaning to the whole. The circle at the top of the figure can only be imagined as a head by virtue of its relation to the rest of the figure. Thus, each portion of the figure, such as legs, arms, and the head, are without meaning until they are viewed as a whole (p. 4). Likewise, a relational perspective would assume that meaningful factors of addiction would not be complete without the contexts and relationships in which addiction occurs.

The stick figure illustration points out one of the key tenets of a relational ontology. That is, the influence of context, at least according to relationality, is indispensable and can literally change the very meaning of things and behaviors (Bishop, 2007; Slife, 2005). Viewing context in this way gives relationality an "it depends" element that applies to any practical question (Slife, 2005). For instance, a relational perspective would concede the negative or "gateway" influences of certain factors on individuals within the environment as necessary conditions. Nonetheless, relational perspectives would also submit an "it depends" proposition to see how the contextual

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world of the individual—other necessary conditions—could change the meaning and therefore the influence of "negative" factors.

According to this "it depends" aspect, relationality accepts that certain factors in one context can be damaging, but those same factors can change from context to context to the point where they actually could be thought of as advantages. For example, contextual disadvantages, such as low SES, may be seen as destructive, disabling, and a primary gateway to addiction. Yet in another context, low SES may be thought of as character building and in some ways protective against "consumptionism" which has also been cited as a gateway to addiction (Cushman, 1995; de Graaf, & Boe, 1997; Schumaker, 2001).

In short then, each ontological category views context from two diverse positions. Abstractionist approaches to addiction would assert that addiction is best understood when the "involvedness" of context is eliminated in order to isolate and prioritize relevant factors associated with the disorder. Decontextualizing addiction thus provides a clearer and more meaningful picture of addiction according to abstractionism. On the other hand, relationality suggests that addiction without an accompanying relevant context could lead to a distorted picture of addiction. Relational approaches to addiction would therefore find further meaning and clarity in the rich contextual world of addiction.

Reduction. Reduction assumes all things, including addicted individuals, can be understood and treated in terms of reducible components, with some components being more "basic" than others (Slife & Richardson, 2008). The purpose of reduction is to locate the most "basic" and "sufficient" issues and assert their primacy (Schaal, 2003). Reduction, therefore, infers that the qualities of things originate and are most evident

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when partitioned at some primary level (Dawkins, 1986). Abstractionist conceptions of addiction, such as the disease model, depend on reductions to establish the most meaningful approaches to addiction. Relational approaches on the other hand avoid reductions (Jackson, 2005; Kirschner, 2005; Reber & Osbeck, 2005; Slife & Richardson, 2008) as wholly definitive of addiction. A relational approach to addiction would regard the shared *mutuality* of relevant components as the most basic reality of addiction, rather than the isolated *primacy* of select components.

Both abstractionism and relationality acknowledge the usefulness of reductions, although on wholly different levels (Slife, 2005). Abstractionism, for example, accepts reductions as the most primary means of establishing a hierarchy of the most basic elements of reality (Bishop, 2007; Dawkins, 1986). Relationality, by contrast, views reductions simply as a necessary convenience to describe or delineate elements of reality but not to assume these abstractions represent the most fundamental approach (Slife & Richardson, 2008).

The most basic elements of reductions are themselves self-sufficient and do not derive any essence or meaning from any other source (Bishop, 2007; Slife & Richardson, 2008). For example, if addiction is understood from a reductionist construct, such as biology, then the disorder can originate from a self-contained component or factor. Addiction, from the abstractionist perspective, can be reduced to such factors as deficits in brain chemistry, hormonal imbalance, or a particular "addictive gene." Since addiction has been reduced to its most fundamental essence, these factors are thus believed to be prior to or more basic than other factors. This implies that any factor arrived at through reduction, such as biology, could be sufficient to explain what some might consider non-

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biological conditions of addiction, such as culture (Peele, 1985; Schaler, 2004; Schumaker, 2001). Additionally, reducing a condition as diverse in its presentation as addiction will in due course establish a hierarchy among relevant factors. One of the key principles of reductionism is to categorize factors according to significance or magnitude (Chiesa, 2003; Marr, 2003).

Relationality, by contrast, assumes that reductions cannot be avoided. Indeed the word *addiction* is a linguistic reduction that carries with it a multitude of connotations. However, relationality would argue that reductions are not to be considered the most basic or fundamental aspect of an object or a behavior. For instance, brain chemistry and hormones may be necessary factors of addiction but according to relationality addiction cannot be reduced to these or other seemingly isolated factors as sufficient conditions.

Relationality would obviously acknowledge the brain's contribution to addiction but only in light of its broader contextual accompaniments rather than its isolated or more "basic" status. Additionally, each factor, e.g., brain chemistry, environment, or culture is not autonomous in its make-up but shares its essence and composition with other factors. This implies that each element of addiction, whether biological, environmental, or cultural, is better understood when viewed in its mutual relation to other factors. Addiction therefore, from this relational perspective, is "thick" with relational and contextual particulars which comprise the most basic and fundamental meaning of addiction.

One implication of a relational concept of addiction is that one factor or aspect of addiction cannot be prioritized over others or viewed as exclusive or predominant. In essence, each pertinent element mutually derives its most basic meaning from its

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relationship to other factors. Essentially, all relevant factors are necessary and but never sufficient conditions for the addiction. They share, in one way or another, a mutual connection and composition with other relevant factors. Drawing upon relational principles, a conceptualization of addiction, then, is not reducible to exclusive components but rather is a nexus of interacting and interrelated factors.

In summary, the abstractionist point of view draws upon reductions as a means to establish causal significance, and the predominance of causal factors (Bishop, 2007; Schaal, 2003; Slife, 2005). Thus abstractionism would assume that addiction is reducible to more basic factors or components such as biology or environment. Relationality, by contrast, views reductions serving as an explanatory and descriptive convenience but not as the most fundamental meaning of the elements of reality. For instance, relationality would concede that language, no matter how refined, is still an abstraction of reality. Relational perspectives would thus only utilize reductions, such as language, to delineate the rich and often complex condition of addiction into readily understandable terms.

Identity. Identity has played a significant and indeed central role in the conceptualization and approach to studying human behavior (Bella, 1985; Cushman, 1995; Guignon, 2004; Taylor, 1989). Wiegert, Teitge, & Teitge (1986) comment "It's theoretical, empirical, and cultural importance shows no sign of abating as social scientists, clinicians, historians, psychologists, philosophers, and the media continue to apply, dispute, and develop the idea." (p. 60). The ontological conceptualization of identity is no less important or relevant when applied to addiction issues and challenges.

The ontological essence of identity, as envisioned by abstractionism and relationality, is conceived of from two distinctly diverse assumptions. Identity by way of

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abstractionism assumes the most basic and fundamental qualities of the individual to be self-contained, isolated, and determined regardless of relationships, context, or volition (Bella, 1985; Christopher, 2005; Cushman, 1995; Slife, 2005; Taylor, 1989). Identity is thus a prelude to the interaction of relationships and contexts. By way of abstractionism, relationships and contexts are accordingly secondary experiences dependent on identity for existence and meaning. Furthermore, identity remains basically unchanged when contexts change or relationships change, suggesting the individual, at least on the fundamental level, is "set" in their ways, such as through "traits," "personality," or "character" (Bishop, 2007; Gergen, 1987; Slife & Richardson, 2008).

This perspective would imply that addictive behavior stems from fixed "inborn" conditions or qualities that constitute the most central part of the individual's identity. Such prior and stable elements may be manifested through systems of biology, personality traits, or temperament. For example, individuals who have not used drugs compulsively for years may still identify themselves as an addict. Such actions stem from the assumption that "core" identity remains fixed regardless of significant changes in attitude, relationships, behaviors, and contexts (Flores, 1997; Menninger, 1938; Jellinek, 1960).

Taylor (1989) refers to these fixed elements of priority and stability as the "punctual self" (p. 159), concluding that identity by way of abstractionism is detached from and is above context (*context* in this case being all sets of factors or circumstances that surround and give meaning to situations and behaviors such as attitudes, relationships, behaviors, history, our bodies, and the environment). Additionally, abstractionism implies that "others" do not *essentially* or *fundamentally* matter in the

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constitution of the individual's identity (Chiesa, 2003). As a result, the "self" is the most crucial aspect of life, living, and identity (Bella et al, 1985; Slife, 2005). Abstractionist understandings of the self would also assume that *others* as well spring from independent sources and are therefore essentially detached at a fundamental level from the influence of contexts and relationships.

The implication for addiction here is threefold. First, individuals similarly "identified" as addicts or who develop into addicts do so by self-contained features of the identity or the "self". Second, *others* only exert a distant or secondary influence on the identity and condition of the addict and therefore do not fundamentally matter to the ontologically abstract individual. Third, an addicted individual's defining features (such as an addictive personality) are still retained in their "core" identity despite significant shifts in contexts, relationships, and behaviors. Such a "core" identity is said to be responsible for the continuity between contexts that seems to define consistent addictive behavior (Gendreau & Gendreau, 1970; Fields, 1998; Williams, 1996). Thus addiction from this perspective assumes that the individual's addiction emanates from within and as such is carried from context to context. From such a perspective therefore, *others* do not significantly factor in the problem, and the essence of addiction remains even if all else changes, including the influence of others.

Identity, thus conceived abstractly, is by and large, an autonomous and static entity despite the emerging, evolving, and engaging world around the individual. Even though the abstractionist recognizes that relationships and context confer some influence on the individual, it only assumes these as weak or less important sources of identity. For that reason, identity by way of abstractionism, assumes that the other is completely

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"other" and is therefore foreign to the self-contained identity of the "self"." One implication of an abstractionist identity, from a therapeutic perspective, is that individuals are essentially "distant" from others and are therefore, in effect, somewhat threatening or at least "closed off" from the very beginning. Therapy, therefore, from a strict individualist ontology, such as abstractionism, may inadvertently establish an unspoken barrier between the addicted individual and valuable networks such as family, friends, professional, and pastoral resources.

Relationality on the other hand would view the individual and his/her identity as fully engaged with the others and the world around them. Relationality would thus view varying contexts and relationships as "strong" and fundamental influences on the identity of the individual. Identity approached from a relational point of view would assume that each person's character and distinctiveness is not a prelude to the interactions of relationships but is mutually constituted from relationships, contexts, and choices. Identity, consequently, is not a static or stable quality but is dynamically engaged and exists only in and through relation to the mutable world, our involvement with that world, and our interpretive meanings of that world.

This implies that the addict's identity is not defined completely or even essentially by universal and consistent features within the individual. The relationist, for example, would assume that there are many contexts or times in which the "addict" does not feel or live out the addiction. Such a relational approach may view addiction not as a constant condition (as reflected in many contemporary theories of addiction) but as a variable or intermittent condition depending on a wide range of relational and contextual factors.

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Each person therefore, is a nexus of lived experiences, which consist of unique and changing relationships, contexts, and choices. Accordingly, relationality would view identity "traits" and "temperaments", not only as changeable but an indication of our continuous and intimate connection, with others, contexts, and choices. Sacks (2002) agrees by stating that "we develop a sense of personal identity only through close and continuous conversation with significant others [and our world]." (p. 150).

The "close and continuous conversation" that Sacks (2002) refers to here would not be possible without continuity between contexts. Continuity between contexts in this instance does not refer to the unchangeable facets of a self-contained identity as in the abstractionist view of identity. A relational view refers rather to the uniformity of relations generated by themes of culture, abstractions of language, or constancy of friendships that permeate our lived experience.

Others then, from the relational position, are not only important but are thus indispensable and necessary to the synthesis of each individual. Slife (2005) once again underscores this position by stating:

> Because others are so important to our individual identities in a strong relationality it is important to understand the status of the "other" in this ontology. No belief or value can serve the other in this relational arrangement unless the other is allowed to truly be "other", in all of his or her singularity and difference…no real relationship is possible if the other is merely a reflection or even a conception of the self (p.16).

Strong relationality, therefore, implies that in spite of differences or similarities among individuals on the superficial level, *others* share a primordial place in the

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composition of each person. This suggests that individuals need not share beliefs or values to relate to one another. Indeed, the relationships between individuals springs from the most fundamental of origins, a deep and fundamental need to be in relationship with others and to belong to a greater whole, such as community (Slife, Mitchell, & Whoolery, 2003; Slife & Richardson, 2008). The abstractionist concept of identity, by contrast, differs in that identities are first and fundamentally separate and self-contained and therefore necessitates finding common ground in which to establish a relationship.

The practical implications for the concept of addiction and for the treatment of addiction using relational perspectives of identity are thus fourfold. First, if the fundamental ethos of addiction therapy is based on a relational ontology of identity, both addicts and non-addicts (including addiction professionals, family, and friends) are interrelated at the most fundamental level despite differences at a behavioral level. Second, differences would not be necessarily viewed as a threat or barrier to relationships (such as the therapeutic relationship) but rather as necessary and indispensable elements in one's identity and connection to others. Third, the most fundamental aspect of the addict's identity is dynamic, and therefore responsive, to contextual, relational, and agentic influences. Fourth, the most vital factor in an individual's identity is his/her connection and relationship to others. This final implication is extremely relevant in light of addiction being referred to as a mental disorder most likely to isolate the individual from significant sources of intervention and help (Flores, 1997; Ray & Ksir, 2004; Peele, 1975).

From the relational point of view, addiction is not a self-contained entity nor is it able to be present or progress without the influence and interaction of others and the

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environment. Indeed, the very notion of a fixed diagnosis of the addicted individual may be obsolete under a relational conception of identity due to identity transformations when interacting with *others* in certain contexts and relationships. Identity and the facets of identity, such as addiction, would not be possible without *others* and their inherent similarities and differences. Because addiction is only a facet of the individual's identity and not a core feature, the addicted individual may not need to radically change his/her core identity to eliminate the feature of addiction.

Experience. The interpretive frameworks of ontological abstractionism and relationality unfold *experience* from two diverse perspectives. Each viewpoint provides what it assumes is the most basic and fundamental way in which to study and understand experience. Likewise, experience, as it relates to addiction and addiction conceptions, can also be explained differently through these ontological frameworks. Whereas experience is such a critical issue to our ontological exploration, it will be important to understand how these frames of reference help shape the way in which addiction and the experiences of the addicted individual are presently comprehended.

In general abstractionism and relationality approach experience from three contrasting assumptions that I will describe as important to an ontological analysis of addiction. First, an abstractionist approach to experience assumes that the objective and subjective realms of human existence can be conceived of as separate worlds (Slife & Richardson, 2008). Relationality by contrast, would assume that these realms comprise one world—a world that is neither objective nor subjective but a nexus of the two (Slife, Mitchell, & Whoolery, 2003). Second, abstractionism would propose that human experience is simply a subjective representation of the more real objective world (Slife,

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2007). Relationality, on the other hand, assumes experience is an interpreted reality consisting of the world of objects and the individual's world of perceptions, ideas, and feelings—each contributing to meaning (Slife, 2007). Third, abstractionism assumes objective entities, e.g., the environment, or the brain, produce and determine the subjective experiences of the individual (Bishop, 2007). This abstractionist perspective of human experience is commonly known as the theory of *determinism* (Chiesa, 2003). Relationality however, contends that objects, such as the brain and the environment, are necessary factors in experience but asserts there are other important factors as well, such as contextual agency, which contribute to the experiences of the individual (Slife, 2007). This third and last section on *experience* involves a significant explanation of *determinism* which will also be the subject of the final heading in this chapter.

According to abstractionism, humans and their realm can be delineated into two distinctively separate worlds, the objective world (i.e., objects) and the subjective world of experience (i.e., perceptions of objects) (Slife, 1995). In other words, the objective world is abstracted from the subjective world. The objective world consists of "… material objects, mechanistic processes, and law governed relations" (Richardson, Guignon, & Guignon, 1999, p. 11). The subjective world involves perceptions, ideas, feelings, and other "mind" related processes (Bishop, 2007; Slife & Hopkins, 2005). Traditionally, the role of science and scientific methods has been used to separate our subjective meanings of the world from the "real" world to ensure a more corresponding view between the perceived and the real (Taylor, 1995).

Using such a conceptual basis for addiction theories would first imply that the subjective experience of addiction is derived from an objective reality—the two being

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separate and distinguishable. Likewise, the individual as an object (e.g., the biology) can be separated (by means of science) from the subjective experience of addiction. The primary implication for addiction theories using this approach is that the subjective experiences of the addicted individual are only recognized as an indication of a more underlying and fundamental problem(e.g., biological). Separating the objective world of the addict from his/her subjective experiences is thought to have significantly contributed to the now widely accepted *disease model* of addiction (Shaffer, 1985; Valliant, 1892; White, 1998).

On the other hand, the relational perspective would assume that humans and their realm cannot be ontologically separated into these two worlds but can only realistically be explained as one world of meaningful reality. Although we can certainly speak informally about "subjectivity" and "objectivity," these are not ontologically (i.e., really and fundamentally) different realms. They are always "in relation" to each other. The subjective does not exist without the objective, and the objective does not exist without the subjective. Indeed, a relational conception of experience is more of an "interpretive reality" of the whole (Bohm, 1980; Slife, 1995). Slife (2005) explains that:

> Although each particular lived experience is unique in its qualities, these unique qualities are a nexus of the experience's relation to the whole, including the experienced past… In this sense, the nexus is rich and thick with contextual and historical relations, and subjectivity and objectivity are inextricably intertwined as interpreted reality (meaning). (Slife, 2005, p.166).

The abstractionist often uses the term *dualism* to describe the theoretical abstraction of the world of objects and our perceptual experiences of those objects

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(Honderich, 2005). Some relationalist, by contrast, use the term *interpreted reality* to describe a world situated among meanings in which all experiencers participate (Slife, 2005). The interpretive reality therefore reflects the relatedness of the addicted individual's perceptions, feelings, and beliefs to the material world around them.

Slife & Hopkins (2005) additionally specify that "Conventional (two-sided) dualism is the notion that humans have two (dual) separate realities—the immaterial mind and the material body" (p. 11). One potential inference and implication of approaches utilizing such orientations of experience is the possibility that individuals' (including addicted individuals) may be *objectified* (Jackson, 2005; Moss, 2005; Slife, Smith, & Burchfield, 2003). Hartling (2004) stresses that:

> Following these dominant theories, substance abuse is viewed individualistically, suggesting that the problem is located [strictly] within the individual, who is deficit in some way—for example, ill-informed, weak-willed, immature,…or one who has low self-esteem…[or] no self-control (p. 199).

Relationality, by comparison would assume that the individual is not exclusively an object that is at the mercy of other objects (similar to a billiard ball). In fact, relationality would assume that individuals and the world around them are mutually constituted and therefore the individual is an agent capable of interacting with and influencing the world through interpretation, relationships, and contexts (Richardson, Fowers, & Guignon, 1999; Slife & Hopkins, 2005).

Conceptualizing experience from such a relational viewpoint means that each person is personally and communally involved with meaning making through mutually responsive relationships with the world (Buber, 1958). That is to say, in a relational

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ontology there is no line of demarcation separating the subjective individual from objective reality but rather each is continually woven into all aspects of the world through the interpreted reality of inter-personal and inter-object relationships.

Abstractionism would assume that the individual's experiences are simply subjective representations of the "outer" world of objects that spring from the individual's "inner" world of subjectivity (Slife, 1995). In this sense, experience, is fundamentally a disengaged subjective piece of the "whole" but is presumed to be a general representation of the objective whole (Richardson, Fowers, & Guignon, 1999). For example, *loss of control* and *relapse* are important and somewhat ubiquitous features of substance addiction (Gorski & Miller, 1986; Potenza, 2007; Rachlin, 2000). An abstractionist approach to the experience of an addict would assume that the meanings or experiences of control loss or relapse are representations that presumably correspond to the causality of addiction. In other words, something abstracted from these pivotal addiction experiences causes them—typically either something from the environment or something from the person's neurochemistry.

The disease model embodies just such a framework with its assertion that loss of control and relapse are the subjective representations of an underlying biological basis of addiction (Brownell, Marlatt, Lichtenstein, & Wilson, 1998; Jellinek, 1960; Potenza, 2007). Such representations are thought to universally correspond and relate to addiction, especially when the addiction involves substance dependence (Gorski & Miller, 1986; Rachlin, 2000; White, 1998).

When loss of control and relapse are envisaged from an abstractionist framework, these noticeable features of addiction (and others) are seen merely as "external"

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expressions of "internal" determining factors. Since all experience, according to abstractionism, is distinguished as subjective representations of more real entities, viz. the brain, the value of subjective experience is utilitarian. That is to say, experience is valuable—at least conceptually and therapeutically—as long as it leads to the more real and underlying causes of addiction (Shaffer, 1997).

This viewpoint would imply that the experiences of the addict, such as relapse or loss of control, are less "real" than underlying objective factors, for instance, brain chemistry. This further implies that such experiences are, in actual fact, the natural and subsequent by-products of mechanistic processes. This means that the individual and his/her day-to-day lived experiences only represent what is real and are not real in the same sense as the processes or structures which initiated them. Therefore, these more real factors are viewed as the originators of experience and are in this manner disconnected from the individual's interpretations, contexts, and relationships of day-to-day life.

The implications for conceptualizing experience as merely subjective representations suggest that the individual functions as a perceiver and processor of the "outer" world but has little mutual or overt engagement with the world. This would imply that research and therapeutic efforts should concentrate on the objective factors of addiction and not necessarily on the lived experiences of the addict. Pharmaceutical interventions are just one example of how researchers address the subjective experiences of the individual (e.g., stress) in an effort to intervene and treat the "experience" at its source (Haefely, 1983; Julian, 2001; Maxmen & Ward, 1995; Rickels, 1981).

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Ultimately, conceptions of experience by way of abstractionism, delete the subjective meaningfulness of the individual's lived experience in an effort to zero in on more real or objective factors. Objects of reality are therefore favored as being more objective and consequently more relevant to the pursuit of reconciling addiction. There is little doubt that concentrating on addiction from abstractionist perspectives, for example neurobiology, has yielded a wide variety of fruitful innovations (Cohen, 1988; Hedges et al, 2003; Heyman, 1995). These efforts have undoubtedly contributed to the overall search for answers to the baffling issues addiction presents to researchers and practitioners (American Medical Association, 2008; American Psychiatric Association, 1994; American Psychological Association, 2007).

Nonetheless, the relationalist would suggest that the search for answers should be widened to include a more fundamental and expansive view of experience. Relationality would assume that each individual's experiences go beyond mere self-contained representations of the real world. For the relationalist, individuals do not first represent the world and then experience it. The world is experienced directly and mutually as a place of evolving and emerging meanings (Bishop, 2007; Macmurray, 1961; Slife, 1995). For example, Heidegger (1968) and Buber (1958) as well, maintain that when we look at a tree in the meadow we are not merely piecing together limbs, leaves, and a trunk through sensory stimuli, which we then represent as a tree (i.e., as an "it"). What is seen and experienced is not only what our senses and learning history have represented as a tree but our relation to and engagement of the tree as it is standing in a meadow.

So too with addiction, experience for the individual is a meaning-filled and meaning-shared encounter (the interpreted reality) between the individual, others, and the

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world. According to relationality, that meaning-filled and meaning-shared encounter is the difference between knowing the "it" of addiction and knowing the lived experience of addiction. In fact, Bell (1995) warns that viewing experience from narrow, contextless perspectives could lead to conceptions where:

> Experience becomes an "it" and is treated like an object that can be expected to do the same thing to us every time. The theory of what experience does then bears no resemblance to the experiences actually occurring in local settings. In fact, the theory is used to shape and direct, or constitute, what does happen, so that it resembles what the theory says is happening (p. 10).

Relational perspectives avoid such "theory fulfilling prophecies" by assuming that each individual experiences life in a uniquely constitutive manner. Life is not merely objects and events to be subjectively perceived and processed by individuals', but rather life and its experiences constitute a mutually effectual "wholeness" that defy separation and self-containment (Buber, 1958; Reber, in press; Slife, 1995).

Experience from this perspective highlights the most fundamental tenet of a relational ontology—we live in and experience the world first and foremost as relationships. Slife (2005) remarks that:

> From a relational perspective, all things, including all practices [i.e. experiences], have a shared being and a mutual constitution in this sense. They start out and forever remain in relationship. Their very qualities, properties, and identities cannot stem completely from what is inherent or "inside" them but must depend on how they are related to each other. The outside is as important as the inside. (p. 4).

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This perspective would imply that addiction, and indeed every human experience, is based on an interrelated and interactive association with ourselves, others, and the world in general. This in turn implies that the addicted individual's personal views, perceptions, and feelings cannot be marginalized in favor of more objective features but must be considered as coequal in priority and significance.

There are a number of important implications to be considered when the addicted individual, and experience, are conceptualized from a relational point of view. First, the subjective experiences of the addicted individual are a rich source of significant meaning. For instance, Taylor (1985b) suggests that to grasp the individual's predicament we have to understand and appreciate his/her "vision of things", the "thoughts and perceptions", and the "meaning things have" for each (p. 120-121). The addict's feelings, perspectives, and personal interpretations are not to be lightly considered or marginalized in favor of therapeutic objectives. But, rather are validated as real, meaningful, and essential for the individual's therapeutic progress. Interventions from this perspective take on a decidedly "human" orientation.

Additionally, the here and now, lived experience, is the most prominent feature of reality for the addicted individual and would, by all rights, be the focus of intervention efforts. This is not to say that other significant features such as history, environment, and biology should be omitted in favor of a purely "subjective" approach. Relational interventions would also assimilate other pertinent areas of concern into interventions in order to facilitate a fully engaged means of addressing addiction. This may include exploring the intersection and influence of neurobiological, environmental, and

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developmental areas to establish their relational impact on the individual's interpreted reality.

Even so, the overarching implications for the addicted individual exist through two primary considerations: First each person's unique interpreted reality would be accepted and validated as significant sources of information and meaning. And secondly, the addicted individual's attitudes, ideas, and interpretations of the world have a significant bearing on addiction itself. This last point implies that the addicted individual shares at least some personal responsibility for the progression or the remission of the disorder.

Abstractionism would assume that objective entities, viz., the brain, are indeed sufficient to determine the subjective experiences of the individual (Slife & Hopkins, 2005). The subjective experiences of the mind are therefore thought to be the product of mechanistic processes similar to that of a computer—i.e., whatever is hard-wired or programmed in, forms the basis of all that comes out (Morris, 2003). Experience viewed under the lens of a rigid abstractionist perspective, such as determinism, would perceive "of all events in the spheres of human action, mental life, emotional dynamics, or the social realm [as] beyond human control" (Bishop, 2007, p. 295-296). The most dominant theory of addiction, the *disease model*, reflects such a view by placing the brain and its processes as the key determinants in addiction (Heyman, 1995). Valenstein (1998) agrees, stating that:

> It was not so very long ago that the cause of mental disorders was thought to be rooted in early experiences within the family, but now it is widely believed by most authorities and the public alike that the course is a chemical imbalance in

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brain…Brain chemistry is believed to be not only the cause of mental disorders, but also the explanation of the normal variations in personality and behavior" (p. 1).

For example, the past three decades have seen an unprecedented increase in the number of research studies focusing on the neurobiological implications of mental disorders, including, addiction (Andreasen, 1984; Cami & Farr, 2003; Shaffer, 2007; Volkow, Fowler, & Wang, 2003). Recent explorations have implicated the mu-opioid gene (Zhang, Kendler, & Chen, 2006), "neural inflexibility" by way of brain trauma (Chambers et al, 2007), and ADHD pathology (Wilens, 2006), just to name a few, as possible foundations of addiction.

If indeed the brain, as conceived by determinism, is the seat of experience, the most serious and onerous implication of addiction from this perspective is that certain individuals possess an innate vulnerability to addiction. Such an innate vulnerability would consequently imply that those who suffer from the disorder had little or no control from the very onset as to whether or not they became addicted. Moreover, this perspective would also imply that addicted individuals are not responsible for their mental states, their personal actions; or accountable for the consequences of their thoughts and actions.

The implications for addiction conceptions and therapies that adhere to an abstractionist and deterministic approach to experience may entail: 1. Interventions that are strongly prescriptive considering the individual's inherent disadvantages imposed by prior and deep-seated factors; 2. Therapeutic emphases that are centered on re-hardwiring (pharmaceutical) or re-programming (cognitive behavioral) the brain so that it adapts

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more positively to inborn deficits; 3. Pharmacological options that have been shown to be the most immediate way to alter brain function (Baenninger et al, 2004; Campbell, 1996; Julian, 2001; Nicholi, 1988).

Each of these particular implications may inadvertently minimize the "human" aspects of the therapeutic venture. Additionally, there is the underlying implication that the "talk" component of therapy may be unnecessary and unfruitful on account of the biological underpinnings of the experiences of the individual. Modern psychiatry in particular exemplifies this possibility by having shifted from a "talk intensive" format of earlier years to presently one of "medication intensive" (Shorter, 1999). Schwartz & Begley (2002) add that adhering to such constructs may mean that "...there is no need for a therapist to acknowledge a patient's inner experiences while attempting to treat, say, a psychological illness [such as addiction]..." (p. 2).

Manifestations in contemporary approaches reflecting this ontology range from psychoanalysis (Director, 2002; Sabshin, 1995) to pharmacological interventions that directly target specific areas of the brain (Cutler, 2005; Flores, 1997; Haefely, 1983; Julian, 2001). These examples and others illustrate how conceiving of experience through deterministic perspectives direct the tone and course of therapies and interventions.

By contrast, a relational perspective would assume that the brain, as a detached entity, is insufficient to produce the subjective experiences of the individual (Hedges & Burchfield, 2005; Slife & Hopkins, 2005; Yancher & Smith, 2005).While the brain has some surprisingly similar features to machines, such as the computer (McEwen & Lasley, 2002; Restak, 1991); according to relationality, unlike the computer, the brain is capable

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of choosing and running a variety of "programs" regardless of mitigating factors such as genetics or brain processes (Slife & Fisher, 2000). Thus, the experiences of each individual are not wholly determined by what might be thought of as "objective" factors.

The relational alternative to deterministic entities is or the capacity to choose within certain contextual parameters. Although the addicted person may have several "known risk factors"—such as those previously mentioned—the individual and their subjective world is not wholly "identified" or confined by these factors alone. Ainslie (2001) asserts that:

> It's possible to see, for instance, exactly where and by what neurotransmitters cocaine rewards the behaviors that obtain it; but pinpointing the transmitters doesn't explain how a conflict between alternative rewards gets resolved or why it fails to get resolved in some cases...It may be, for instance, that some alcoholics have inherited settings in their reward mechanisms that make alcohol more rewarding for them than for most people; but this doesn't tell why many alcoholics are conflicted about their drinking—[and]why they often decide not to drink despite the intensity of the reward... (p. 10).

Relationality would propose that the inexplicable variations referred to by Ainslie (2001) can be accounted for through the relational construct of contextual agency. Contextual agency here indicates the synthesis of the individual's context, such as biology or environment, and their ability to act within the constraints of those particular contexts (Slife, Yancher, & Williams, 1999).

Contextual agency assumes that factors such as neurotransmitters, reward mechanisms, history, environment, cultural, and other factors do indeed exert a

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meaningful influence on the experiences of each person's life (Slife, Burchfield, & Hedges, 2002). Relationality would also allow that certain factors are strong enough to exert continuity across contexts. For example, an individual severely addicted to alcohol who abruptly stops drinking could probably not escape serious withdrawal simply by choosing to change perspectives on life and their problems (Maxmen & Ward, 1995). However, the individual does possess many optional choices when perceiving or acting upon any aspect of addiction, including withdrawal, with varying degrees of freedom within the context.

Utilizing the previous example; contextual agency would imply that the individual may choose to either humbly view the experience of withdrawal as an opportunity to grasp the formidable consequences of addiction, or to view the event as evidence that they are indeed helpless victims of forces beyond one's control. The unique constituency and interplay of the alcoholic's contexts, relationships, and personally held beliefs form the basis of meaning for each of the individual's self-determined experiences.

A relational perspective of experience may also imply that addicted individuals are not "stuck" with any particular set of experiences according to antecedents or determinants (Slife, in press). For example, addicted individuals may not be able to choose their genetic inheritance, nationality, or demographic, but they can choose who and what to believe in (within contextual parameters) (May, 1991; Grof, 1993). In fact, relationality would assert that all addicted individuals are able to exercise degrees of contextual freedom which may in turn enhance the possibility of favorable recovery outcomes. The individual may exercise this freedom by also choosing to develop resources through "others" such as education and faith that may further enable them to

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act within and expand the boundaries of certain contexts (Slife & Reber, 2001). This approach implies that addicted individuals can "redefine" themselves and break out of the stereotypical roles that often accompany addiction disorders. Therefore, those who have a relational orientation are more likely to avoid "totalizing" the addict as a helpless victim in favor of an empowered view of the addicted individual.

Brigham (1991) seems to agree by warning that "Drug users who define themselves as sick or addicted have an explanation that seems both to account for their behavior and release them from personal responsibility for altering it" (p. 612). Since relational perspectives avoid abstractions such as stereotypical roles and labels the individual may be encouraged to think of themselves as not only possessing the problem but also possessing a significant part of the solution to the problem.

For instance, contextual agency implies that within the unique borders of each person's life is ample room to expand their personal possibilities through exploration, discovery, and choices (Slife & Richardson, 2008). Consequently, possibility, both positive and negative, becomes the natural by-product of a "self-determination" that influences the present, transforms the meanings of the past, and thus shapes the future (Taylor, 1985, 2007). The addicted individual would therefore have the opportunity to create constructive recovery experiences based on caring relationships, healthy environments, and wise choices (Flores, 1997; White, in press).

Determinism. The final comparative issue to be developed, relative and prior to an ontological analysis, is determinism. Although the previous section on experience covered some specific implications of determinism, this section will give a much broader

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overview as it relates to addiction in general. There will obviously be some conceptual overlap as this last section and its subject is addressed.

As used in an ontological sense, *determinism* is a fundamental view that all events are an effect of prior events or the culmination of a solid chain of events (Honderich, 2005; Slife, Yanchar, & Williams, 1999). Abstractionism is manifested in determinism by its rigid acceptance of natural laws that govern the human experience (Bishop, 2007). Natural laws are understood to be abstractions that reflect a fundamental and universal application regardless of contexts (Griffin, 2000). Slife, Mitchell, & Whoolery (2003) state "From laws of gravity to principles of pleasure (psychoanalysis), reinforcement (behaviorism), and organismic enhancement (humanism), these types of natural laws and principles supposedly govern all aspects of human beings, including our bodies, minds, and even spirits." (p. 3).

Relationality on the other hand emphasizes that antecedent events, although influential as contexts, are subject to the influences of interpretation, contextual variation, relationships, and agency. Abstractionism maintains that antecedents are important based on their fundamentally stable and unchanging nature. Conversely, relationality acknowledges the influence of antecedents but only in light of their co-constitutive, dynamic, and changeable nature.

Addiction, as conceived of from an abstracted deterministic viewpoint, is a condition precipitated by a sequence of antecedents such as genetics, environment, familial influence, cultural persuasion, etc. Schwartz & Begley (2002) comment that:

> ...what is clear is that the cascade of discoveries in neuroscience and genetics has created an image of individuals as automata, slaves to their genes or their

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> neurotransmitters, with no more free will than a child's windup toy...This scientific determinism holds that every happenstance [including addiction] has a causally sufficient antecedent in the physical world (p. 300).

For instance, if addicted individuals are a members of an ethnic group with a presumed predisposition to addiction (there are several, see NIDA, 2005; Valliant, 1995; White, 1998), live in the inner city, have an abusive parent, or have friends that use drugs, their present condition is traceable to one or a combination of these antecedents. Determinism is this sense carries with it a strong implication of vulnerability or exposure that in turn implies limited or no possibilities (Bishop, 2007; Slife & Hopkins, 2005). Simply put, precipitating factors such as biology and environment are the "cause" and the addicted individual is thought to be the "effect". Thus, the "whole" of addiction can be reduced to any number of causal factors.

Griffin (2000) provides another important way to understand this determinism "Determinism, in other words, leads to ontological reductionism, according to which all vertical causation goes upward, so that every "whole" is determined by its parts: The whole as such exerts no self-determined causation back upon its parts" (p. 250). This implies that the addicted individual as a "whole" is not only determined by prior and predominant elements, but also that the individual as a "whole" is powerless to exert a reciprocal influence upon the originating antecedents (Slife & Williams, 1995). Once again, this view, at its foundation, implies that "The self...is not imagined to be ultimately responsible for itself, or its ends and purposes. Rather, the self is entirely a function of environment and genetics..." (Schwartz & Begley, 2002, p. 300).

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Relationality, by comparison, would view addicted individuals as maintaining an interdependent and engaged relationship between their own unique elements and the world in which they live. This ontology views the individual as a nexus of interrelated relationships—linking contextual agency (see pp. 44-47 this chapter) with what might be considered "internal" (e.g., biology) and "external" contexts (e.g., environment). The capacity to choose within in a context of both possibilities and constraints mutually forms the "whole" of the individual. At the outset, this implies that individuals not only influence their "life outcomes" through the exercise of agency but are accountable, at least to some degree, on how individual circumstances are arrived at. This would seem to indicate that meaningful changes of context within the life of the individual could translate into a number of meaningful possibilities. Slife (in press) emphasizes this point by stating:

> Because clients [individuals] are always a constitutive part of their own contexts, they always contribute to and are thus (at least partly) responsible for the situation in which they find themselves...Suffering clients [e.g., addicted individuals] often experience themselves as "trapped" or "stuck," as if they are without possibilities. Part of the relational therapist's role in such cases is to attend to this "stuckness" as it arises and to explore with clients what responsibility they bear for their situation, however small it may be. As clients recognize and acknowledge their responsibility, they become aware of possibilities that have been hidden to them and these possibilities become alive once more (p. 13).

Slife's (in press) recommendation further implies that the faulty assumptions of individuals, such as feeling victimized by "determinants", may indeed be a significant

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constituent of the problem. In short, the addicted individual may also be addicted to assumptions that have no basis in reality. By this same reasoning, the assumption that individuals inherently possess the capacity to enlarge possibilities, exercise wise choices, and thus alter outcomes, may likewise be a significant constituent of any solution. Thus relationality, at its foundation, leaves the individuals not only more empowered but also more accountable for their life circumstances and outcomes (Bishop, 2007; Slife, in press; Slife & Williams, 1995).

Thus, relationality asserts that separating individuals and their choices from their ever widening contexts is neither possible nor desirable, especially as it relates to therapeutic endeavors (Slife, Harris, Williams & Zenger, 2005). Relationality would further support an approach to addiction that recognizes both the freedoms and the constraints specific to each individual. For instance, the therapeutic setting may provide a timely opportunity for the therapist to raise the consciousness of the addicted individual about specific contexts which either sabotage or reinforce recovery efforts.

Velasquez, Maurer, Crouch, & DiClemente (2001) support just such a contextual approach by drawing attention to the necessity of stimulating the addicted client's awareness of strengths and weaknesses in a variety of situations. These authors suggest several steps that not only aid the individual in being grounded in the here-and-now but also open the door for expanding personal possibilities. Suggestions such as *environmental reevaluation, social liberation, self-liberation,* and *helping relationships* are but a few categories intended to raise contextual awareness and set the stage for promising possibilities. For example, under the category of helping relationships the aforementioned authors advocate:

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> Relationships that provide support, caring, and acceptance to someone who is attempting to make a change. Clients who have abused substances often feel alienated and alone. By engaging in this change process, clients realize that they have a support system and are not isolated in addressing their substance use (Velasquez, Maurer, Crouch, & DiClemente, 2001, p. 9).

Here the implementation of supportive and virtuous relationships simultaneously minimize a known "trigger" for relapse, namely loneliness and alienation (Flores, 1997; Kurtz, 1982; Gorski & Miller, 1986), while also expanding the contextual boundaries of the individual through inter/intrapersonal contact.

Such approaches suggested by these and others would be dynamic and evolving enterprises based on the contextual possibilities and realities revealed in the therapeutic relationship. Slife (in press) emphasizes this point by noting that:

> ...the relational therapist attends closely to how the clients' relational patterns manifest themselves in the here-and-now therapeutic relationship. The here-and-now is perhaps the richest and most concrete manifestation of the client's context available to the therapist, and the strong relationist assumes that it is often where the greatest client change is to be found (p. 13).

In conclusion, relationality would propose that the individual is never fully determined by elements of "causation" but shares an interdependent relationship with the "determining" contextual factors. In this perspective neither the so called "causal" elements, e.g., genetics, nor the behaviors of individuals, e.g., their addiction, exist separately. Relationality assumes that individuals are always and forever in relationship

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with all aspects of their being and as such are able to influence these aspects to alter future outcomes (Slife, 2005).

Conclusion. As we have learned, ontological abstractionism and relationality have a fundamental bearing on how subjects within the natural and behavioral sciences are conceptualized (Honderich, 2005; Neuhaus, 1993; Slife, 2005). Also brought to light is how the five distinguishing features of ontology can serve as criteria for discovering the most basic assumptions undergirding theories of addiction. Once an adequate description and history of addiction theories is presented, at the beginning of Chapter Three, we should be fully prepared to bring to bear the ontological analysis on the selected frameworks.

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Chapter 3: An Ontological Analysis of Mainstream Addiction Conceptions

We will now undertake the ontological analysis of the more historically influential and presently mainstream conceptions of addiction. Prior to this analysis an ample grounding in the overall history of conceptualizing addiction will be provided.

Chapter 3 Overview, Relevance, and Rationale

Overview. Chapter Three is divided into five main topical headings: 1. A general overview and introduction of the chapter, including a basic review of addiction concepts, and a comparative review of the three frameworks under analysis, 2. A historical overview and introductory ontological analysis of the first and second eras of the *disease model* of addiction, 3. A historical overview and analysis of the third and current era of the *disease model* of addiction, 4. A historical overview and analysis of the *life process* model of addiction, 5. A historical overview and analysis of the *compound models* such as the *biopsychosocial model*. This particular order was chosen based on the chronology of addiction concepts and the relevance that the third interpretive period of the disease model and compound models has on the overall goals of this dissertation.

Relevance. The ontological analysis of each framework within Chapter 3 will be delineated into three basic areas of relevance. First, each conceptual framework will be described in detail including a brief historical overview. Understanding the cultural and historical background associated with the three frameworks is essential for appreciating the overall context in which the theories were conceived. Second, a brief analysis of the concerns and problems reported with each specific framework will be addressed. This segment will not only provide a contextual understanding of competing views but will also present an insight into the genesis of alternative ideas. And third, the mainstream

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approaches will be analyzed using the five conceptual topics developed in Chapter 2 and condensed as the Table of Distinguishing Features (found in the appendix).

Rationale for selecting the models for analysis. As explained in Chapters 1 and 2, carrying out an ontological analysis of addiction concepts will help determine the most fundamental assumptions that underlie each theoretical approach. The theories chosen for examination are evidenced in a variety of contemporary treatment applications that are presently being used or have at one time been explored as possible therapeutic approaches to addiction (Acker, 1993; Engs, 1990; Shaffer, 1997, 2007).

Each particular theory and its accompanying therapeutic methods have been selected for analysis because they are generally situated within one of the expansive conceptual frameworks and meet the following four criteria: 1. Theories chosen reflect the philosophical, professional, and societal contexts in which they were conceived (Flores, 1997; Mendola, 2003; Vaillant, 1982, 1995); 2. Each theory has had an enduring influence on the way in which addiction is presently faced (Farr, 1944; Kolb, 1925; Rush, 1814); 3. Each theory and its methods are exemplars of the framework in which they reside (Griffiths, 2005; Khantzian, 2003; Peele, 1985; Raistrick, 2008; Shaffer, 1986); 4. And finally, each theory chosen represents either historically significant approaches or novel contributions that may be less well known but nonetheless highlight an ontologically important perspective (Fingarette, 1990; Keller, 1976; Trudeau, 2005). These theories have served either in the past or present as prototypical approaches hoped to offer some basic truths about addiction.

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Conceptualizing Addiction: Historical Review

An abundance and diversity of concepts. To better appreciate each specific ontological analysis it may be helpful to provide a general outline of how addiction, up until the present, has been approached. Although the phenomenon known as addiction has been with us since recorded history the formal study and conceptualization of addiction is quite new (Shaffer & Burglass, 1981; White, 1998). For little more than two hundred years, conceptualizing addiction has presented a unique and daunting challenge for those working in the human and behavioral sciences (Shorter, 1991; White, 1998). Despite that challenge, many in the field have responded by proposing an abundance of intriguing and often unusual explanations of addiction (Collins, 1995; Vaillant, 1995). Indeed, just in last one hundred years, conceptualized explanations of addictive behavior, from academic, sociological, and scientific sources, have increased at an almost exponential rate (Acker, 1993; Miller, 1995; Neilson et al, 2008; White, 1998).

Science's response to addiction. Many early scientists believed that addiction emanated from: hidden desires for self-injury (Abraham, 1908, 1926; Rush, 1814), subconscious motivations to resolve castration anxiety (Simmel, 1929), or inner neuroses that were manifested in "autoerotic like" oral rituals such as drinking (Rado, 1933), just to name a few. However, the latter part of the 20th century has seen a definitive shift from psychodynamic orientations, such as these, to approaches that clearly follow a strong medical and specifically neurological frame of reference (Halikas, 1983; Hohmann, Larson, Thompson, & Beardsley, 1991; Kushner, 2006). Addiction history in the last forty years has been impacted by the implementation of fMRI scans and other medical technologies that shore up theories of addiction which highlight the brain's

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inborn functions, predispositions, and deficiencies (Miller & Giannini, 1990). For example, addiction may be predisposed through: dopaminergic deficiency in brain reward circuits (O'Brian, 2004; Sevy et al, 2006; Volkow, Fowler, & Wang, 2002), the brain's adaptation to early injury or neurotransmitter dysfunction (Koob, 2007; Blum et al, 2000), or life-stressors that negatively impact brain structures possibly resulting in maladaptive self-medicating behaviors (Khantzian, 1990; Selye, 1974; Sher & Levinson, 1982).

As we shall see, each particular conception, whether psychological or medical in its orientation has exerted, to a greater or lesser degree, an influence on the way in which addiction is confronted and treated today (Shaffer, 1986; White, 1998). Indeed, each contemporary method, technique, or institutional approach, within the three frameworks we will be analyzing, owes much of its success or lack thereof to theoretical alternatives previously explored (Acker, 1993; Cahalan, 1988; Shaffer, 1982).

Three Frameworks of Addiction Conceptions: A Brief Comparison

Introduction. There are literally hundreds of theoretical explanations of the phenomenon loosely referred to as addiction (Acker, 1993; Griffiths & Larkin, 2004; Mann, Hermann, & Heinz, 2000; White, 1998). Many approaches conceptually overlap and make it somewhat difficult to precisely categorize each under distinct frameworks (Shaffer, 1997). However, many scholars agree that the majority of contemporary conceptualizations and the more historically significant contributions fall under one of three general areas (Acker, 1993; Batson, 1992; Graham, Young, Valach, & Wood, 2008; Santrock, 2006; Shuttleworth, 2002). Each of these three frameworks represents a significantly different approach to dealing with addiction, although they may share

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similarities on the level of basic ontological assumptions (DuPont, 1998; Hughes, 2007; Neuhaus, 1993). Consequently, I will first summarize each model briefly here, and then engage in a more extensive analysis of their ontological assumptions, including important examples and illustrations as I go.

The disease model of addiction. The *disease model* of addiction, for example, strongly emphasizes the *susceptibility* of the individual to addiction through biological or psychological components, states, and processes (Acker, 1993; Flores, 1997; Jellinek, 1960; Wilkerson, 1966). Consequently, much of the research is preoccupied with positivistic, individualistic, and linear approaches to causality which includes certain mechanisms of addiction at the cellular level (Badiani & Robinson, 2004; Hughes, 2007; O'Brian, 2004). Thus, the disease model views the addicted individual as essentially vulnerable to becoming addicted prior to the exposure of an "addictive" substance or behavior (Andresen, 1984; Bell, 1993). Therapeutic approaches that reflect this particular philosophy design treatment protocols that are typically devised to alter inner states (such as pharmacology or psychotherapy) and merge the teaching of coping skills that enable individuals to deal with their condition (such as cognitive behavior techniques) (Alcoholics Anonymous, 2001; Lewis, 1994; White, 2008). Although the disease model is the most widely accepted approach to addiction, some have hesitated to fully embrace its primarily biological orientation.

The life-process model of addiction. The *life-process model*, on the other hand, strongly emphasizes the *culpability* of the individual as they choose personal and social preferences that ultimately expand into habitual patterns of indulging, coping, and relating (Peele & Brodsky, 1991; Szasz, 2003). While it shares the disease concepts

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assumption that addiction transpires within the individual, the life-process model opposes any inference that addiction occurs within the context of a disease process (Prentiss, 2005). Indeed, the life-process model is as much a statement of opposition to the disease model as it is a model of addiction (Davies, 1997). As a matter of fact, it is generally acknowledge that the debate between life-process and disease model advocates is one of the most contentious in the social sciences (Peele & Brodsky, 1991; Stein & Baldwin, 2000; Szasz, 2003; Wallace, 1993). The key tenet that seems to set the life-process model apart from the disease concept is it's distinctively non-science orientation (Peele, 1987).

Although the disease model and the life-process models approach addiction from divergent orientations, they both can be thought of as single construct models (Miller, 2002; Peele, 1987; Peteet et al, 1998; Raistrick, 2008). Single construct models no doubt offer some advantages in identifying the salient features of addiction (Acker, 1993; Leshner, 1997; Volkow, 2005); however, others have suggested more inclusive approaches in an effort to recognize the complex nature of addiction (Goldsmith, 1993; O'Brian, 2004; Stratyner, 2006).

The compound models of addiction. The *compound models* of addiction, such as the *biopsychosocial model*, vary from the previous two models in as much as they emphasize the blending and interaction of a variety of separate factors—such as biology, mental states, and environment (Epstein, 1995; Gifford & Humphries, 2006; Griffiths, 2005). The action and interaction of these factors are thought to initiate, reinforce, and increase the incidence and intensity of addiction (Kumpfer, Trunnell, & Whiteside, 1990). Addiction therefore is not the product of one particular determinant but is

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determined through several separate factors interacting to produce a pathological condition (Baer, 1993; Stratyner, 2006).

Therapies that reflect this multi-component model of addiction integrate a variety of measures such as: the mitigation of physical symptoms, awareness of psychological assets and liabilities, and the teaching of "life-skills" to promote healthy standards of living and appropriate social interaction (Epstein et al, 1995; Gifford & Humphries, 2006; Graham, Young, Valach, & Wood, 2008). These therapies may include the latest pharmaceutical agents, cognitive behavioral therapy, exercise therapy, massage therapy, and music therapy, just to name a few (Libby, 1982; Perlmutter, 1992; Slaght, Lyman, & Lyman, 2004; Treder-Wolff, 1990).

Not withstanding the multi-component approach of compound models they nonetheless have one important aspect in common with the disease model— both emphasize the susceptibility of individuals by way of a variety factors beyond their control (Wallace, 1985; Utena, 1996; Zuker & Gomberg, 1986). As we shall see, this commonality is a defining feature of these two concepts and has an important bearing on the overall theme of this analysis (Adame & Knudson, 2007; Baer, 1993; Efran, 1991).

The Analysis of the Disease Model of Addition

Of all the frameworks used to conceptualize addiction, the disease model has by far generated the most interest, research, and subsequent treatment protocols (Leshner, 1997; Mendola, 2003; Miller, 1991; White, 1998). Not by accident the disease model has also garnered the most criticism and spawned more theoretical spin-offs than any other approach to addiction (Cahalan, 1988; Fingarette, 1990; Neuhaus, 1993; Peele & Brodsky, 1991; Szasz, 2003; White, 1998).

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General Overview.

Introduction. The disease model has generally undergone three interpretive periods in the past two hundred or so years (Acker, 1993). Each period represents conceptual shifts that mirror a particular phase of development in the unraveling of addiction. Not to be overlooked, these conceptual shifts are also a reflection of the societal contexts in which these developments appear (Acker, 1993; Khantzian, 2003; Keller, 1943, 1976; White, 1998, 2002). This section will provide an analysis of the formative concepts of addiction which were developed in the first and second interpretive periods of the disease model. The third and current interpretive period of the disease model will be attended to later in this chapter.

In order to effectively understand the genesis and subsequent influence of the disease model, it is vital that we adequately ground it in the broader historical contexts of the times. In fact, each particular framework and its ontological assumptions are only accessible and meaningful through the thread of social and cultural contexts (Adame & Knudson, 2008; Hughes; 2007; White, 2004). In these contexts the various theoretical approaches to addiction were developed. Moreover, situated within these approaches are salient ontological assumptions which undoubtedly have shaped our efforts to mitigate addiction (Collins, 1995; Edwards, 1994; White, 2004, 2008).

As mentioned previously, the three historical periods have reflected the changing interpretation of what the disease model of addiction most fully represents (Acker, 1993; Jaffe, 1978; Keller, 1943, 1976). As we shall see, each period represents a different philosophical approach to addiction; although as this section and other sections unfold it will become apparent that there is some theoretical overlap between the various models.

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Review of ontology. It may be helpful, prior to the ontological analysis, to briefly review some of the more central aspects of ontology. Recall from Chapters One and Two that ontology, understood in its most basic form, simply means our assumptions of what is ultimately real and fundamental (Honderich, 2005; Slife & Richardson, 2008). Bear in mind that abstractionism and relationality have been chosen for this analysis in light of their application and prominence within the social sciences (Bishop, 2007; Slife, 2005).

On the one hand *abstractionism* assumes addiction is most real, and therefore most relevant for conceptualizations, when some elements of the phenomenon are separated from other elements; for example, the material aspects of addiction e.g., alcohol, are detached from the immaterial aspects of addiction e.g., contexts and relationships (Bishop, 2007; Slife, 2005).

On the other hand, *relationality* would assume that addiction is most real, and therefore more accurately conceptualized, when the material and immaterial aspects of addiction, are joined through contexts and mutually constitutive relationships (Slife & Richardson, 2008). Put simply, abstractionist methods would seek the separation or reduction of the factors from their contexts in order to identify and categorize the salient features of addiction (Bishop, 2007); and conversely relationality would seek the constitutive connection of the factors with their contexts and relationships in order to find the salient meanings of addiction (Slife, 2005).

As we recollect, context is only one of five distinguishing features of ontology, relevant to addiction, chosen to explicate the fundamental assumptions of addiction theories. However, the use or lack thereof of context will play a key role in establishing

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the ontological underpinnings of the addiction theories examined. Context also provides additional clarification and meaning to the other four features; reduction, identity, experience, and determinism. These points of interest will become more apparent as the analysis moves forward.

Ontological analysis of the first era of the disease model

Introduction. Somewhat concealed within the unique history of the disease model resides the philosophical underpinnings of what is now considered to be the most well received view of addiction (Colin, Kosten, & Kosten, 2007; Kuehn, 2006; Le Moal & Koob, 2007; Neilson, 2008; Volkow, 2005; White, 1998). The disease concept initiated nearly two hundred years ago has served as a master narrative, influencing every subsequent approach to conceptualizing and treating addiction (Heffernan, 2007; Keller, 1943; Levine, 1978; Mendola, 2003).

The ontological analyses of this model's first two formative eras will provide the reader with; a foundational understanding of conceptualizing addiction, a cursory ontological analysis of the initial concepts of addiction, and a brief preview of what the more in-depth analyses of subsequent models will be like.

Historical context. The first and foundational period of the disease concept has, by far, exerted the most revolutionary and lasting influence; and this primarily due to the efforts of one man (Farr, 1944; Jaffe, 1978; Warner, 1994; White, 1998). Although the earliest configurations of the disease model may have had various contributors; the majority of its principle teachings and indeed its enduring success can be traced to the work of Benjamin Rush (1745-1813) (Acker, 1993; Keller, 1943; Warner, 1994; White, 1998). Rush (1745-1814), a medical doctor and member of the First Continental

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Congress, held ideas on addiction and medicine that were as radical as his political views—he was one of the signers of the Declaration of Independence (Farr, 1944; White, 1998).

Rush lived in an era that was characterized by war, famine, disease, and hardship of every description (Farr, 1944; White, 1998). In fact, the earliest seeds of the disease concept and its fundamental precepts took root in the midst of the American Revolutionary War (1775-1783) (White, 1998). Not by chance, Rush's perspectives on addiction and especially alcoholism came when General George Washington, himself, was alarmed at the level of drunkenness in the Continental Army (Cherrington, 1920).

The first era's ontology

Introduction. Benjamin Rush (1745-1813), who was accorded the honor "Father of American Psychiatry" by the American Psychiatric Association in 1965 (North, 2000; Shorter, 1997), is also acknowledged by many as the principal originator of the disease concept of addiction (Acker, 1993; Keller, 1943; Warner, 1994; White, 1998). Rush (1814) considered the phenomenon of addiction to be a disease on the grounds that it appeared to be analogous to other diseases the medical profession treated (Braceland, 1976; Mendola, 2003; Rush, 1814; White, 1998)—that is to say it appeared to have a specific etiology (i.e., cause) and an observable pathology (i.e., course) (Campbell, 1996).

Rush's (1745-1813) training in the medical arts unquestionably oriented his investigations, primarily, to the area of etiology or the "... underlying mechanisms... [and] biological reality" of disorders (Campbell, 1996, p. 204). In the following sections I will demonstrate what Rush (1745-1813) and others thought were the most

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fundamental truths of addiction. In doing so, the distinguishing features of context, reduction, and determinism will be used to highlight the ontological assumptions inherent in each conception.

The power of intoxicants. The central and most overarching theoretical feature of the disease model, at its earliest, was the belief that intoxicating substances had the power to addict regardless of the individual's social standing, moral "constitution", or life setting (Keller, 1943; Levine, 1978; Mendola, 2003; White, 1998). So overwhelming were the addictive powers of substances thought to be; the indulgence of the person taking the substance was not considered a necessary condition for addiction and bodily harm to occur (Arthur, 1877; Beard, 1871; Day, 1867).

Consider for example these comments by Rush (1814) and other early scientist that allude to alcohol being thought of as sufficient to cause addiction and its attendant impairments:

> I have known many persons destroyed by ardent spirits who were never completely intoxicated during the whole course of their lives" (Rush, 1814, p. 4)... No one is safe from the approach of countless maladies, who is in the daily habit of using even the smallest portion of ardent spirit (Dods, 1887, p. 16)... The moderate use of spirituous liquors has destroyed many who were never drunk (Harris, 1887, p. 16)... In all its numberless forms, and in every quantity, it is the potent adversary of the mind (Youmans, 1887, p. 17).

Rush's (1814) coining of the term "ardent spirits" illustrates the extent to which alcohol was conceived of as the overwhelming agent of addiction. *Ardent* in this case is synonymous with flaming, consuming, and irrational behavior (Rodale, 1986) and *spirits*

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conveys an "other worldly" or disembodied power to the substances themselves (Rush, 1814). Notice how even the language used to characterize intoxicants suggests an abstractionist approach; given that "even the smallest portion of ardent spirits" has been decontextualized from the personal and wider context of the individual. This confers a dominant quality to intoxicants thus empowering them to the point where "no one is safe" from the overwhelming influence of "ardent spirits" (Dods, 1887, p. 16). Recall from Chapter 2 that the abstractionists' ontology of contextlessness assumes the most real and fundamental things are those that do not change across varying contexts.

In this instance, the "disembodied power" of ardent spirits was accorded a "stand-alone" status in the conceptualizing of addiction since it was abstracted from many types of contexts. It is abstracted from those who were "never completely intoxicated" (Rush, 1814, p. 4). It is abstracted from any particular "course of their lives" (p. 4). It is abstracted from people in general because "no one is safe" (Dods, 1887, p. 16). Moreover, the substances are so universally overwhelming that dosage is irrelevant since "even the smallest portion" is sufficient to addict those "who were never drunk." (Harris, 1887, p. 16). A relational perspective would assume that "ardent spirits" cannot be abstracted from contexts; indicating that the affects of intoxicants are variable in response to the relationships between them and the context in which they are used.

Notice how the abstractionist approach situates the influence of intoxicants in no particular context but in a more or less contextless state. This would imply that the qualities of the intoxicants would be addictive—without any appreciable change—from one context to the next. This is in contrast to a relational approach that would presume the qualities of the substances no doubt manifest various consistencies across some

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contexts; but would similarly assume that these qualities could also likely change in different people and contexts. For example, the overall qualities would likely be different for the Rabbi in the context of ritual religious use than that of the grief stricken individual in the context of "drowning their sorrows".

In spite of all the variables that undoubtedly were observed in this early stage of the disease model, Rush (1814) and others believed the "... countless maladies" of addiction stemmed from one basic factor; the presumed powers of "... ardent spirits" (Dod, 1887, p. 16). Since this approach bypasses accompanying contexts; all the ills of addiction, i.e., countless maladies, are reduced to the overwhelming properties of intoxicants. Reductionism as we remember from Chapter 2 assumes all things, including addicted individuals, can be understood and treated in terms of reducible components, with some components being more "basic" than others (Slife & Richardson, 2008). This perspective is clearly not relational since it suggests that intoxicants are more fundamental than other aspects of addiction. Such an abstraction implies that since intoxicants are more basic to addiction, they are then causal to addiction. Relationality however, would suggest that the intoxicant is no more "basic" than many other aspects of the addiction situation, such as addicted persons, their history, and their choices, to name just a few. All relevant components of addiction are irreducible given that they share the common similarity of mutual relationships (Slife, 2005).

The abstractionist assumptions in these perspectives however, are clear; anyone, anywhere, drinking even "the smallest portion ardent spirits" was generally vulnerable to "the countless maladies" of addiction (Dods, 1887, p. 16). This infers that "no one is safe from the "numberless forms" and "every quantity" of substances (Dods, 1887, p.

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16). . In short, the eventual outcome of addiction for the individual is determined by "moderate use", even "the smallest portion", and indeed even those "who were never drunk" (Rush, 1814, p. 4).

This situates intoxicants in the foreground of addiction and contextual features in the background of addiction; therefore the foremost determinant and thus "potent adversary of the mind" is capable of addicting anyone who is "in the daily habit" (Dods, 1887, p. 16). In Chapter 2 we are reminded that the abstractionist use of determinism assumes that human behavior can be determined by self-contained factors that obviate the influence of contexts and relationships. This approach differs noticeably in respect to the relational assumption that the individual is "determined" among other things, by a relational nexus of relevant factors, contextual possibilities (i.e., choices within contextual boundaries), environments, and relationships (Slife & Fisher, 2000).

If intoxicating substances were in fact abstracted from choices, contexts, and relationships; this undoubtedly reduced the complex "whole" of addiction to the contextless qualities of substances thus the "countless maladies" of addiction can be traced back to the deterministic features of addiction of "spirituous liquors" (Dods, 1887, p. 16). This is of course is completely unlike relationality, which would conceive of addiction being best understood as a behavioral "intersection" of dynamic factors, contextual possibilities, and changing meanings. The notion of "contextual possibilities," in particular, takes this ontological approach completely outside the deterministic conception, because it implies that the addict has the power to have "done otherwise."

Interactions between self-fontained factors. The first significant refinement of the disease model of addiction came in later years as Rush (1814) and others recognized

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the possibility that additional factors could interact with the self-contained properties of "ardent spirits" to produce addiction (p. 1). At this subsequent stage of the development of the disease model substances were no longer thought exclusively responsible for "many being destroyed [by] ardent spirits" (White, 1998; Rush, 1814, p. 4). For example, Rush (1814) commented:

> It is further remarkable, that drunkenness resembles certain hereditary, family and contagious diseases. I have once known it to descend from a father to four out of five of his children. I have seen three and once four brothers...affected by it (p. 3).

Here Rush (1814) describes the influence of "certain hereditary" traits (p. 3) that may be implicated in addiction through its interaction with the "smallest portions of ardent spirits" (Dods, 1887, p. 16). Hereditary influences are generally known as "the forces responsible for the resemblance between an individual and his ancestors" (Campbell, 1996, p. 319). Therefore the trait of drunkenness, as a hereditary force, may "descend from a father to four out of five of his children" to determine addiction if it interacts with intoxicants (Rush, 1814, p. 3).

In this case, the conceptual boundaries of the disease concept have been broadened considerably. The ontological orientation, however, still remains abstractionist due to the *interaction* of the self-contained factors of heredity and substances. The interaction at this point could also be considered self-contained because its addictive qualities are situated outside the influence of other contexts and relationships. After all, Rush (1814) witnessed this interaction's "contagious" affects determine addiction in "... three and once four brothers" (Rush, 1814, p. 3).

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Relationality, on the other hand, may indeed acknowledge the influence of heredity, substances and familial environments in the development of addiction. But, relationality would additionally assume other contexts such as individual history, positive family influences, cultural contexts, and individual choices as mutually constitutive and "determinant" of addiction.

Rush's (1814) expanded version infers that the addicted individual's present condition—"drunkenness"—is determined by the interaction of two contextless factors, i.e., "ardent spirits" and "certain hereditary" traits (p. 4-5). Heredity in this case, would be comparable to substances—i.e., essentially self-contained—since it is also assumed to be a contextless feature of the individual (as in eye or hair color). Eye color is not thought, by and large, to change with each change of context. Here, the abstractionist feature of reduction is clear. Even though addiction is no longer reducible to the intoxicants alone, its interaction with heredity is reduced to that of a powerful determinant; that "descend[s]... from a father to four out of five children" (Rush, 1814, p. 3). Thus, addiction as "contagious disease" is transmitted [from] "certain hereditary" traits despite the personal and broader contexts in which they are manifest (Rush, 1814, p. 3). Conversely, relationality would assume that the individual is never fully determined even by the interaction of substances and heredity; but is determined by the mutual relationship of a variety of factors and contexts, including the person's own ability to have done otherwise (his or her choices).

Many decades after Rush's (1745-1813) passing, the idea that spirituous liquors could somehow interact with the internal traits of the individual was a ubiquitous feature of scientific and popular ideas of addiction. For example, Mother Stewart of the

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Women's Temperance Christian Union warned children that "...many had the inherited taint coursing through their veins, and if they did not surrender to the inborn craving they would only escape through a lifelong battle." (Stewart, 1888, p. 275). Crothers (1904) even coined the expression "the inebriate constitution" as a simple way of describing the tendency of some to become addicted even in the presence of other mutually constitutive contexts such as traits, dispositions, and environments (Valverde, 1998, p. 50). Great Britain's leading expert on addiction Dr. Norman Kerr (1894) was even more specific by stating "the female parent is the more general transmitter of the hereditary alcoholic taint [of that] I have little doubt" (p. 142).

Notice how these quotes affirm the idea that an individual's inborn heredity produces traits, cravings, and a person's constitution which in turn operate beyond the realm of contextual realities. From this abstractionist perspective addiction was reduced to the contextless and self-contained properties of the "inherited taint", the "inborn craving", the "inebriate constitution" and the "alcoholic taint" (Stewart, 1888, p. 275; Crothers, 1904, p. 50; Kerr, 1894, p. 142). We can tell immediately, that such a position is not relational since it abstracts heredity and its resulting conditions from surrounding contexts, one of which would be the context of choice or agency. In fact, these early perspectives imply that the individual's choice has been superseded by the overwhelming determinant of heredity. Therefore, a person predisposed by heredity and its products is left with only two options; surrender [or a]... lifelong battle" (Stewart, 1888, p. 275).

The Second Era's Ontology

Introduction. The first major theoretical shift of the disease model emerged in the early 1900's as many in psychology resisted a purely biological explanation for

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mental illness and addiction in particular (Jaffe, 1978; Keller, 1976; Levine, 1978). As a result "The dominant view of the etiology of addiction shifted from physiological theories to psychological theories" (White, Kurtz, & Acker, 2008, p. 1). In fact, White, Kurtz, & Acker (2008) found that much of the psychology literature in this era "portrayed alcoholism not as a disease but as a symptom of disturbed character" (p. 1). It may be helpful at this time to note that portraying addiction as a non-disease meant physical disease; the "disturbed character' was in fact thought of as a product of a mental disease process (Roiblatt & Dinis, 2004; White, 1998). However, Rush's (1814) era where alcohol was thought to be the "great destroyer" was gradually coming to a close (p. 12).

Historical context. Even though first part of the 20th century was beginning to see a conceptual shift in addiction science; it also witnessed a victory for proponents of the disease concept who believed alcoholism originated in the substances themselves. The enactment of the 18th Amendment in 1920 was believed to the beginning of a new era in which "forced abstinence" would bring about an almost millennial reign of sobriety, prosperity, and peace (Levine, 1984). In fact, the charismatic preacher Billy Sunday (1862-1935) made such a pronouncement in 1919 before a crowd of 10,000, including a large radio audience:

> The reign of tears is over. The slums will soon be a memory. We will turn our prisons into factories and our jails into storehouses and corncribs. Men will walk upright now, women will smile and children will laugh. Hell will be forever for rent (Kobler, 1973, p. 5).

Despite Reverend Sunday's optimism, addiction and its attendant consequences continued to present practical challenges for the government and theoretical challenges

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for science. Just one of the practical challenges of government was whether to incarcerate or hospitalize those with continuing intoxicant use in spite of Prohibition. This particular dilemma highlighted the ongoing debate that sought to reconcile the issue of free-will or agency and its place or lack thereof in the disease concept (Adame & Knudson, 2007; Mendola, 2003).

A new perspective-a familiar ontology. Even as the proponents of Prohibition were regaling in their victory the perspectives surrounding addiction were already beginning to experience transformation at the theoretical level (Acker, 1993). Although some of the most fundamental aspects of addiction changed during this second historical period; I will argue that these new perspectives nevertheless continued to be situated as ontologically self-contained and abstracted factors. This era's core theoretical shift was centered on the idea that addiction emanated from psychological flaws and deficits found "within" the individual (Acker, 1993; Cherrington, 1920; Kolb, 1925). These seemingly innate features were expressed through the addicted individual's "willful" and pathological behavior (Acker, 2003; Levine, 1078; Roiblatt & Dinis, 2004; White, 1998). Indeed, the addicted individual's primary character or identity was most often defined by labels or criteria that indicated the presence of self-contained and deterministic influences. For instance Irwin Neff (1915), a psychiatrist, superintendent of the Foxboro State Hospital in Boston, and a leading proponent of this conceptual shift concluded that:

> ...inebriety is an expression of nervous weakness, the nervous weakness being inherited, and a psycho-neurotic fault; founded on this weakness, manifestly a defect, is a habit we call drunkenness. The inebriate is therefore the sum total of

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> his personality, or make-up, and the symptoms which we call drunkenness (p. 401).

Notice the way in which Neff (1915) reduces the addicted individual's identity to that of "inebriate" by way of a set of internal and self-contained entities – the identity feature of the abstractionist ontology. Entities such as "nervous weakness", "psycho-neurotic fault[s]", and "defect[s]" are viewed as "inherited" aspects of the individual and thus unresponsive to the wider context of the individual. Bear in mind, that some of the ways of viewing heredity are themselves generally understood as abstractive since inherited traits are typically thought to be indicative of some aspects of an unchanging identity and thus beyond the influence of contexts. Additionally, we learned in Chapter 2 that an abstractionist approach to identity assumes that; identity can be reduced to self-contained factors (e.g., weakness, faults, and defects), identity is the deterministic result of these self-contained factors (the inebriate identity), and identity remains autonomous and constant despite the evolving and emerging world around it (as heredity is assumed to be) (Appendix A).

Concepts from this perspective notably lack the relational assumption of identity that even hereditary features are essentially responsive to the contexts, relationships, and choices of each individual (German, Hurst, Wood, & Gilchrist, 1998; Imesch, Wallow, & Albert, 1997; Starr, 1999). Remember from Chapter 2 that relationality assumes "all things [including psychological aspects and personality traits] are not first self-contained entities and then interactive... [But] have a shared being and a mutual constitution" (Slife, 2005, p. 4).

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Neff (1915) uses abstractionism to reduce "drunkenness" and even the individual's "inebriate" identity to the "sum total of his personality, or make-up, and the symptoms which we call drunkenness" (Neff, 1915, p. 401). This in essence reduces addicted individuals and their experiences to a seemingly static set of "internal" features i.e., personality, make-up and symptoms – the reductive feature of abstractionism. In doing so, Neff (1915) essentially personifies or objectifies the addicted individual's identity according to seemingly internal and preexisting psychological or characterological conditions. Once more we see that the distinguishing feature of identity has been highlighted by Neff's (1915) reductions of "personality, make-up, and symptoms" (Neff, 1915, p. 401).

This approach also does not allude to these and other features being in a mutually constitutive relationship; in which case the relationship assures the ongoing and transformative influence of contexts, relationships, and choice on identity. Bear in mind that identity from a relational perspective is not simply the "sum total" of any given set of factors. To "sum" something is to assume the independence of the factors being summed. Merely summing mutually constitutive factors does not account for the inherent influence that each factor has on the other in its very essence.

Neff's (1915) perspective also seems to be missing any reference to the "ebb and flow" nature of a relational identity, "that is neither static nor autonomous but reveals a changeable quality that is dependent on and evolves through relationship, context, and contextual agency" (Appendix A). Thus Neff's (1915) perspective manifests a similar ontology to that of Rush's (1814) in as much as only the precipitating factors have

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changed, from that of the biological interacting with the intoxicants to one of the psychological (e.g., character flaw) interacting with the intoxicants.

Momentum for a psychological or characterological perspective of addiction grew and received a noticeable boost when Lawrence Kolb (1881-1972) conducted a number of landmark studies which supposedly repudiated a biological basis for addiction (White, Kurtz, & Acker, 2008). In fact, Kolb (1925), who later became Assistant Surgeon General of the U. S., received critical acclaim for a study that overturned previous findings of Bishop (1913) and Pettey (1913) who claimed that blood born antibodies were the biological starting point for addiction (Acker, 1993; Kolb & Dumez, 1925). Once Kolb (1925) had "refuted," to his and many others satisfaction, an etiology of addiction which originated in biology he concentrated primarily on what he believed to be its psychological origins. Acker (1993) illuminates these sentiments and conceptual orientation by observing:

> Kolb (1925) argued that while anyone could become dependent on opiates given sufficient continuous administration, only certain types of individuals would develop problems with addiction. These individuals, he claimed, had "psychoneurotic deficits" that pre-existed their drug use. Kolb (1925) characterized addicts "as 'little men' with powerful social ambitions but without the requisite abilities to fulfill them" (p. 201).

Kolb (1925) further conceptualized addicts as "unstable individuals, who are so susceptible to addiction, [they] get a sense of relief from the use of narcotics that *normal* [italics added] people do not experience" (p. 300). Indeed, Kolb's (1925) personification of addicts as abnormal or "little men" was evidenced in his research in which he required

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"supplementary corroboration to rule out uncertainty ...because of the addict's reputation for untruthfulness" (p. 300).

Kolb's (1925) approach to conceptualizing addiction fits an abstractionist's ontology much in the same way as Neff's (1915) perspectives do. That is, a number of psychological and characterological factors were abstracted from the contexts and relationships in which they appeared as well as being abstracted from the individual's agency – the determinism feature of abstractionism. For example, the preexisting "psychoneurotic deficits... of certain types of individuals" were decontextualized and therefore unresponsive to other contexts. Consequently, "certain types of ... unstable individuals" were determined to respond abnormally to one context—that of the narcotic—but remain unresponsive to other contexts that may mediate the narcotics overly "relieving" affects, e.g., individual health, medication, and a public environment (Kolb, 1925, p. 300). In short, it seems that Kolb (1925) endowed these internal and preexisting "deficits" and inherited instabilities with a dominant quality that superseded context and therefore determined the individual.

Relationality would grant that "psychoneurotic deficits..., certain types of... unstable... individuals" and the overly relieving qualities of narcotics do indeed manifest somewhat of a consistency in their influence from context to context. However, relationality would also assume that the individual's capacity to choose—that is their contextual agency—can also provide the possibility for change. From this perspective, relationality would presume that each individual's possibilities may contract or expand in response to changing contexts and the way in which the individual chooses to act within that changing context.

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Kolb (1925) also approached the distinguishing feature of experience from an ontologically abstract perspective. As we remember from Chapter 2, according to abstractionism, humans and their realm can be delineated into two distinctively separate worlds, the objective world (i.e., objects) and the subjective world of experience (i.e., perceptions of objects) (Slife, 1995). The subjective world involves perceptions, ideas, feelings, and other "mind" related processes (Bishop, 2007; Slife & Hopkins, 2005).

Kolb (1925) abstracts the "sense of relief from the use of narcotics that normal people do not experience" from all other contextual considerations except for; the constitutional susceptibility and resultant instability of the individual (p. 300). In other words, Kolb (1925) accounts for the individual's abnormal experience with narcotics as being determined primarily by the self-contained forces of preexisting "psychoneurotic deficits" (p. 300). However, singling out one or a set of self-contained entities does not account for experience from the relational perspective. Rather relationality would assume that each individual's experience is an interpretive reality made up of a synthesis of historical contexts, biological distinctiveness, environment, relationships, and an individual's personal preferences on how they choose to view their experience.

Kolb (1925) also describes addiction as the product of certain psychological limitations that lead to the individual's being personified as "Little men... unstable individuals... and susceptible [individuals]". Such characterizations were abstracted from and thus unresponsive to other specific and/or expansive contextual features of the individual. Such features may include but not be limited to; the past as a whole, family upbringing, community "norms", and faith commitments. Kolb (1962) continued throughout his career to use reductionism and determinism to assert the dominance of

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psychological factors in the etiology of addiction. His assertions leave little doubt that this one principle element could override all other contextual influences. For example, Kolb (1962) emphasized:

> The question whether drug addicts are recruited from the ranks of the mentally ill is frequently raised. Excluding the few normal persons who become addicted through the use of a narcotic in a medical treatment, the answer is affirmative. This was the over-ridding conclusion of an intensive study which I made of the personalities of 230 addicts representative of all walks of life and from many different areas of the country...The present-day addict combines a number of traits which add up to his being an immature, hedonistic, and socially inadequate personality... The inebriate impulse is the most important cause of drug addiction (p. 5-6, 38 & 42).

As we shall see, Kolb's (1962) use of abstractions in situating addiction as a condition precipitated by mental illness and the abnormal personality highlights the distinguishing features of context, reduction, and determinism. For example, in this quote, Kolb (1962) reduces the etiology of addiction to mental states and personalities that are manifested as deterministic agents of inebriety. In doing so, Kolb (1962) bypasses, and therefore negates, the influence of a variety of contexts embedded within "all walks of life and... many different areas of the country" (p. 38). This seems to imply that mental states and personalities are self-contained entities that supersede even the widest of contexts.

Positioning mental states and personalities as being essentially unchanging across all areas of life is contrary to a relational perspective. Relationality would assume that

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the individual is a unique and dynamic nexus of embedded contexts (e.g., "walks of life [and] different areas), relationships, and choices. However, when Kolb (1962) uses the term "inebriate impulse" he implies these forces are so overwhelming that individuals are in effect "captive" to their own personality, defects, and deficits. In short, the unfortunate individual has little choice but to follow the inclined slope of "susceptibility" which leads to "inebriate impulse[s]" (Kolb, 1925, p. 300).

Kolb (1962) goes so far as to assert addicted individuals have been "recruited" (or determined) into a life of inebriety through "mental illness..., traits..., and impulses [which] cannot help but to "add up to an immature, hedonistic, and socially inadequate" life (Kolb, 1962, p. 5-6). If Kolb (1962) had used a relational approach he no doubt would have conversely assumed the individual is not "determined" by one set of psychological contexts alone, but lives in a world of a changing relationships, contexts, and possibilities (Slife, 2005).

For the next forty years, Neff (1915) and Kolb's (1925) viewpoints of the innate flawed character were to have a lasting impact on the way in which addicts were regarded and addiction was subsequently treated (Acker, 1993). As we have seen, these scientists and others preserved the abstractionist tradition previously established by Rush (1745-1813) and others. The second era's views of the deviant and pathological nature of the addict no doubt contributed to the growing discontent about how addicted individuals were regarded and may have once again set the stage for conceptual transformation (Acker, 1993; Heald, 2004; Wilentz, 2007).

The third era's ontology

Introduction. If there is one word that describes, and indeed epitomizes, the third

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and current era of the disease model of addiction that word is *technology*. In particular, medical technologies such as DNA sequencing, imaging technologies, and pharmacological breakthroughs have significantly altered the way in which addiction has been perceived over the last sixty years (Armstrong & Armstrong, 1991; Le Moal & Koob, 2007; Mixdorf & Goldsworthy, 1996; Olbrich et al, 2006; Shorter, 1997). The development of these and other medical specialties have helped create a climate in which older "stigmatizing views of addiction gave way in some circles to less punitive and more pragmatic [views]" (Acker, 1993, p.202). Beginning in the early 1950's medicine and its supportive technologies were poised to offer addiction conceptions a more scientific and less moralistic frame of reference (Keller, 1976; Levine & Reinarman, 1994). As Acker (1993) points out "In this setting, a conceptual shift occurred in the disease model of addiction, a new functionalist description emphasized behavior out of control (a system in disorder)...not an inherent flaw in character structure as posited in Kolb's model" (p. 203).

Whereas, previous perspectives have pinpointed intoxicants or the psychology of the individual as the basis for addiction, this era, through the use of medical technologies, has located the underlying bases for addiction in the brain (Nestler & Malenka, 2004; Olbrich et al, 2006; Quickfall & Crockford, 2006; Volkow, 2005). Such a linear perspective carries with it "the notion that addiction is caused by some irreversible deficiency or pathology and that treatment is, therefore, primarily a medical concern (Raistrick, 2008, p. 2).

Although this third period represents a notable conceptual departure from the previous eras (Acker, 1993; Mendola, 2003), I will attempt to show that it nonetheless

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retains abstractionism in what is believed to be the most fundamental aspects of addiction. For convenience and clarity I will also distinguish this concept from previous others by referring to it as the *modern disease concept*, a term readily accepted by many in the field (Acker, 1993; Wallace, 1993; White, 1998).

Historical context. The historical context for the formative years of the modern disease concept of addiction has often been alluded to as the Vietnam War Years (1959-1975) (Stanton, 1976; Wilentz, 2007). The social and cultural backdrop for this period was marked not only by the war but by astonishing advances in the sciences, and unprecedented social events such as civil rights legislation, the feminist movement, and reform of the criminal justice system (Acker, 1993; Edelman, 1985; Helzer, Robbins, & Davis, 1974; Stanton, 1976). Some of the more noteworthy populations that addiction was impacting during this period were poor African Americans, Vietnam veterans, and increasing numbers of women (Golosow & Childs, 1973; White, 1998; Wilentz, 2007).

In our present social and cultural context addiction is no less daunting than previous eras. In fact, trends in the abuse of intoxicants and their consequences continue to kindle a disproportionate investment of both human and financial resources (American Medical Association, 2008; Miller & Brown, 1997; NIDA, 2008; Schumaker, 2001; White, 1998). Indeed, today more than 11% of the total federal budget of 3.3 trillion dollars is spent on the research, treatment, and consequences of addiction (SAMHSA, 2009).

The era of biology. The research, conceptualization, and treatment of addiction in the modern era appear to be focused almost exclusively on a biological—specifically neurological—frame of reference. Dr. Alan Leshner (1997), former director of the

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National Institute of Drug Abuse, emphasizes "...addiction is, at its core, a consequence of fundamental changes in brain function... changes in brain structure and function is what makes it, fundamentally, a brain disease. If the brain is the core of the problem, attending to the brain needs to be a core part of the solution."(pp. 45-47).

In order to explicate this approach and analyze this period's ontological assumptions, I will endeavor to concentrate on what seems to be this model's three most distinctive conceptual facets. First, addition is notably viewed as pathological in origin, symptoms, and outcomes (Flores, 1997; Jellinek, 1960; Valliant, 1983). Second, addicted individuals are thought to experience a fundamental loss of control over their use of intoxicants (Miller, 1991). And third, addiction is considered a life-long and defining ailment that maintains an unseen presence within individuals regardless of the actions of individuals or any transformations in their personal or surrounding contexts (Neuhaus, 1993).

Distinctive ontological perspectives in the modern disease model.

Addiction as pathology. To understand the ontological assumptions of the issue of pathology in the modern disease concept of addiction is to first understand the concept of heredity (Crabbe, 2002; Edenberg, 2002; Kreek, Nielson, Butelman, & LaForge, 2005). Indeed, Neilson (2008), at Rockefeller University's Laboratory of Biology of Addictive Disorders, demonstrates this concept by asserting that "A major contributing factor to the development of addiction is genetic predisposition. Epidemiological studies in men have found that approximately 40-60% of the risk of developing an addiction to heroin is genetically determined..." (p. 417). Thus, addiction fits a mainly linear conception of disease etiology and pathology as evidence by a strong genetic component

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(Engle, 1997; Smith, 2005; White, 2005). That is to say, there is a sequential ordering of factors in the initiation and processes of addiction. Higuchi, Matsushita, & Kashima (2006) also assume this point by stating "Alcohol dependence is a complex disorder with a well documented highly hereditary nature... two gene complexes, ADH and ALDH2, have been identified as having defined effects on alcohol use and liability to dependence in humans." (p. 253).

Addiction that is "genetically determined" implies that the individual has been predisposed to addiction from birth, i.e., they have within them a "liability to dependence" (Neilson, 2008, p. 417; Higuchi, Matsushita, & Kashima, 2006, p. 253). Considering all the factors that could be thought of as constituting addiction, emphasizing inheritance and genetics in such a way expresses a strong preference for conceptualizing dependence as the result of abstracted and self-contained entities of biological origin. As we shall see, these general conceptions manifest the distinguishing abstractionist features of r*eductionism, de-contextualism, and determinism.*

In the case of *reductionism*, addiction has been reduced to the "Major contributing factors [of] gene complexes [such as] ADH and ALDH2 [and their] defined effects" (Higuchi, Matsushita, & Kashima, 2006, p. 253). That is to say, the pathology or course of the disease can be reduced or traced back to its most fundamental source, the individual's genes. Regarding *de-contextualism*, "If the brain is the core of the problem..."—i.e., the central, innermost, and essential factor in addiction—then other contextual factors such as history, environment, relationships, and choices are at the periphery of the problem (Leshner, 1997, p. 47). This implies that the brain and its "hereditary nature" are fundamentally unresponsive to the contexts in which the

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individual lives (Higuchi, Matsushita, & Kashima, 2006, p. 253).

With reference to *determinism* the individual's response to intoxicants—i.e., their "brain disease"—has already been determined due to their "genetic predisposition" or "liability to dependence" (Leshner, 1997, p. 47; Nielson, 2008, p. 417). Even if some researchers would add in nurture (environments) with their nature (genetics), the conception, as we will see in another section, is still determinative of the addict. In other words, individuals have no real choice in what genes they have (or environment they have experienced); consequentially they have no choice in their "genetically determined" response to intoxicants (Nielson, 2008, p. 417). This implies that even though addicts and their condition are "highly complex", addiction is something of a foregone conclusion for those predisposed by the brain and its genetic endowment (Higuchi, Matsushita, & Kashima, 2006, p. 253).

The relational perspective of the concept of pathology, as it relates to addiction, would agree with some of the abovementioned assumptions but would no doubt express a different view on others. For example, relationality would no doubt assume that the brain and its genetics may be "major contributing factors" in the development of addiction (Higuchi, Matsushita, & Kashima, 2006, p. 253). However, relationality would assume that the "core of the problem" regarding addiction could be better articulated from the assumption that factors are of a mutually constitutive character rather than self-contained reductions (Leshner, 1997, p. 47). Thus, individuals are not determined by their "liability to dependence" but live in a nexus of possibilities dependent on the individual and general context and their choices within that context (Slife, Harris, Wiggins, & Zenger, 2005).

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Addiction as loss of control. From the earliest formal theories of addiction in Benjamin Rush's era (1745-1813) to present-day conceptualizations, loss of control has been and still is the most enduring theme in nearly all perspectives of addiction (Acker, 1993; Jellinek, 1960; Menninger, 1938; Vaillant, 1995; White, 1998). Indeed, the modern disease theory places loss of control as the "hallmark of addiction" (Raistrick, 2008, p. 2) and the defining feature of its model (American Psychiatric Association, 2000; Flores, 1997; Fields, 1998; Khantzian, 2003; Leshner, 1997; Raistrick, 2008; Shaffer, 2007). Miller & Kurtz (1994) agree specifically by commenting "The definitive symptom of alcoholism is loss of control." (p. 160). As we shall find, there are a number of compelling arguments as to why loss of control has been situated as "The cardinal manifestation of an addictive disorder..." (Miller, 1993, p. 18). We will further discover these arguments are situated in the framework of the abstractionist ontology.

For example, Dr. Steven Hyman (1995), a professor of Neurobiology at Harvard University, expressed an outlook that "... views addiction as a disease uniquely tied into the neural underpinnings of motivation and emotion... This results in a perversion of the normal volitional control of behavior." (Flores, 1997, p. 17). Viewing the compulsivity of addictive behavior in this way involves a number of abstractionist assumptions. First, reductionism has been employed to support addiction as a "disease" since the pathology of "[perverted] volitional control" can be reduced to the etiology of "neural underpinnings"—thus bypassing the specific and general contexts of the individual (Flores, 1997, p. 17). That is to say, the "definitive symptom", *loss of control*, can be traced to an underlying mechanism—in this case the biological reality of neural underpinnings (Flores, 1997, p. 17).

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Secondly, abstracting the issue of "volitional control" from the entirety of addiction issues suggests that this particular feature of addiction is a self-contained set of symptoms and therefore becomes the "hallmark of addiction" (Raistrick, 2008, p. 2). In short, other features of addiction such as the contexts in which loss of control is experienced are only secondary to any meaning conferred by "The cardinal manifestation of an addictive disorder" (Miller, 1993, p. 18).

And third, since loss of control is placed in the forefront of this perspective it is assumed that the individual is unable to choose other "volitional... behavior[s]" when it comes to the addictive substance. That is to say, the context of "normal volitional control" has been subsumed in the context of abnormal or defective brain functions (Flores, 1997, p. 17). Thus, through the feature of determinism the individual's motivation and emotion can primarily be accounted for through a "unique" causal relationship between "neural underpinnings... [and] volitional control..." (Flores, 1997, p. 17).

As medical technology has moved forward in the 20th and 21st centuries the subject of loss of control has been explored extensively where not only the brain is implicated but in particular precise brain regions and their processes (Seeram, 2005; Sevy et al, 2006; Volkow, 2005). These specific brain sites and their processes are now targeted within research to pinpoint the neurological underpinnings of loss of control and the causal links to addiction (Kuehn, 2006; Miller & Kurtz, 1994; Trudeau, 2005). Referring to this emphasis Spanagel & Heilig (2005), researchers for the National Institute of Drug Abuse, report "The application of various brain imaging techniques to drug addicts have so far provided the most insights into the brain sites involved in

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craving and loss of control." (p. 1818). This is born out by Trudeau (2005), writing for the Journal of the American Medical Association, who reports:

> [Laboratory] findings have led scientists to postulate that low levels of D2 dopamine receptors could increase an individual's susceptibility to addiction or, conversely, that high levels of D2 dopamine receptors could have a protective effect. These findings suggest that improper regulation of these regions by dopamine in addicted individuals may underlie their loss of control and compulsive drug intake. (p. 1828).

As we recall from the Table of Distinguishing Features, abstractionism assumes "The best knowledge stems from separating or abstracting the object of interest from its context... Contextual factors are separated and eliminated, as much as possible (e.g., the laboratory), to minimize distortion of the phenomenon of interest" (Appendix A). In this example, scientists in the laboratory arrive at the "best knowledge" by utilizing "various brain imaging techniques" to separate "brain sites involved in craving and loss of control" from the specific and general contexts of the individual. Thus, "loss of control and compulsive drug intake" are reduced (through de-contextualization) to the "improper regulation of [brain]... regions by dopamine" (Trudeau, 2005, p. 1828). By the same token, individuals are determined by their "susceptibility" or immunity to addiction based on specific levels of "D2 dopamine receptors" regardless of other "determining" factors such as context, relationships, and volition (Trudeau, 2005, p. 1828).

Had relationality been used to articulate the phenomenon of loss of control, in the context of a modern disease concept, it may have included three primary assumptions. First, relationality would assume that the "mutually constitutive and inextricably

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intertwined" nature of addiction is its "Cardinal manifestation" (Miller, 1993, p. 18). This means that all important features of addiction share a mutual and interconnected relationship rather than the reductionism of self-containment or causal relationships. In contrast to the abstractionist perspective; motivation, emotion, and volitional behavior cannot be reduced to neural underpinnings but are "inextricably intertwined with their concrete contexts ..." (Slife, 2005, p. 2). Such "mutuality" creates possibilities within the parameters of context rather than a determined course of addiction and loss of control i.e., self-contained entities, such as the brain and its component "sites" (Josselson, 1996).

Second, a relational perspective would view volitional will as an integral and embedded constituent of the individual's experiences and contexts—occupying the same relational space as other more readily observable contexts, i.e., brain sites and neurotransmitters. This assumes all significant factors of addiction, including volition, are joined through a nexus of mutual relationships and influential contexts. Loss of control from this perspective suggests that individual's personal experiences of volition may expand or contract as their contexts change—indicating an agentic rather than determined character of volition.

Third, *control* for the relationalist exists as a contextual feature embedded within other contexts, such as culture, history, environment, and the contexts of physiology. This would imply that control has a distinct "ebb and flow" rather than the deterministic or set nature assumed by abstractionist perspectives. In this sense, *mutuality* rather than *specificity* of factors accounts for the behaviors and phenomena of addiction. Relationality would thus presume the individual is not determined on the basis of neurological "liabilities" or "assets" (i.e., dopamine levels) but lives in a continuum of

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possibilities created by choices, contexts (of which the brain is an important context), and relationships. Indeed, the relationist would hold that some type of control is used in every aspect of addiction, such as, choosing gratification, escape, and virtual experiences over fulfillment, engagement, and authentic experiences. Often short-term control (e.g., acquiring substances, avoiding detection) is chosen over long-term control (e.g., measures to initiate recovery), but the person's "human agency" is never really relinquished.

Addiction as a defining ailment. In the previous two sections, Addiction as Pathology and Addiction as Loss of Control, we have seen how the modern disease model uses the abstractionist features of decontextualization, reduction, and determinism to conceptualize addiction. In this concluding section, Addiction as Defining Ailment, our analysis will address how the distinguishing features of identity, experience, and context are likewise used to frame addiction from an abstractionist point of view.

One of the most stable aspects of addiction theories, including the modern disease concept, is the notion that addictive behavior, once initiated, largely defines the individual (Gorski & Miller, 1986; Jellinek, 1960; Menninger, 1938; White, 1998). Recall from the Table of Distinguishing Features that abstractionism views identity as prior to relationships (i.e., the self-contained self), and that identity is based on relationships of similarities e.g., universals laws and traits (Appendix A). The modern disease concept reflects this perspective by framing the addictive identity from the perspectives of *innate vulnerability, constitutional incapability, powerlessness, and the addictive personality* (Alcoholics Anonymous, 1939; Eysenck, 1997; Kellogg, 1993; Le Moal & Koob, 2007). Indeed, the concepts of "once an addict, always an addict" and the

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"dry drunk" emblemize a commonly held perception of the addict's enduring identity (Flores, 1998; Kellogg, 1993, Koski-Jannes, 2002; Walters, 1996; White, 1998). In truth, the very definition of *addict* is someone who has wholly bound themselves over for life to something or someone in servitude, devotion, or loyalty (Redfield & Brodie, 2002, p. 2). In this sense, addicts—just as diabetics, asthmatics, or epileptics—are identified and in fact exemplified by the dominance and permanence of their condition. Defining the individual and conceptualizing the disorder as universally consistent across all contexts illustrates the abstractionist approach to what is considered the most real and fundamental aspects of addiction.

Indeed, the modern disease model notably reinforces, through an abstractionist point of view, the intractability of addiction as a ubiquitous and lasting constituent of the addict identity. For example, noted author and sociologist Gerda Reith (2004) observes:

> The relinquishing of control over one's consumption formed the basis of a specific type of person – a 'singular nature'. The figure of 'the addict' was characterized as a deviant identity; one that was lacking in willpower, and whose consumption was characterized by frenzied craving, repetition, and loss of control. (Reith, 2004, p. 289).

Sedgwick (1993) strengthens such a position by noting "Addiction, under this definition, resides only in the structure of a will that is always somehow insufficiently free, a choice whose voluntarity is insufficiently pure." (Sedgwick, 1993, p. 132). And, the distinguished neurologists' Le Moal & Koob (2007) remind us that genetic perspectives assume the addictive identity of some even prior to consumption "...it is important to bear in mind that some individuals may become addicted almost after the first encounter with

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a drug ... [implicating] an individuals intrinsic vulnerability." (p. 378).

From the above quotes we see how the issue of identity in the modern disease concept is situated as an essential, self-contained, and abstracted concept. In this case, the "relinquishing of control" over substances is abstracted from control in other areas of the individual's life. The "deviate identity" is assumed to stem from "a singular nature" (i.e., identity) which is the abstractionist reduction of "frenzied craving, repetition, and loss of control." (Reith, 2004, p. 289). All other contextual and relational aspects such as the overall identity, contexts, relationships, and choices of the individual are bypassed. In fact, the addict identity is abstracted from contextual agency since the addict possess "a will that is always somehow insufficiently free"—a condition formed by contextless and unchangeable laws of nature (Sedgwick, 1993, p. 132). Such natural and presumably immutable laws, e.g., genetics or developmental contingencies, shape an "individual's intrinsic vulnerability" to form the addictive identity (Le Moal & Koob, 2007, p. 378). Thus, the individual's core identity is the unchanging byproduct of forces which seem beyond the influence of contexts, relationship, and choice—i.e., identity is decontextualized.

The distinguishing feature of *experience* is similarly used in an abstractionist way to further define individuals and their disorder. As we remember from Chapter 2, all experience, according to abstractionism, is distinguished as subjective representations of more real objective entities, viz. the brain. Therefore any value attributed to the addict's experiences, by scientists using abstractionism, would only be of utilitarian interest. That is to say, experience is only valuable in some scientific circles—at least conceptually and therapeutically—as long as it leads to the more real and underlying causes of addiction,

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such as those offered by neuroscience (Hughes, 2007).

To locate the more objective and underlying causes of addiction, imaging technologies have been used to measure what is believed to be the most active sites of addiction in the brain (Mixdorf & Goldsworthy, 1996; Volkow et al, 2007; Yucel & Lubman, 2007). In fact, studies mapping addiction in the brain have become so specific that one area of the brain, the *nucleus accumbens,* has been referred to as the "universal addiction site" (Dackis & Miller, 2003, p. 587).

Abstractionism is noted in this approach since the nucleus accumbens has been separated from an abundance of other contexts, such as additional brain sites, physiological processes, and non-brain contexts. Additionally, the nucleus accumbens has been accorded "universal" status, implying that all addiction emanates from this one area (Dackis & Miller, 2003, p. 587). Thus, one "site" in the addict's brain has been decontextualized from the many other sites in the addict's overall context in order to establish its universality and prominence in addiction. Such decontextualization and universality seems to draw the conclusion that all addictive experience, regardless of the contexts or relationships of the individual, can be reduced to a distinct region of the brain. In this sense, the lived experiences of the addict are only subjective representations of the individuals more real objective world, i.e., the brain. Ontologically separating the "subjective" and the "objective" world of the individual indicates a basic abstractionist approach to addiction.

Abstractions that situate the individual's identity and experiences as self-contained and unresponsive to contexts are not only found in laboratory brain scans but also in the culture of addiction prevention and therapeutics. The following two

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illustrations highlight how addiction and its underlying causes are thought to transcend numerous contexts, relationships, and choices.

Our first illustration focuses on a public service campaign by the National Institutes of Alcohol Abuse and Alcoholism (AA) in1989. A poster entitled "The Typical American Alcoholic" reflects a fundamental belief in the modern disease model that context is not a significant factor in alcoholism. The poster depicts sixteen men and women from obviously different ethnic, cultural, and social walks of life. Here the minister, nurse, construction worker, person of color, and others are portrayed as being equally at risk for addiction—inferring that alcoholism is an "equal opportunity destroyer" capable of addicting anyone despite their personal or cultural contexts (NIAAA, 1989). This perspective reinforces the view that the individual's unique experiences and contexts are not primary considerations in addiction, but only the universality of unseen and underlying factors. Such a widespread view supports the previous scientific examples by inferring that addiction is, for the most part, a process abstracted from even the most fundamental contexts and relationships.

The second illustration comes from the most well known "self-help" organization for addiction, Alcoholics Anonymous. This non-profit and non-professional group informally embraces many of the general concepts of the modern disease concept of addiction (McElrath, 1997; Morrojele & Stephenson, 1992; White, 1998). In fact, "In AA discourse, 'being alcoholic' goes beyond being sick or allergic; being alcoholic is an identity, as opposed to a behavior. It is not about what you do or even what you have done; it is about who you are. (Warhol, 2002, p. 99). From the "Big Book" of AA (1939, no author indicated), we read:

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> Those who do not recover are people who cannot or will not completely give themselves to this simple program, usually men and women who are constitutionally incapable of being honest with themselves. There are such unfortunates... they are not at fault; they seem to have been born that way. They are naturally incapable of grasping and developing a manner of living which demands rigorous honesty (Alcoholics Anonymous, 1939, p. 58).

Represented here, by this non-scientific source, is a perspective that explains the noncompliance of some addicted individuals as the result of conditions of which "they are not at fault [since] they seem to have been born that way" (AA, 1939, p. 58).

This view strongly suggests that some individuals are confronted by forces that make them "constitutionally [and] naturally incapable" of actions which facilitate recovery from addiction (AA, 1939, p. 58). These "unfortunates" are abstracted from agentic choices since they "cannot or will not give themselves to this program... [or to] a manner of living which demands rigorous honesty." (AA, 1939, p. 58).

This point of view defines the individual so deeply that the addict identity "... is not about what you do or even what you have done; it is about who you are". (Warhol, 2002, p. 99). Thus, these individual's and their behaviors are abstracted from every context of the past and every context in the present—they exist only in the context of addiction. This assumes that regardless of other factors—within the contexts of the past and present—there are "unfortunates" consigned to addiction since they are "naturally incapable" of recovery. Since these individuals have "been born that way", the context of hereditary overshadows all other contexts, relationships, and even the individual's agency—i.e., "they are not at fault..." (AA, 1939, p. 58).

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There are, of course, a number of contrasting relational perspectives regarding the topic of this section, Addiction as a Defining Ailment. First, relationality would no doubt presume that substance dependence is an immensely strong constituent of the individual's overall identity. However, relationality would also assume that dependence is not in itself nor is it derived from self-contained and contextless factors. In fact, relationality would assume that identity is a dynamic nexus of contexts (including neurological contexts), relationships, and choices made within the margins of that dynamic nexus. Thus, instead of a "singular nature" the individual is "defined" on the basis of a contextual, relational, and agentic "nature" (Reith, 2004, p. 289). Addiction, in this sense, is far more variable. The relationist scientist would attend as much to the addict's differences across contexts as the addict's similarities.

Next, relationality would assume that the addicted individual's experience of addiction cannot be reduced to objective entities such as the brain and its processes. Rather, experience from the relational outlook would take for granted that all experience is neither wholly subjective nor wholly objective but is an interpretive reality based on personally held beliefs, contextual meanings, mutual relationships, and choice. Although these choices and beliefs may be reflected in some way in the addict's brain, they are not identical with the chemical processes occurring. Thus, rather than the nucleus accumbens being singled out as the "universal addiction site", the complex mutuality of contexts, relationships, and choices would assume that distinction. By this token, the uniqueness of every individual's lived experience would be as important for addiction concepts and therapies as the similarities among factors and behaviors.

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As a final point, relationality would assume that abstractionist labels and explanations are inadequate to capture the full and rich meanings inherent in the lives of persons dealing with addiction, and these rich meanings have import for understanding and treatment. Relationality would thus assume that the abstractionist preoccupation with causality and classification offers only a limited glimpse of the lived experience of addiction. The relationalist would therefore assume that the unique nature of each addict's experiences—comprising their contexts, relationships, and agency—represent a significant source of conceptual information, just as neurology or genetics do. In this sense, no one factor or set of self-contained factors can be conceptualized as independent in their influence in the formation or maintenance of addiction. Furthermore, relationality would reject the notion of "once an addict, always an addict" based on the possibilities created within the mutuality of these contexts, relationships, and agency.

The Analysis of the Life-Process Model of Addiction

For all its popularity and widespread use, the disease model of addiction is not without its skeptics and rather vocal critics. Indeed, the Life-Process Model of Addiction is generally regarded as a broad "sounding board" for any concept that situates addiction in the expansive contexts of the individual's life rather than in biological structures and processes (Peele & Brodsky, 1991; Santrock, 2008; Schaler, 2004). As we shall find however, locating the origins of addiction in areas other than the realm of physiology does not necessarily insure a non-abstractionist approach to the phenomenon.

General overview

Introduction. Rather than being a specific approach to addiction, the life-process model encompasses any number of philosophies that reject a predominantly biological

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orientation for the etiology or even pathology of addiction (Peele, 1987; Peele & Brodsky, 1991; Schaler, 2004). Santrock (2008) explains:

> In contrast to the disease model of addiction, which focuses on biological mechanisms, some psychologist believe that understanding addition requires that it be placed in context as part of people's lives, their personalities, their relationships, their environments, and their perspective... addiction is not a disease but rather a habitual response and a source of gratification or security that can be understood best in the context of social relationships and experiences. (p. 471).

Thus, addiction from the life-process perspective situates addiction in the *willful impairment* not the *impaired will* of individual (Peele, 1985; Peele & Brodsky, 1991; Schaler, 2004). While most life-process advocates do not object to the term addiction, most believe the term has been reified—that is to say the concept of addiction has been made into a material reality through biological constructs (Fingarette, 1990; Hammersley & Reid, 2002; Peele, 2000; Schaler, 2004). Many life-process advocates, therefore, hold that the concept of addiction is merely a social construction designed to objectify the plight of ostensibly "sick" individuals for the purpose of alleviating guilt and providing medical intervention and treatment (Davies, 1996).

Historical context. The life-process model of addiction has evolved in the last fifty years or so as a rebuttal to the physiological frame of reference used in the disease model (Peele, 1985; Schaler, 2004). As Fingarette (1985) has asserted "This is no mystery or puzzle, no rarity, no pathology or disease needing a special explanation." (p. 199). Schaler (2004) confirms this by commenting:

> ... 'addictions' are now claimed to be medical illnesses, characterized by self-

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> destructiveness..., loss of control... and some mysterious, as-yet-unidentified physiological component. This is entirely fanciful. [Although] It may not be as easy as snapping one's fingers, there is no need to dream up some far fetched, scientifically worthless fantasy about "physical addiction" to account for this fact, familiar as it has been down through the ages... People become classified as 'addicts' or 'alcoholics' because of their behavior... the motions of the human body are either involuntary reflexes or meaningful human action (pp. xvii & 221).

Fingarette's (1990) final comment sums up the strong emphasis on accountability that, historically, has permeated the life-process perspective of addiction:

> [Addiction is] a pattern of conduct that must be distinguished from a mere sequence of reflex-like reactions. The idea that alcoholism is a disease has always been a political and moral notion with no scientific basis... This myth, [i.e., the disease model] now widely advertised and accepted... promotes false beliefs and inappropriate attitudes, as well as harmful, wasteful, and ineffective social policies (p. 48).

Ontological analysis of the life-process model. As previously noted, the life-process model of addiction negates a physiological and primarily neurological basis for addiction. Much like Kolb's (1925) earlier views on addiction (see Chapter 3 pp. 72-74), the life-process model isolates the willfulness of the individual—i.e., the individual's choices, preferences for pleasurable states, and their disregard for reasonable alternatives—as the locus of addiction (Fingarette, 1990; Peele & Brodsky, 1991; Szasz, 1984). As we analyze the preceding and subsequent quotations regarding the life-process model of addiction, we will see how the distinguishing ontological features—context,

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determinism, and reduction—are each used in an abstractionist approach to conceptualizing addiction.

At the outset, Santrock (2008) draws attention to the distinguishing feature of context as an important aspect of the life-process model. Santrock (2008) reports "... understanding addition requires that it be placed in context as part of people's lives, their personalities, their relationships, their environments, and their perspective... addiction is not a disease." (p. 471). Initially, this statement seems to conceptualize addiction in what might be thought of as a contextual, and thus relational, frame of reference. However, we find that the context of "biological mechanisms" clearly has been abstracted and thus negated as an important factor in the "whole" of addiction (Santrock, 2008, p. 471). Bypassing one context in favor of another illustrates the abstractionist assumption that one context can be decontextualized in favor of others in an effort to identify what is most essential in addiction.

There is no doubt that relationality agrees with the importance of "relationships and contexts" highlighted in the life-process model. Yet, relationality would assume that these aspects, important as they may be, are not self-contained entities capable, in and of themselves, of providing the most meaningful account of addiction. Aspects of the person's holistic life, what some call a *lifeworld*, simply cannot be studied, according to a relational ontology, separately from one another without those aspects being misunderstood. An unambiguous relational approach to addiction would therefore, as Santrock (2008) alludes, be "understood best in the context of social relationships and experiences" but would also encompass all important contexts of the individual's life, including the contexts of the brain. In this respect addiction exists not solely as "a

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habitual response... [And] a source of gratification or security" (Santrock, 2008, p. 471) but as a "unique nexus of our relationships" i.e., the aspect of mutuality that connects the brain, context, personality, etc. (Slife & Richardson, 2009, p.9).

Next, Fingarette (1990) and Schaler (2004) draw attention to the feature of determinism as they discount any "pathology", "physical addiction", or "as-yet-unidentified physiological component" as "scientifically worthless fantasy" in the conceptualization of addiction. Negating the influence of any physiological factor obviously, by inference, draws attention to what is believed to be the more important factors or determinants in addiction. Additionally, since any determining effect of physiology, i.e., "involuntary reflexes" is negated, the determining factors of addiction must be in situated in the realm of what has been articulated as "meaningful actions" (Schaler, 2004, p. 221).

It seems as if this perspective, ontologically, establishes the underpinnings of addiction in a self-contained essence, namely in the *will*, much in the same way the disease model situates addiction in the *brain*. That is to say, "meaningful actions" (the intentional processes of the *mind*, such as any willful action) have supplanted "involuntary reflexes" (i.e., the autonomic processes of the *body*, such as those found in the brain) as the locus of addiction (Schaler, 2004, p. 221). In effect, the individual's "self-contained choices", (i.e., their volition, will, or agency) determine the addictive state of the individual.

Even though agency or free will is most often thought of as non-deterministic, in this case the decontextualized and thus self-contained *will* seems sufficient to cause addiction. There is of course a tradition within relationality which relates meaningful

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actions to contextual agency (Richardson, Fowers, & Guignon, 1999). However, in this instance "meaningful actions" are clearly decontextualized from "involuntary reflexes" suggesting that the willfulness of the addict is so self-contained that other contexts either have a modest influence or no "scientific basis" at all (Fingarette, 1990, p. 48).

As we recall, determinism is manifest when any antecedent, e.g., the agency of the individual, is considered self-contained, sufficient, and thus causal to the effect, i.e., addiction. Consequently, the feature of determinism is manifest when addiction is solely the effect of "meaningful actions" but is independent of other contexts, such as physiology and its "involuntary reflexes" (Schaler, 2004, p. 221).

A relational perspective on these points would assume that the agency and physiology of the individual are mutually constitutive and therefore ontologically inseparable (Slife & Hopkins, 2005). In this sense, even the agency of the individual does not lie beyond the influence of contexts and relationships. Thus, from an ontological perspective the *will* of the individual cannot transcend the context of the brain, anymore than the brain can transcend the context of the *will*. This would suggest that neither the *body* nor the *mind* is meaningful, in the sense of addiction, as self-contained entities but rather derive their significance from the contexts in which they exist and their mutually constitutive relationships.

This intersection or nexus of factors is the *contextual agency* spoken of in Chapter 2. Contextual agency is the relational assumption that possibilities (i.e., choices) are not grounded solely in the *will* of the individual but such choices are mutually constitutive with the contexts and relationships of the individual. Thus, addiction at its most fundamental essence is not determined from a self-contained *will* but from a *will* that is

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embedded within the contexts and relationships of the individual.

Situating the choices as the overarching factor in addiction indicates how isolating what might be considered a relational facet, such as a decontextualized agency, condenses addiction to an abstractionist reduction. For example, Stanton Peele (1946-) a respected psychologist, attorney, and notably the most vocal advocate of the life-process model has noted " ... addiction is a medicalized version of an essential element in all areas of human conduct, an element that has been explained by concepts of habit and will or the lack of it." (Peele, 1987, p. 199). In this next quote Peele (1987) supports the assumption that addiction can be reduced to an essential element, namely that of the *will*:

> What has changed in the twentieth century is the claim that these compulsive activities somehow represent a codifiable disease-state... the inability to control one's drinking is today proposed to be an inherited trait. This is wrong... Neither laboratory nor epidemiological experimentation provides support for the idea that alcoholics lose control... [Rather] alcoholic drinking represents largely purposive behavior, even if the alcoholic's purposes are quite alien to most people and even though alcoholics frequently regret their choices... The life study of alcoholism provides good support for the idea of alcoholism as an accumulation of choices." (p. 199).

Schaler (2004) strongly agrees with this non-physiological construct of addiction by asserting "People become classified as 'addicts' or 'alcoholics' because of their behavior. 'Behavior' in humans refers to intentional conduct... The behavior of heavy drinking is not a form of neurological reflex but is the expression of values through action." (p. 221).

Although Peele (1987) and Schaler (2004) reject the notion of loss of control; that

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is to say a behavior or condition that can be traced scientifically to "neurological reflexes", "inherited trait[s]" or "disease state[s]", they support the reduction of addiction as "largely purposive", "an accumulation of choices" and "values through action" (Peele, 1987, p. 199; Schaler, 2004, p. 221). Notwithstanding the relational aspects (e.g., agency, choice, and purpose) that are mentioned by Peele (1987) and Schaler (2004) in the life-process model, these points of view are nonetheless abstractionist based on their being situated as a non-contextual factors and foundational factors. Without "laboratory or epidemiological" support, "neurological reflexes" are considered unimportant and become abstracted from the more "essential element... [of] expression of values through action" (Peele, 1987, p. 1999; Schaler, 2004, p. 221). Abstracting the contexts of physiology from the contexts of choice is one way the life-process advocate identifies the more real issues in addiction (Schaler, 2004, p. 221).

To by pass, minimize, or decontextualize such a significant aspect of each individual's life (i.e., physiology) is to assert the reduction of addiction to the *wills* self-containment and dominance. That is to say, the *will* must be decontextualized to account for addiction as the "accumulation of choices" and not the accumulation of choices within contexts (Peele, 1987, p. 199). As Peele (2009) advises addicts "You do not have an incurable disease; you have a dependency that has been brought on by your choices. Since they are your choices, you control them (p. 1).

The relationist would argue against such a proposal by assuming that the *will* or the *choices* of the individual are mutually constitutive with all other significant factors of addiction, including the factors of physiology or heredity. This means that the *will* is not only enabled by preferences for pleasurable states or a disregard for reasonable

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alternatives but may also be constrained by contexts such as history, culture, and relationships. Once again this is the relational assumption of *contextual agency*, i.e., the "freedom" to act within the limits of contexts and relationships (Appendix A).

The relationist would additionally counter with the assumption that the best diagnostic criteria of addiction comes from the "real world" contexts and relationships of the individual. The relationist would furthermore assume that with each agentic preference there exist the mitigating influence of mutually constitutive factors such as culture, personal history, and even physiological contexts. This is not to say that a relational view would find the individual free from responsibility on account of contexts and relationships; rather each individual "arrives" at addiction or non-addiction through the mutuality of factors not factors of "self-containment".

As a final point, both Peele (1987) and Schaler (2004) seem to support the assumption that addiction or the specific behavior reported as addiction, can be reduced to "an essential element... an element that has been explained as habit and will or the lack of it" (p. 199) and "intentional conduct" (p. 221). As we have previously learned, reductionism assumes that some features of reality are more fundamental than others; therefore some aspects of addiction are causal and essential while others are non-causal and non-essential. In this case, the *will* is seen as the bottom most reduction in addiction, i.e., addiction is the final consequence in the "accumulation of choices" by the addict (Peele, 1987, p. 199). Such a distinct assumption implies that agency or the lack of it is the only, or at least the most important factor, sufficient to establish addiction. All other contexts are minimized in favor of the "essential element" of *choice* and its influence on the "intentional conduct" of the individual (Peele, 1987, p. 199; Schaler, 2004, p. 211).

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The implicit assumption of such a viewpoint is that if people can *will* themselves into addiction, regardless of the contexts and relationships around them, they can likewise *will* themselves out of addiction (Fingarette, 1990; Peele & Brodsky, 1991; Schaler, 2004; Szasz, 2003). Thus, the *will*—devoid of contextual influence—creates the most motivating and explanatory force at the foundation of addiction.

In agreement with the life-process perspective is the relational assumption that intentions, choices, and values are vital factors in the formation and maintenance of addiction. Nonetheless, relationality would situate these and other vital factors in the context of a shared rather than self-contained identity. Each factor, according to this ontological framework, is more meaningful and foundational when they are considered as mutually constitutive and context dependent. From this point of view, addiction is not simply *willed* into existence by poor choices and recovery from addiction is likewise not simply *willed* out of existence by positive choices alone. The relationist would assume that the etiology and pathology of addiction—as well as any recovery or resolution of addiction—is best conceptualized as a relational interlacing of many significant factors.

The Analysis of Compound Models of Addiction

The compound approach to addiction is an effort to bridge the conceptual and therapeutic gap between the divergent philosophies of, the biomedical, psychological, and sociological perspectives of human behavior (Graham, Young, Valach, & Wood, 2008; Levant, 2004; Pilgrim, 2002; Wallace, 1993). Compound approaches are based on the assumption that the interaction of a number of well defined factors is sufficient for the formation and maintenance of addictive behavior (Griffiths, 2005; Griffiths & Larkin, 2005; Shuttleworth, 2002).

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General overview

Introduction. The assessment of the biopsychosocial model of addiction will be the concluding ontological analysis of this chapter. Although there are numerous concepts of addiction which may be classified under the heading of a compound model, the *biopsychosocial* concept is by far the most widely recognized compound approach to addiction (Griffiths, 2005; Levant, 2004; Stratyner, 2006; Shuttleworth, 2002; Wallace, 1993; White, 2005). Since the biopsychosocial model represents the major conceptual emphasis under the framework of compound theories it will be the focus of this final ontological analysis.

Compound models of addiction have been known by an assortment of names and descriptions. For example, the biopsychosocial, multi-component, multi-cultural, integrated, and complex systems models are but a few of the ways in which addiction has been conceptualized to reflect the influence of multiple factors in the etiology and pathology of the disorder (Alexander, 1987; Batson, 1992; Goldsmith, 1993; Griffiths & Larkin, 2004; Griswold & Ezekoye, 1985; Stratyner, 2006). These models and others are indicative of the discontent with perspectives that single out one particular aspect of addiction as its definitive trait (Gifford & Humphries, 2006; Shuttleworth, 2002).

Within the general framework of what might be considered a compound model is the assumption that multiple factors influence the origin and maintenance of addiction (Batson, 1992; Griffiths, 2005; Slaght, Lyman, & Lyman, 2004; Wallace, 1985, 1993). Each conceptualization of this nature regards the interaction of biological factors, e.g., the brain, psychological factors, e.g., coping skills, and social factors e.g., the environment, as the most fundamental explanation for addiction. When compared to other models

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previously explored, the biopsychosocial model manifests a willingness of its formulators to grant many significant aspects of addiction a role in its origin and its subsequent nature.

Admittedly, this approach could be viewed as approximating a relational ontology. However, when the issues of relationship, context, and agency are fully considered we will uncover a number of hidden assumptions within the biopsychosocial model that attest to its abstractionist underpinnings.

Historical context. For the most part, the biopsychosocial approach to addiction seems to be a by-product of an overall trend in the social and medical sciences where scholars attempt to find answers to difficult questions by appealing to a multiplicity of factors (Engle, 1977; Wallace, 1993; White, 2005). Additionally, emphases of this nature are also undergirded by motivations to more fully "humanize" the conceptualization and treatment of mental disorders (Acker, 1993; Engle, 1977; Kersting, 2005; Sarafino, 2001).

George L. Engle (1913-1999) a prominent New York psychiatrist is credited with the initial philosophical treatise recognizing the interplay between the biological, psychological, and sociological aspects of human behavior, and even coining the term *biopsychosocial* (Engle, 1977; Halligan & Aylward, 2006; Santrock, 2007). So concerned was Engle (1977) over the polarity of these seemingly diverse aspects in the medical and behavioral sciences he asserts:

> I contend that all medicine is in a crisis and, further, that medicine's crisis derives from the same basic fault as psychiatry's, namely, adherence to a model of disease no longer adequate for the scientific tasks and social responsibilities of

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> either medicine or psychiatry... The boundaries between health and disease, between well and sick, are far from clear and never will be clear, for they are diffused by cultural, social, and psychological considerations. (p. 324).

This particular conception of human behavior strives to fill a practical void left by the more constricted models, such as the biomedical and psychoanalytical, where the dominance of specific factors prevails (Griffiths, 2005; Levant, 2004; Slife & Hopkins, 2005; White, 2005). Engle's (1980) response to the crisis was to redefine how diseases were perceived—namely from the single construct approach of the biomedical model to the systems approach pioneered by Bertalanffy (1968) and Weiss (1969).

Clearly, this approach was formulated in addiction science to stress that no one isolated aspect of addiction is solely responsible for the condition (Griffiths, 2005; Wallace, 1993). More specifically, addiction from this perspective considers the "whole", i.e., the entirety of the phenomenon, to be an effect of the causal interactions of its "parts". That is to say, addiction is considered most meaningful from a framework that situates underlying links—i.e., the biological, psychological, and sociological—as the most vital antecedents in the establishment of addiction (Gifford & Humphries, 2006). Notwithstanding the apparent willingness to acknowledge multiple factors in addiction; simply classifying a model by a compound expression, as we will discover, does not automatically eliminate fundamentally abstractionists' assumptions. For the sake of brevity, the abbreviation BPS will be used periodically to represent the biopsychosocial model.

Ontology of the biopsychosocial model. In this final analysis, I endeavor to bring to light the abstractionist use of de-contextualism, reductionism, and determinism in the

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biopsychosocial model of addiction. To help clarify these abstractionist features, the relational features of context, relationship, and agency will be used to explicate the abstractionist's assumptions within the BPS model. As we have seen in past analyses, contrasting the ontological qualities of abstractionism with relationality more fully facilitates an in-depth analysis. I will argue that the BPS model can be contrasted with a relational approach in two primary ways—through the separation of factors and the prioritization of factors.

Separation of factors. On the surface, the biopsychosocial model of addiction seems to exhibit at least some of the basic tenets of a relational ontology. After all, even the designation, *biopsychosocial* (hereafter, BPS) seems to affirm that many scientists are uncomfortable with the conceptual deficits of single construct approaches (Levant, 2004; Wallace, 1993; Whitbourne, 2000). Griffiths (2005) agrees by emphasizing "Research and clinical interventions [for addiction] are best served by a biopsychosocial approach that incorporates the best strands of contemporary psychology, biology, and sociology." (p. 195).

Abstracting the elements of addiction into "the best strands" gives us an early and clear example that certain aspects of addiction, from this viewpoint, are best understood when separated from one another and from the contexts in which they appear (Griffiths, 2005, p. 195). A relational understanding, by contrast, would assume that addiction is most meaningful when its salient aspects are thought of as mutually constitutive of one another.

Griffiths' (2005) assumption that "interventions are best served" by the "best strands" (p. 195) of biological, psychological, and sociological entities seems to indicate

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they are also best conceptualized as separate or "self-contained individualities" (Slife, 2005, p. 3). Consequently, the biological context is decontextualized from the psychological context, etc. That is to say biology is abstracted from or does not serve as a context for the psychological. The relationalist on the other hand would assume each context (i.e., the bio-psycho-social) derives its most fundamental meanings from the nexus of relationships that are shared with other contexts of addiction. Simply put, each element of addiction is inseparably woven into the meaning and identity of every other element of the disorder. Thus, the phenomenon of addiction as a "whole", according to the BPS model, is most meaningful when thought of as decontextualized or self-contained "strands" (Griffiths, 2005, p. 195).

Although Griffiths (2005) acknowledges the reality of a unique relationship within the biopsychosocial, this connection is meaningful—at least to the contexts of addiction—when the "strands" are brought into the context of an interaction (p. 195). Such a relationship would be considered abstractionist owing to its separation prior to the biopsychosocial interaction. The relationist would assume, however, that separating one element from another, even if only pre-interaction, abstracts meaning away from the "whole" of addiction. Recall the simple illustration of the stick figure referenced in Chapter 2 (p. 20). Slife (2005) explains "The circle at the top of the figure is only a 'head' by virtue of its relationship to the remainder of the figure." (p. 4). So too, are the "best strands of contemporary psychology, biology, and sociology"; they only have meaning by virtue of their mutually constitutive relationships (Griffiths, 2005, p. 195).

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Engle (1980), the acknowledged father of the *biopsychosocial model*, confirms the existence of abstractions, by means of self-contained entities, in the BPS model by stating:

> Each system [within the BPS framework] as a whole has its own unique characteristics and dynamics... The designation "system" bespeaks the existence of a stable configuration in time and space... Stable configuration also implies the existence of boundaries between organized systems... Each level in the hierarchy represents an organized dynamic whole, a system of sufficient persistence and identity to justify being named. Its name reflects its distinctive properties and characteristics (Engle, 1980, p. 536- 538).

In this instance, the BPS model is characterized as a hierarchical system with "... its own unique characteristics and dynamics... a stable configuration in time and space [which also] implies the existence of boundaries..." (Engle, 1980, p. 536-538). Thus, the level of biological systems is abstracted from the level of psychological systems; the level of the psychological system is abstracted from the social system, etc. Such a perspective inherently reduces the "whole" of a disease, e.g., addiction to a variety of "stable configurations in time and space" (Engle, 1980, p. 536). Relationality by contrast, would assume that each "system" is uniquely in relation with other "systems". Using this approach, addiction per se and any important factor associated with addiction, is irreducible if we take into consideration the mutuality of each important aspect, i.e., the biopsychosocial. Additionally, a relational perspective would view individuals and their diseases as "irreducible" since individuals and their contexts are "dynamic rather than static" or stable entities (Slife & Wiggins, 2009, p. 22).

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However, if we apply Engle's perspective of disease to addiction we must assume that addiction can be reduced to a "stable configuration [with] boundaries between organized systems" (Engle, 1980, p. 536). Individuation or separation of factors (i.e., abstractionism) is thus assured since each of these self-contained factors must demonstrate "sufficient persistence and identity to justify being named" (Engle, 1980, p. 536). According to relationality however, these biopsychosocial aspects do not, as the BPS model assumes, exclusively derive their meaning from "stable configurations... [and] distinctive properties and characteristics" (Engle, 1980, p. 536-537). They do however, according to relationality, derive their meanings from one another and the context in which they are found.

Recall from the Table of Distinguishing Features that reductionist abstractions assume that self-contained things—i.e., "distinctive properties and characteristics" (Engle, 1980, p. 536)—form the self sufficient links in each causal chain of behavior (Appendix A). The BPS model, much like the disease model, inserts a number of distinctive factors known for their "sufficient persistence and identity" in a hierarchy of reductions that presumably precede diseases, e.g., addiction. Contrasting this view is a relational perspective which assumes the biopsychosocial characteristics of addiction are only meaningful and unique because of the mutually constitutive relationships and contexts in which they exist. This implies that each aspect of addiction shares a uniquely related origin, not only with other aspects of the disorder but also with the contexts in which they exist. Rather than addiction being reduced to "an organized dynamic whole" (Engle, 1980, p. 537), relationality would conceive of addiction as a dynamic nexus of

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relationships and contexts. This may seem like a small or technical distinction; however, as our analysis proceeds we will see how this distinction is an important one.

Prioritizing of factors. Thus far, our analysis has revealed the BPS model's assumption that separating factors of addiction is the most viable way in which to conceptualize the disorder. As we will see, however, when factors are separated it is tempting for most scholars to make one factor more important than the rest. Indeed, within the ranks of leading BPS supporters there is a definite emphasis on the crucial nature of biology, namely neurobiology, in the formation and maintenance of diseases, such as alcoholism. For example, in the Presidential Address of the journal *Psychosomatic Medicine*, Williams (1994) asserts:

> My major message is that optimal growth in our understanding of how biopsychosocial factors interact in the etiology and course of human disease will come only if our research incorporates theories and techniques from neurobiology and cellular and molecular biology. (p. 308).

Williams (1994) underscores this focus in the neurobiological aspects of the BPS model by proposing that the personality trait of *hostility*, which is characterized, among other things, by "increased smoking, increased eating, and increased alcohol use" originates in a specific neurological system (p. 310). Williams' (1994) research at Duke University led him to accept the "serotonin deficiency hypothesis" (p. 310) as the fundamental explanation for early death due to "coronary disease... cancer... and increased alcohol consumption" (p. 310-311). Williams (1994) asserts:

> Rather than saying that a hostile personality trait somehow "causes" the clustering of the characteristics making up the hostility syndrome, I am proposing that all the

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> characteristics [including smoking, eating, and alcohol use]... could be the result of a single underlying neurological condition [or] mechanism: deficient central nervous system (CNS) serotonergic function... Low CNS serotonin function has effects on biology and behavior that could be responsible for both the biobehavioral traits and consequent high rates of disease and death that have been found associated with high hostility... There is very convincing and extensive evidence that weak brain serotonin function contributes to increased alcohol consumption (p. 310-311).

Positioning "a single neurological condition [or] mechanism" as the determining feature of a variety of diseases illuminates the tendency of abstractions of this kind to attribute "the material of the body (biology) alone for explaining our minds and behaviors" (Slife & Hopkins, 2005, p. 2). Relationality, however, would assume the involvement of many non-material entities such as relationships, contexts, and agency as being equally constitutive elements in all human phenomena, including disease. In Williams' (1994) example however, these elements are not involved, while a number of abstractions are disclosed as precursors in a deterministic chain that leads to early "disease and death" (p. 311).

Using Williams' (1994) excerpt I will point out three ways in which abstractions underlie this particular approach to diseases such as addiction. First, death is reduced to "coronary disease... cancer... and increased alcohol consumption", which is reduced to "hostility", which is reduced to "low serotonin function... [in the] CNS" (p. 310). The final reduction (low serotonin function) inherently assumes the prioritization of neurological structures. Relationality, by comparison, would assume that "hostility,

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coronary disease, cancer, and increased alcohol consumption... [and] low serotonin function are mutually constitutive contexts (even within the realm of the purely biological). Indeed, the relationalist would take for granted that any disease or its processes is irreducible to a "single... condition" since any such condition shares its identity and meanings with other important contextual features (Williams, 1994, p. 310).

Next, the primacy and dominance of "neurological... mechanisms" is assumed by situating "a single underlying condition" i.e., "serotonin deficiency", as the primary "underlying" causal link to which disease states such as "increased alcohol consumption" are attributed (Williams, 1994, p. 311). Thus, the "underlying condition" of "low serotonin function" is established as the decisive or determining feature of both "biology and behavior" which in turn determines to a great extent "increased alcohol consumption" (Williams, 1994, p. 311). This perspective, by inference, assumes that some individuals inherit vulnerabilities or dispositions due to the overwhelming "mechanisms", "deficiencies" or "weak brain... functions" they inherently possess (Williams, 1994, p. 311).

A relational perspective would suggest that while neurological conditions for "diseases" such as addiction are necessary, neither they nor other "biopsychosocial" interactions are sufficient to account for human disorders. Relationality would further assume that instead of decisive factors, e.g., neurological aspects, being the ontological focus of addiction, that the relationships between and among factors constitute the most decisive element in the formation and maintenance of "disease".

And last, Williams (1994) labels human behaviors—those that may otherwise be listed under a psychosocial heading, e.g., increased smoking, increased eating, and

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increased alcohol use"—as "biobehavioral traits" further abstracting these factors from the overall contexts in which they exist. (p. 311). A relational understanding would assume that all human behaviors are a nexus of physical, psychological, social, and agentic realties present in each individual's life. The relationist would assume that "traits" change and vary in relation to differing contexts—therefore they are not confined to boundaries implicit within any one designation, i.e., "biobehavioral". As Slife (2005) comments "The outside [i.e., the realities of context] is as important as the inside [the realities of biology]; meaning that no one factor dominates or has priority in a relational conception of human behaviors (p. 4).

Abstracting biological factors from psychosocial factors, i.e., "biobehavioral traits" and "single underlying neurological conditions" infers that the identity of the individual is determined, to some extent, prior to any sort of psychosocial relationship (Williams, 1994, p. 311). This suggests that the context of agency, as an influential factor in the development of a "disease", e.g., addiction, may be minimized. This point of view also implies that the influence of agency in the restoration of health, i.e., recovery is also minimized. As we see in this example, "... the central proposition of neuroscience is that the mechanisms of biology are sufficient to explain the human mind and behaviors [such as addiction]... whereby other, nonmaterial and nonbiological are viewed as less than fundamental or unimportant (Slife & Hopkins, 2005, p. 2-3).

The relationist would naturally assume that biological factors are indeed an important key to unlocking the mysteries of addiction. However, the relationist would also assume that no factor can be fully understood outside the many contexts in which it exists. Indeed, the relationalist would argue that if there is a priority ascribed to disease

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and its processes, it is that meaning and substance are found in the nexus of relationships and contexts of the individual (Slife & Wiggins, 2008). A relational perspective would therefore assume "... all things have a shared being and a mutual constitution... They start out and forever remain in relationship." (Slife, 2005, p. 4). The relationalist would thus assume that the relationship inferred by terms such as "biobehavioral" is only an abstraction that fails to capture "the infinitely rich details... of relationships and context" (Slife, in press, p. 14).

Further implicating the prioritization of biological factors, Paris (1993) notes "Biological predispositions are reflected in heritable personality traits, which can then be amplified by psychosocial factors" (Paris, 1993, p. 255). This perspective illustrates that "biological predispositions" are at first sequentially separated from the influences of psychosocial factors. Thus, addiction from this view is an abstracted sequential process that starts with "biological predispositions" and then proceeds "to... psychosocial factors" (Paris, 1993, p. 255). Thus, "biological predispositions, heritable personality traits, and psychosocial factors" only relate to one another through cause and effect and thus deterministic relations (Paris, 1993, p. 255). Relationality, by contrast, would suppose that influential factors in addiction share a mutually constitutive and simultaneous relationship among themselves and the context in which they appear. This implies that biological, psychological, and sociological factors are relationally and contextually dependent for their most fundamental meanings.

Although Paris (1993) establishes a relationship between "biological factors, heritable personality traits, [and] psychosocial factors", the relationship is ontologically weak due to the reduction of factors to the self-contained properties of each.

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Furthermore, biology is so fundamentally decontextualized or self-contained, from this perspective, that the interaction of the ontologically less basic "psychosocial factors" does not fundamentally change the essence of biology but only amplifies its self-contained properties (Paris, 1993, p. 255). This implies that only the biological can fundamentally change the psychosocial, hence its prioritization in and its initialization of the deterministic chain of addiction.

By comparison, relationality would assume that biological and psychosocial factors share a mutually constitutive relationship with one another. They are each necessary conditions for the phenomenon being explained; no single condition is more or less necessary than—or more or less in control of—any of the others. As Slife, Burchfield, & Hedges confirm "All the relevant necessary conditions—all the parts of the whole—are intimately and inseparably related" (p. 20). Thus, biology—as a self-contained entity—is not "amplified by [self-contained] psychosocial factors" but each entity serves to give meaning and identity to one another (Paris, 1993, p. 255).

Abstractionism assumes that self-contained entities, such as "heritable personality traits" only relate to other entities, such as "psychosocial factors" through *cause-and-effect* and thus deterministic relations (Paris, 1993, p. 255). Thus, the individual's agency is only an *effect* of the "amplified" relationship between the causal antecedents of biological and psychosocial factors (Paris, 1993, p. 255). We find within such approaches the strong inference that individuals inheriting certain "personality traits" (Paris, 1993, p. 255) also inherits a diminished responsibility for their actions (Acker, 1993; Leshner, 1997; Mendola, 2003; Raistrick, 2008).

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While the relationist would no doubt agree that "biological predispositions [and] heritable personality traits" are ubiquitous features of each individual's life; the relationist would equally assume that within these particular contexts exist the context of choice. Slife & Wiggins (2009) remind us:

> A relational agency implies a will situated in a context of both possibilities and constraints. For example, the physical body presents amazing possibilities (e.g., mobility, speech, physical affection, etc.) as well as significant constraints or limits (e.g., illness, limited strength, stress, fatigue, etc.). From this perspective, such things as inherited traits, chemical imbalances, traumatic experiences, or habitual patterns do not strictly determine a person's particular pathology, behavior, or experience of the world (p.21).

From this point of view the "agentic factor" would not only be seen as an essential part of the "problem" of addiction but likewise an essential part of the "solution" of addiction as well. In short, relationality would assume a contextual agency—that is, possibilities and responsibilities exist within the same relational and contextual nexus as vulnerabilities and diminished responsibilities.

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Chapter 4: A Relational Alternative for Addiction Theory and Therapy

Introduction and Overview

Introduction. The central emphasis of this chapter will be to offer a relational alternative to the theory of addiction. In doing so, I will use the foundational information regarding ontology, discussed in Chapter 2, in unison with the findings of the ontological analysis in Chapter 3. By doing so, I hope to be able to fully explore the implications of a relational approach to addiction theory in the context of mainstream applications. Chapter 4 therefore, presents a theoretical alternative that may be able to address some of the concerns surrounding the "... conceptual crisis" in the field of addiction (Shaffer, 1986, p. 285).

Overview. Chapter 4 will contain one primary emphasis, using relational guideline to inform addiction theory. First, a relational approach to the theory of addiction will be presented using the five distinguishing ontological features outlined in Chapter 2 and utilized in Chapter Three's analyses. Each distinguishing feature will be presented in a relational perspective to foreground the alternative theory to addiction. Concurrently, examples from addiction literature will be used to illustrate abstractionist ideals, providing a contrast in which the fundamentals of relationality will be illuminated. Comparing and contrasting these examples of mainstream approaches with relationality will afford the reader the opportunity to see first hand the rationale behind this alternative ontology. As I will argue, these manifestations of abstractionism are not only evidenced in the theory of addiction but have also been assimilated into the treatment, culture, and overall philosophy of addiction.

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A Relational Theory of Addiction: Five Distinguishing Features and Their Relevance to Addiction

Introduction. As we recall from Chapters 2 and 3 the ontological underpinnings of a particular concept are more easily understood when analyzed through the "lens" of distinguishing features. The Five Distinguishing Features of Ontology (Table A1), i.e., context, reduction, identity, experience, and determinism, were used to illuminate the abstractionist assumptions found within addiction theories and therapies. Conjointly, a relational ontology was often used to underscore the abstractionist approach in a particular theory.

In light of what has been learned in the ontological analysis, this section will once again implement the five distinguishing features to propose a relational alternative to addiction. Abstractionism in this context will be used as the contrasting element to underscore the relationalist approach to addiction theory. As I will argue, a relational alternative to addiction fits more closely the dynamics found within addiction and more appropriately addresses the individual's unique challenges.

Context. In Chapter 2 we learned that context is that set of factors and circumstances that surround and give meaning to objects, situations, and behaviors (Bishop, 2007; Miller & Rollnick, 2002; Slife, 2005). A relational ontology would assume each individual embodies particular contextual elements which are in relationship and mutually constituted with the broader contexts of the world in which they live. Mutually constituted in this case refers to the constant and simultaneous relationship between the individual, the world, others, and themselves. Slife (2005) clarifies *mutually constituted* by commenting:

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> ...all things have a shared being and a mutual constitution... They start out and forever remain in relationship. Their very qualities, properties, and identities cannot stem completely from what is inherent or 'inside' them but must depend on how they are related to each other." (p. 4).

Therefore according to a relational theory of addiction, context would convey a richer and more evocative sense of awareness regarding the most fundamental realities of addicts, their condition, and their world. As applied to an alternative approach to addiction, the relationist would assume that addiction or even the absence of addiction can only be understood, on a meaningful level, if situated in the contexts in which they appear. In this respect, context is critical to not only comprehending addiction per se but also in recognizing how context is inseparable from any meaningful change in the addicted individual. For example, Blomqvist and Cameron (2002) report that a profound change in the qualities of the individual's social support system impacts the overall probability of sustained recovery.

As applied to a relational alternative to addiction, helpful support systems would be seen as an influential context in which the addict shares a mutual and dynamic relationship. Under such circumstances the individual is a responsive agent of change. As Slife and Richardson (2008) assert:

> If the hammer [see p. 16 this dissertation] really can be different from context to context, there is a sense in which the hammer literally changes from context to context—from a nail driver to a paper weight to an art object, and so on (p. 702).

So too the addict and the factors of addiction become essentially different with each accompanying context. By this reasoning, an addict's behavior will be distinctly

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different in some contexts, or within other contexts the addictive behavior may not be manifested at all. As Moos (2003) emphasizes "People with addictive disorders exist in a complex web of forces, not on an island unto themselves, free of social context." (p. 3). Relationality would agree with this commonsense analogy but would also identify contexts other than the social sphere in which the individual has a mutually constitutive relationship. For example, profound changes within addicted individuals have been reported in the context of religious affiliation and commitment (Brown, Parks, Zimmerman, & Philips, 2001; Flores, 1997).

However, most theories of addiction, as we have noted in our earlier analysis, have sought to separate the fundamentals of addiction into self-contained properties expressed more often as not as materialistic constructs (Acker, 1993; Cummings, 1979; Edwards, 1994). Relationality, on the other hand, would expand the influential conditions of addiction to include, among other things, the relationships between the factors of addiction and the context in which they exist. In this perspective, properties of addiction, are not carried from one context to the next but are subject to contextual influences which may initiate substantive change.

Situating addiction in this manner conveys a richer and more in-depth understanding of individuals and the uniqueness of their addiction. Consider, for example, the universal contexts of age, gender, and ethnicity. Yucel, Lubman, Solowij, and Brewer (2009) assert that the context of adolescence is critical to the conceptualization and treatment of drug addiction. Liebert, Wicks-Nelson, and Kail (1986) as well assert "Treating young people is fundamentally different from treating adults." (p. 477). Lewis (1994) reports "Until recently the bulk of information about

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substance abuse treatment was based on research carried out with white male subjects. Many of the generalizations accepted by substance abuse counselors were therefore severely limited." (p. 37). Relationality would agree with these perspectives that the theoretical conclusions reached by scientist and the treatment options made available by therapists are fundamentally reliant on recognizing the vital influence of context on addiction (Collins & Laursen, 2004; Florentine & Hillhouse, 2004; Miller, 2001; Palva, 1985; Trudeau, 2005; Vaughn & Long, 1999; White, 1998, 2001).

As we have noted throughout the Chapter Three's analysis, such fundamental assumptions are often negated in favor of abstractions such as genetics, brain chemistry, and psychological defects. These and other factors are predominantly thought to be so consistent they vary little from one context to the next. Yet, the relationist would counter that an addict may have profound urges in one context but relatively negligible temptations in the next. Some addicts, according to a relational alternative, may even experience the complete absence of addictive symptoms or feelings in certain situations, especially if they are permitted to think that this possibility is, in fact, plausible (or even likely).

For example; after years of studying returning Viet Nam veterans, Robbins (1993) found that only 6% of returning veterans reported still being addicted to heroin, despite 75% of those same vets feeling they had been addicted in South East Asia. Robbins (1993) concludes that the variance may be accounted for in the multidimensional contexts which changed from location to location. This supports a relational perspective that even changing the context of setting will confer at least some changes in the overall meanings and manifestations of addiction. Understanding this variance, as conferred by a

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multiplicity of contexts, is pivotal for a relational alternative to the theory of addiction. Nevertheless, a relational point of view, in addressing addiction, has certainly been the exception and not the rule.

One of the most predominate themes in the conceptualization of addiction is the brain and its complex array of neurotransmitters (Koob, 2007; Yucel & Lubman, 2007; Pomerantz, 2005). In fact, many scientists have taken advantage of recent advances in neuroimaging to focus in on the connection between the deficits of certain dopamine receptors (in particular the D_2 receptor) and vulnerability to addiction (Collin, Kosten, & Kosten, 2007; LaFolla, Gallo, Le Strat, Lu, & Gorwood, 2009; Nader & Czoty, 2005; Sunderwirth & Milkman, 1991; Trudeau, 2005). However, the relationalist would assume that even such an important context as the brain is in a constant contextual relationship with many other factors of addiction.

For example, the relationalist would assume that even the influence of neurotransmitter deficiencies found within some individual's varies from one context to the next. The neuropharmacology research team of Nader and Czoty (2005) seems to corroborate, at least in part, the importance of this relational precept as it relates to specifics of the brain, dopamine function, and addiction to cocaine. Nader and Czoty (2005) affirm:

> Environmental stress and enrichment can influence brain function and vulnerability to drug abuse. Furthermore, even following long term drug use, environmental variables can affect the behavioral effects of cocaine... this review reflects the growing number of studies documenting the benefits of environmental enrichment, irrespective of genetic predispositions to abuse drugs... outcome

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> measures will be enhanced not only by taking individuals out of a stressful environment, but also by providing alternative reinforcers—whether these are better living conditions, jobs, or other activities. (p. 1480).

Although this particular viewpoint articulates context from a single construct perspective (neurology), the message is clear: context matters. The relationalist of course would suggest that genetics and context have always shared a meaningful and mutually constitutive relationship (Hedges & Burchfield, 2005; Slife & Hopkins, 2005). The relationalist would also assume that these and other contextual relationships exist prior to addiction, during addiction, and subsequent to addiction. In fact, Buchman (2007) notes:

> The brain image may not necessarily indicate the brain's neuroplastic 'rewiring' over time from genomic, epigenetic, environmental, and social conditions. These factors are all necessary to understand the diverse nature of our brains, especially complex concerns such as addiction. (p. 1).

Without a doubt, relationality would explain the overall phenomenon of addiction as being inseparably linked to the "variables" of context, relationship, and the "environment" of choice. Many contextual relationships are involved in the whole of addiction "irrespective" of the [context of] genetic predispositions..." (Nader & Czoty, 2005, p. 1480). Therefore, a relational concept of addiction would focus on the implicit meanings within these relationships to further understand addiction and to inform the particular qualities of treatment. Indeed, a relational conception of addiction would find meanings in a wide variety of contextual relationships both material and intangible in the hope of "... providing alternative reinforcers" (Nader & Czoty, p. 1480).

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One such notable example of attributing meaning to intangible contextual relationships, is found within the Jewish people who, as a whole, have never had, to any noticeable extent, a problem with addiction (Bainwol & Gressard, 1985; Bales, 1946; Gilman, 2006; Sanua, 1981; Shaler, 1996; Wechsler, Demone, Thum, & Kasey, 1970). This example illustrates how context is essential for meanings, for both material and intangible factors. Although history has noted for nearly four thousand years the frequent use of wine, both as a staple in the home and as an integral part of ritual worship in the synagogue, addiction is evidenced only to a miniscule degree in the Jewish community (Diamant & Cooper, 2007; Johnson, 1987). In this example, the relationist would look for differences in contextual factors and their relationship to provide clues as to why addiction is conspicuously absent in Jewish culture.

For example, several contextual factors have been cited that may possibly indicate how alcohol's addictive influence is negated within the context of the Jewish community; e.g., obedience to scriptural commandments, family solidarity, group identification, community coherence, and the religious meaning ascribed to sacramental wine (Bainwol & Gressard, 1985; Sanua, 1981; Shaler, 1996). Each of these intangibles seems to indicate, that at least for one large population, the broader context may be an integral factor in the non-occurrence of addiction. This is a notable departure to many mainstream concepts which readily acknowledge the importance of context, as long as the context is biological in nature (Acker, 1993; Adame & Knudson, 2007).

The relationalist would, of course, view all behavior, especially the occurrence of addiction, as being most relevant when viewed in relation to its context. This means that addictions of every kind are not just the reflection of specific and identifiable contexts but

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addiction is also an expression of unidentified—or at least previously minimized—contexts that confer meaning and depth to all aspects of all addictions. For example, psychiatrist Norman Doidge (2007) of Columbia University asserts that when pornography is viewed repeatedly in the contexts of secrecy, isolation, and familial alienation the individual is at risk for developing a kind of "neosexuality or rebuilt libido" (p. 106) that acts as a precursor to hardcore pornography addiction. In light of this example, the relationalist would not view pornography per se as the focal point of pornography addiction but would assume that a number of mutually constitutive elements are involved in its most meaningful aspects.

We thus see that many kinds of addiction, e.g., tobacco, alcohol, drugs, sex, or gambling, etc., are nuanced by the particular dynamic which occurs in certain contextual relationships. Just as the hammer is perceptibly different from one context to the next, the underlying dynamics of all addictions, according to a relational alternative, are only discernible when viewed from the perspective of context (Slife, 2005).

Reduction. We previously learned (in Chapter 2) that ontological reduction assumes all things, including addicted individuals, can be understood and treated in terms of reducible components, with some components being more "basic" than others (Slife & Richardson, 2008). The purpose of reductions then is to locate the most "basic" issues and "sufficient" factors and assert their priority (Honderich, 2005; Schaal, 2003). From an addictions perspective, most concepts reduce the behavioral phenomenon of addiction to self-contained entities, such as biology or other similarly conceived materialistic constructs. For example, Leshner's (1997) states, "Understanding that addiction is, at its

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core, a consequence of fundamental changes in brain function means that a major goal of treatment must be either to reverse or to compensate for those brain changes. (p. 46).

The relational alternative to such approaches would first assume that addiction is indeed reducible in some senses. In fact, relationality would take for granted that some types of reductions, such as linguistic reductions, are inevitable in everyday use (Slife & Richardson, 2008). For example, the word *addiction* is, itself, a linguistic reduction based on the "Latin root *addicere* meaning to adore or to surrender oneself to a master" (White, 1998, p. xv). Most theories of addiction seem to reflect this linguistic reduction based on the broad acceptance of *craving* and *loss of control* as central features of the disorder (Nestler & Malenka, 2004; Potenza, 2007; Stevens, 1987). Some types of reductions, in the study of addiction, therefore, do seem to capture, at least fractionally, the widely variable phenomenon of addiction. Thus, reductions are helpful in one sense when facilitating at least a cursory understanding and appreciation of addiction. Even so, abstractions, such as reductionism, tend to reify certain factors of addiction as wholly explanatory.

However, a relational alternative to reductionist approaches would presume greater meanings and understandings are more accessible when theories of addiction do not reify these linguistic descriptions as self-contained or governing principles, i.e., contextless and reductionist. For example, three types of abstractionist reductions associated with the biopsychosocial model are thought to initiate a chain of events which culminate into addiction; the nucleus accumbens deep within the brain (Cornish & Kalivas, 2000; De Chiara et al., 2004), traumatic experiences in childhood (Kerr et al., 2009; Kumpfer, Trunnell, & Whiteside, 1990), and risks associated with the adversity of

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low SES environments (Bailey, Hser, Hsieh, & Anglin, 1994 Suchman & Luthar, 2000). Thus, the biopsychosocial model brings together seemingly independent factors that are thought sufficient to either initiate mental health issues or sufficient to commence a sequence of interactions which lead to mental health issues, e.g., addiction (Engle, 1992; Shuttleworth, 2002).

The relational alternative would view these areas of interest not as self-contained and sufficient but rather as mutually constitutive and necessary for addiction to occur. As Slife & Hopkins (2005) point out:

> No one condition can be sufficient in itself for explanation and understanding. However, each condition plays an irreducibly necessary role in understanding human behavior in the same way that each part plays an irreducibly necessary role in the whole...In other words, each part has a unique and unduplicated function in the whole, but each part plays a pivotal role in the qualities of the other parts... (p. 17).

In this respect, the nucleus accumbens, childhood trauma, and low SES environments, highlighted in the BPS model, may possibly serve a "unique and unduplicated function in the whole" of addiction. Additionally, a relational alternative would assume the "whole" may contain a diverse assortment of necessary "parts" not inevitably restricted to an established framework. In short, the phenomenon of addiction, under this perspective, is not limited to any defined categorization of factors but may be situated (and thus changeable) in other areas of the human experience as well. As we have noted in Chapter 3 this is not always the case since seemingly dominant aspects are often considered the defining features of addiction.

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For example, since the addictive phenomenon of craving is so ubiquitous and seemingly powerful it is often referred to as the cardinal feature of addiction. (Haney, 2008; Miller, 1993; Oslin et al., 2009). In this case, addiction has been reduced to one particular defining aspect, which is typically situated as biological in origin and thus observable on brain scans (Milkman & Sunderwith, 1987; Olbrich et al., 2006).

However, the relationalist would regard craving not as an independent biological phenomenon representative of all addiction but rather as an addiction factor that is responsive to relationships and the context in which it occurs. For instance, Lee et al. (2005) have found that cravings are mediated by such factors as emotion, environmental cues, and cue interpretation. Buchman (2007) concludes "... interpreting a drug craving brain scan as foundationally biological is troubling [since] ... cravings are largely cue elicited and triggered by environmental stimuli." (p. 3). The relationalist would further assume that cravings, emotions, environmental cues, and other features of addiction are most meaningful when viewed as being in a mutually constitutive relationship with one another and the context in which they are found. Although Buchman (2007) rightly concludes that there is more to cravings than can be measure on "brain scans", there is still an added dimension that relationality would address more fully. For example, the relationalist would further assume that the brain and its mutual relationships with cravings, cues, and stimuli; i.e., are, at their most basic level of understanding, ontologically inseparable. That is to say, phenomena, such as cravings, cannot be understood correctly without taking in to account such relationships. Despite Buchman's appraisal that cravings are not merely biological, there is the hidden assumption that these factors somehow operate separately until their interaction.

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This alternative approach conceives of factors as irreducible in meaning since their meanings are inseparable from the meanings of other factors and the contexts in which they are situated. For example, one of the most resolute factors found within the disease concept reduces addiction, fundamentally and sequentially, to brain structures and neurotransmitters (Blum, 2000; Leshner, 1997; Nestler & Malenka, 2004; Olbrich et al., 2006). Such reductions have led to the assumption that brain structures and their attendant neural processes are fundamentally independent and unchanging over time (Acker, 1993; Levine, 1994; Raistrick, 2008). However, recent advances in neurobiology suggest that neurological features are in constant flux depending on a number of "internal" and "external" relationships (Buchman, 2007).

The emerging field of *epigenetics* is one such example of science taking notice of changes that emanate from contexts outside the individual. Epigenetics supports the hypothesis of non-biological mechanisms, such as the environment, social and cultural contexts, and behavioral factors that are implicated in gene expression (Bird, 2007; Reik, 2007). In fact, Barrett & Wood (2008) comment "... epigenetics has become central to several fields of neurobiology such as, drug addiction, depression, neurodegenerative diseases, and memory." (p. 490).

Although epigeneticists are confident that the individual, environmental conditions, and addiction do in fact share a fundamental and dynamic relationship, the details of how this is played out is not yet clear (Hanson, 2008). Still, the relationalist would suggest that the fundamental meanings, functions, and influences of such relationships are irreducible to factors that are considered to be sufficient in and of themselves. For instance, Slife & Hopkins (2005) submit:

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> ... irreducibility is evidenced by two commonsensical qualities of any whole. First, a part's existence within a whole depends upon its being uniquely differentiated and identified as a part. Second, and perhaps more importantly, each part is a necessary condition for the whole. Each part has a distinct and necessary status because deleting any one part destroys or changes the identity of the whole. (p. 18).

Recall Slife's (2005) illustration of a stick figure mentioned in Chapter 2 (p. 21). Addiction by this same token cannot be reduced to separate factors regardless of how significant they appear to be. Although specific biopsychosocial features of addiction may be identified, each has meanings that are fundamentally bound up with the meanings of other factors of interest. Because of these relationships, a relational approach to addiction would reject any hierarchy implicit in reductions where certain aspects are considered "core" factors and where "treatment goals" reflect such considerations. (Leshner, 1997, p. 46).

A relational alternative would suggest that addiction cannot be understood or dealt with unless each factor is valued as "a necessary condition for the whole" (Slife & Hopkins, 2005, p. 18).Consider the examples Flores (1997) and Muggeridge (1980) give that seem to support the relational view that addiction and recovery from addiction involves the dynamics between numbers of factors, many of which are often overlooked in reductionist approaches. First, Flores (1997) comments on the attitudes of the addicted individual:

> Alcohol and drugs reward self-centeredness and hedonistic pleasure... Thinking of this sort is a form of idolatry in which alcoholics use chemicals as a way of

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> facing the world when the limits they face are found to be unacceptable... For the recovering alcoholic, the pursuit and understanding of happiness requires a shift in perspective... Pleasure must be authentically earned by a subtle and important interplay between values, beliefs, customs, ideas, and behavior that cause no harm to others. (pp. 278-279).

In this illustration, recovery for the addict is a matter of altering one's beliefs and behaviors in direct opposition to current addictive attitudes and actions. That is to say, the individual's frame of reference is changed from one of "self-centeredness and hedonistic pleasure", to "the pursuit and understanding of happiness" (Flores, 1997, p. 278). The relationship between perspectives and actions in this case seems to be mutually constitutive and a "necessary condition for the whole" of recovery (Slife, 2005, p. 18). Since each factor is mutually embedded there is no line of demarcation signifying when attitudes and actions begin and end, since they are ontologically inseparable.

Of course the relationalist would assume that all significant factors of addiction are in a perpetual contextual relationship, which conveys the most meaning to the disorder. In this sense relationality permits us to comprehend addiction from the vantage points of relationships and contexts, rather than from isolated components and processes offered by reductions. In fact, one of the practical advantages to a relational conception of addiction is a greater awareness of the unique circumstances created by factors having mutually constitutive foundations. Unlike reductionism, relationality would thus permit us to "see" that within addiction there exists the possibility of many other factors in addictive relationships (for example, spirituality and culture) that should be taken into account and treated (Flores, 1997, p. 278).

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Next, Muggeridge (1980) provides an example of one particular aspect of the human experience that has application to addiction and which is regularly overlooked in favor of more apparent reductions. He remarks:

> When mortal men try to live without faith or a belief in God, or in AA terms, a higher power, they will unfailingly succumb to megalomania or erotomania or both. Faith in God teaches us humility and without humility we will continue to pursue excitement, pleasure, and the obsessive satisfaction of our appetites. In a state of arrogance, we will remain in danger of substituting pleasure for happiness... (As cited in Flores, 1997, p. 279).

In this case Muggeridge (1980) introduces a number of aspects of addiction which are difficult to reconcile using strictly reductionist methods, that of moral and religious values. Although the relational alternatives proposed in this chapter do not recommend any one religion or religion per se, there is, however, within some of the suggestions a strong moral context. A relational approach to addiction would, however, allow for the influence of a personal God, rather than situate such possibilities exclusively in the realm of natural laws or "rational moral philosophies" (see Dawkins, 2000, p. 318-322).

For example, in a paper examining the existential and spiritual aspects of living with addiction, Wiklund (2008) outlines six issues—which she considers spiritually foundational to addiction—that pervade the addict's day to day life. She argues "... that people living with addiction are constantly struggling to overcome... [the issues of] meaning-meaninglessness, connectedness-loneliness, life-death, freedom-adjustment, responsibility-guilt, and control-chaos." (p. 2435). Wiklund goes on to suggest that integrating such themes as: "restoring dignity, forgiveness, community, acceptance, and

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reinterpreting life" into a caring therapeutic forms a spiritual connection to the existential needs of the individual. In fact, Wiklund assumes that "spirituality as a driving force should be considered when caring for addicted persons" (p. 2435). Why would the addiction researcher rule out such moral or even religious factors before investigation? How scientific is it to rule out such factors before examining them? Yet, this is what is currently happening in the abstractionism of addictionology from a relationalist perspective. A relational perspective, by contrast, would be open to the possibility of spiritual struggles in addiction.

Although many other contemporary theories of addiction take notice of the spiritual aspects of addiction, most consider it as "both an independent and a dependent variable" but a not mutually constitutive factor as relationality would (Cook, 2004, p. 546). While a relational alternative to addiction would not define spirituality per se, it would assume that allied topics such as relatedness, transcendence, purposeful living, and non-materiality are relevant to addiction and should not be set aside in favor of more reductionist factors.

For instance, the moral quality of humility, mentioned by Muggeridge (1980), is uniquely related to many of the relational conceptions presented here and is often referred to as spiritual in nature (Flores, 1997; Gordon, 2008; White, 2004. Since addiction is a complex nexus of contextual relationships not easily defined or ever fully discerned (Anderson, Moore, & Zaff, 2008), the relationalist would assume that the quality of humility is important both for the addict and from significant others (e.g., family, therapist, supportive individuals, etc.).

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For the addict, humility is likened to a gateway quality that is integral in dismantling the destructive cycle of "feelings of isolation, actions of self-indulgence, feelings of hatred [humiliation], and actions of self-concealment" so prevalent in addiction (Beck & Beck, 1990, p. 16). For the therapist and those involved in trying to understand addicts and their unique contexts, humility is the acknowledgement that "experts" and novices alike do not have, nor will ever have, all the answers that guarantee a complete understanding of addicts and their behaviors (Acker, 1993; Cummings, 1979; Glaser, 1974; White, 1998). In fact, the relationalist would assume that many so called "epiphanies," for addicts and others, comes in the context of a nexus of humble attitudes and caring relationships.

Humility then, for the relationalist, is acknowledging that the individual is qualitatively different from all others and also personally different in a variety of contexts and relationships. Indeed, Slife & Richardson (2008) would propose that "A relational ontology requires us to cultivate a sense of humility and a deep appreciation of enduring human limitations." (p. 710).

Identity. The matter of identity, as we recall from Chapter 2, has been a significant topic of interest in the study of human behavior (Bella, 1985; Cushman, 1995; Guignon, 2004; Taylor, 1989). The addiction sciences have been no less involved in finding the best approach to this important area of concern. For example, the major conceptualizations of addiction are generally inclined to underscore three primary abstractionist assumptions concerning the issue of identity; the addictive identity is self-contained, exists prior to relationships, and is largely consistent across all contexts. This section will address these assumptions and provide a contrasting alternative.

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First, most conceptual approaches to addiction assume that the addictive "identity" originates in self-contained internal factors or from external factors that initiate internal processes (Engle, 1977; Hughes, 2007; Redfish, Jenson, & Johnson, 2008). The addicted identity is therefore based on the dominance of factors that arise from within and foster "The creature of habit... and [their] loss of control" (Stevens & Marlatt, 1987, p. 85). This in turn implies an individualistic frame of reference concerning addictive behavior and thus overall identity (Cushman, 1995; Khantzian, 2003; Walters, 1996).

The relationalist would respond to this conceptualization by first assuming that addiction is not a bounded disorder enveloped within the bounded identity of the individual. Indeed, addiction and the vast assortment of factors considered constitutive of it and the individual's identity have little meaning without considering the context of relationship. Once more Slife (2005) reminds us:

> Each thing, including each person, is first and always a nexus of relations. All things have a shared being and mutual constitution. They start out and forever remain in relationship. Their very qualities, properties, and identities cannot stem completely from what is inherent or 'inside' them but must depend on how they are related to each other. The outside is as important as the inside. (p. 159).

Adhering to this view, the relationalist would begin by assuming that the identities of addicts, and indeed all identities, are essentially unbounded, evolving, and responsive to relationships and contexts. In this respect the addicted individual is not assumed to be a static entity or "... a living scarecrow that responds to stimuli" (Panksepp, 2006, p. 1)—as some approaches seem to suggest—but rather is shaped and identified by factors which

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have no clear lines of separation and indeed no real meaning without mutual relationships (Gergen, 2009).

This implies that a relational approach would first assume that individuals with various addictions form identity from numerous mutually constitutive sources not limited to self-contained factors perceived to exist only within the individual. For example, the *culture* in which we live with its attitudes, perceptions, and trends is ontologically inseparable from the *brain* with its structures, chemistry, and processes. Indeed, culture and the brain, at least where issues of addictive identity are concerned, are ontologically inseparable from all aspects of the individual's life.

Second, the addictive identity is thought to be an essential element that exists prior to relationships and thus confers a significant amount of influence on later conditions (Kreek, Neilson, Butelman, & LaForge, 2005; Sevy et al., 2006). Such perspectives assume that addicted individuals, at their core, possess an innate weakness or vulnerability for substance abuse previous to contact with others, the environment, or even addictive substances (Nader & Czoty, 2005; Redfish, Jensen, & Johnson, 2008). Discovering the physiological locations of these weaknesses has become one of the major research focuses of the addiction sciences (American Medical Association, 2008; American Psychological Association, 2007; Buchman, 2007). In fact, Acker (1993) points out that "The search for conclusive evidence of genetic predisposition symbolizes the hope that a biological explanation [for addiction] can be found..." (p. 203).

Relationality, by contrast, would assume that the "core" identity of the individual and addiction is neither autonomous nor sequential but is situated in the ever-present shared nature of factors, contexts, and relationships. For example, the relationalist would

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assume that the brain is an important characteristic in understanding the most fundamental "truths" concerning addiction. Indeed, the relationalist would view biological factors as not only compatible with a relational approach to addiction but crucial to comprehending the whole context of addiction. However, relationality would situate the brain as being in a shared relationship with other important factors, such as the context of "identity", rather than it being abstracted from other factors. In fact, relationality would suggest that abstracting an important factor, such as the brain, may lead to incomplete "truths" and thus faulty assumptions.

Under a relational ontology no core trait or self-contained set of traits is considered sufficient to the addictive identity; relationships are the indispensable key to understanding addiction. For example, in most modern conceptions of addiction *vulnerability*—a direct effect of abstracted factors—is considered a ubiquitous feature of addiction etiology (Acker, 1993; Dodes, 1990; Mendola, 2003). Whether from genetics, environment, a weak will, or the traumatic past, the individual's present and future identity is somehow shaped by prior or preexisting factors (Horgan, Cassidy, & Corrigan, 1998; Khantzian, 2003; Marcenko, Kemp, & Larson, 2000; Peele, 1990). Thus, an underlying vulnerability in a previous context is manifest in the future context as addiction.

Under a relational alternative to addiction, vulnerability and its connection to the addictive identity would not be cast as a self-contained feature, complete with its own meanings and implications, but rather would derive its meanings and implications from its mutually constitutive relationship with all other significant aspects of addiction. In

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this respect, addiction or an inherent weakness to addiction is not, under a relational perspective, invariable from one context to the next.

For example, under a number of theoretical views vulnerability to addiction is often conferred by precursors of a traumatic nature situated in the individual's past—especially if the trauma occurs during childhood development (Bernstein, 2000; Kalivas & O'Brian, 2008; Somer, 2003). Relationality would assume that although childhood trauma is strongly correlated with a number of addictions (Carnes & Delmonico, 1996; Schneider, Sealy, Montgomery, & Irons, 2005), this does not mean the trauma or the resulting factor of "vulnerability" to addiction occurs in a contextual or relational vacuum. As Slife & Richardson (2008) explain "... all things [including identities] are profoundly interdependent—past and present, one culture and another, individual and society, self and other (p. 714). From such a perspective, vulnerability or lack of vulnerability to addiction is mutually constitutive of many "interdependent" factors including, the contexts of the past and the "here and now" contexts of the present (Slife & Richardson, p. 714). The practical implications, therefore, for addiction through a relational approach to identity are many. For example, if the influence of vulnerability differs from one addict to the next and from one context to the next, then a "one size fits all" approach to addiction would be inconsistent with the fundamentals of addiction. However, Chris Prentiss (2005) of Passages Malibu, a renowned treatment facility, reports:

> In almost every treatment center in the world... [They] offer a one-program-fits-all type of service, which is rather like a department store that sells one-size-fits-all clothing... It doesn't happen like that. Every client is different. (p. 133).

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A relational approach to addiction, would agree that not only is every client different but every client's identity is variable according to the contexts in which they exist and the mutual contexts of the past.

In a relational perspective the individual's past is a nexus of meanings derived from present experiences and choices, and expectations of the future that are meaningfully woven into the here and now (Slife, 2005). In this sense, vulnerability to addiction for the individual does not merely arise out of the past but is co-constituted with the present as a moment to moment reality. In this respect, "Time [i.e., the meanings associated with the past, present, and future] is not outside the events as an independent and self-sufficient entity. It occurs *through* events as "... relationships and changes occur." (Slife, 1993, p. 248).

For instance, individuals with a traumatic past may choose to "experience" again and again their history through feelings of victimization and resentment (Morrison, 1989) and thus be "vulnerable" to perpetuating the cycle of maladaptive coping. Other individuals may humbly choose to "make peace" with the past and draw upon it as a learning experience, refining process, or cautionary guide for the future (Hilton, 2009); thus, devaluing their victim status and recognizing the worth of even regrettable incidents in their history. In this sense, the past and its implications for present identities are bound up in a relational connection with the present contexts, one of which, according to relationality, is the context of choice.

The third and final abstraction, concerning the issue of the addictive identity, is the conception that the identity of the addict is thought to be largely consistent across a variety of contexts and relationships (Acker, 1993; Heyman, 1995). That is to say the

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"causal" elements of addiction—which in fact define the individual—remain largely unresponsive to the contexts which they are in. Such a position tacitly assumes the addictive identity is intrinsic to the addict prior to addiction, in the midst of addiction, and even in recovery from addiction (Flores, 1997; Leshner, 1997; Menninger, 1938). In short, individuals inherit life-long diagnoses in which they have little or no choice or power to fundamentally alter their essential identity; thus giving credibility to the notion of "once an addict, always an addict" (Kellogg, 1993, p. 236).

However, as with vulnerability (above), from the vantage point of relationality such assumptions appear inadequate to capture the fundamentals of the addictive identity. For example, powerlessness in one form or the other is thought be a consistent and ubiquitous feature of the addictive identity (situated within the *will*) regardless of contexts or relationships (Alcoholics Anonymous, 2001; Dyslin, 2008; Honeyman, 1989). In fact, the first step of the Twelve Steps of Alcoholics Anonymous (2001) states "We admitted we were powerless over alcohol – that our lives had become unmanageable" (p. 30). Although this author heartily endorses the good done by AA, a close ontological inspection and relational interpretation of powerlessness may facilitate a clearer understanding of identity.

Powerlessness, as it relates to the addictive identity, has been characterized as "unrelenting compulsion, disregard for reasonable limitations, and loss of ego autonomy." (Dodes, 1990, p. 398). A relational view of this well researched characteristic of addiction would first assume that "powerlessness" is variable according to relationships, contexts, and the important context of agency. This means there are unlimited variations of addiction according individuals, their relationships, their choices,

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and the contexts in which each occurs. This first implies that "powerlessness" is situated in a nexus of factors that change it and the individual's very meaning from one situation to the next.

For example, in one context, the addict may expend a great deal of time, energy, and resources (i.e., power) in the service of locating, purchasing, and keeping secret the use of illegal substances (Peele, 1990). Without a doubt, an addict's expertise in manipulating, deceiving, and cajoling others into facilitating their drug use is, in itself, an enormous display of power (Brodie & Redfield, 2002; Flores, 1998). Alcoholics and addicts, in fact, will standardize and ritualize their use of substances to maximize the power of the substance to produce just the right results (Osborn, 1988; Schneider, Sealy, Montgomery, & Irons, 2005; Sandoz, 2004), i.e., the addict has the power to produce more "powerlessness". In another context, addicted individuals may be powerless to change the consequences of certain aspects of substance abuse, e.g., withdrawal, damaged relationships, or legal entanglements (Frey, 2003). In yet another context, the addict may even exert considerable power (i.e., agency) over the substance itself; for instance when maintaining a commitment to family and religious values not to relapse.

As we see, powerlessness for the addicted individual may have many meanings and ensuing implications. Nonetheless, the conventional approaches to addiction attribute the addict with a form of powerlessness that has been reified into a self-contained effect of self-contained causes (Dyslin, 2008; Honeyman, 1989; Ronell, 2003). Relationality on the other hand would view powerlessness in the context in which it is assumed to exist and equally recognize the many variable forms of power that the individual may possess. Such insights may lead to promising therapeutic approaches

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where the individual is taught to "transfer" power in a negative sense to more productive applications. Thus, powerlessness, as it applies to the addictive identity, is much more variable from a relational perspective. A relational theory of addiction, and any subsequent therapeutic application, would recognize these nuances of contexts and tailor treatment options to "channel" the power that individual addicts may already possess. As these forgoing examples illustrate, relationality has the power to enhance the meanings of the addictive identity, through increased awareness of contexts, relationships, and choices.

A relational alternative would, thus, assume that labels alone, e.g., powerlessness,—which simply offer an abstractionist snapshot of addiction and perhaps contribute to stereotypes—are inadequate to capture more fully the important nuances of the "addictive identity". By reinvisioning the "addicted identity", relationality expands what previously may have been considered impersonal determinants (e.g., genetic, environmental, psychopathology) to include factors considered more personal and variable in relationship to all significant aspects of addiction. For example, the level of an individual's choices, spiritual resolve, and personal accountability have each been mentioned as important features of addiction and recovery (Gordon, 2008; Hilton, 2009; May, 1988). The relationalist would go even further by suggesting that such "personal" features (often considered *subjective*) are ontologically inseparable from "impersonal features" (likewise considered *objective*) in establishing identity. As we recall from the previous section's illustration of epigenetics, a whole host of contextual factors are in relationship with, and thus responsive to, our most basic ideas of identity (Buchman, 2007). In this sense, a relational conception could enhance the biological perspectives of

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addiction by bringing attention to variables infused within factors and their mutual relationships.

One interdependent factor of identity that relationality would assume plays a significant role in addiction is the factor of contextual agency (see pp. 43-46). In fact, Slife, Burchfield, & Hedges (2002) maintain that "... no biological account of mental, social, or even neurological functioning is complete without important additional factors like human agency." (p. 19). Noted author and Harvard Medical School lecturer Gene Heyman (2009) seems to agree, especially where addiction is concerned, "... it is not possible to understand addition without understanding how we make choices." (p. vii). Although our final topic in this section, determinism, will address the issue of agency in depth, it is important that we refer to it here briefly to fully appreciate its relevance to identity.

In contrast to many conceptualizations where agency is thought of as an effect of causal determinants (Kalivas, 2004; Pomerantz, 2005; Raistrick, 2008), relationality situates agency as a significant necessary factor in the formation and maintenance of identity, as it relates to addiction. In this respect the individual is never constrained nor empowered by "factors" alone but makes choices within the boundaries of personal strengths, limitations, contexts, and relationships. Agency then is a mutually constitutive characteristic of addiction that shares the same ontological footing as biological and psychosocial factors.

As we recall, from earlier in this section, the contexts of victimhood or empowerment are inseparably connected with the context of agency. If, for example, an addicted individual is awakened to a new sense of possibilities made available in present

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context, and uses these possibilities to initiate positive changes, relationality would assume that the qualities of the past are simultaneously changed as well (Slife, 2005). No longer need the individual be imprisoned by guilt, remorse, or shame but is brought to the point where the possibilities of the present literally change the qualities of the past.

In view of this perspective, a relational conception of addiction and the "addictive identity" places a considerable emphasis on personal responsibility and accountability in the here-and-now, conceptualizing the addict as an agent of the present rather than a victim of past. Perhaps in no other way does relationality offer a more contrasting alternative to current views of addiction, which frequently abstracts the individual's identity into "once an addict, always an addict" stereotypes (Heyman, 2009, p. 65).

Experience. According to the Table of Distinguishing Features (see Appendix A); experience can be approached from two diverse perspectives. First, the abstractionist perspective situates experience into two separate "worlds", that of "objective realities" and "subjective experience" (Slife, 2005, pp. 13-28). By contrast, the relational perspective assumes that all experience is neither objective nor subjective but constitutes an interpretive reality or meaning. Conventional conceptions of addiction tend to favor the former approach (Acker, 1993; Leshner, 1997; Mendola, 2003; Raistrick, 2008).

This section will briefly review three prominent abstractionist conceptions of experience, within addiction, and then introduce a more in-depth relational alternative to each. These particular abstractionist views exemplify approaches in addiction theory and therapy in which commonalities of the addictive experience are taken for the most fundamental realities of each individual experience. The abstractions selected for comparison are: 1) Experience within addiction is widespread and universal from person

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to person and from context to context; 2) such experience is part of a linear continuum that is ultimately reducible to objective entities; and 3) experience is, by and large, a self-contained phenomenon that originates from self-contained sources.

The first abstractionist assumption is situated in the belief that experience within addiction is manifest so consistently across a broad spectrum of contexts that it is often seen as a homogenous and more or less static entity rather than a uniquely personal and dynamic occurrence (Alcoholics Anonymous, 2001; Jellinek, 1960; Menninger, 1938). Consider for example, the way in which Hobson (1993) abstracts, and then reifies the aspect of *feelings* within addiction:

> The life-world of the addicted person is set within intense feelings. These feelings form the context within which the addicted person lives. The world is ordered by feelings and the actions of the addicted person are organized around an attempt to manage feelings. The feelings are often, though not always negative, and are experienced as potentially overwhelming and always intense. (p. 491).

Since "intense feelings" appear, on the surface, to be such a ubiquitous "reality" of addicts—i.e., "[Their] world is ordered by feelings"—feelings are assumed to be ontologically explanatory in and of themselves (Hobson, 1993, p. 491). In this respect, the unique particulars embedded within each individual's experience are overlooked in favor of more obvious or common manifestations, for example, *feelings*. Consequently, explanations of this sort are based on abstractions that are considered so consistent and ubiquitous; they are often reified into theory and practice (Acker, 1993, Darke, 2008; Edwards, 1994; Hughes, 2007).

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A relational explanation of such an addiction factor, as feelings, would start by assuming that feelings are mutually constitutive with the individual's personal and greater context, and likewise in relationship with all factors. This means that feelings, per se, are an interpretive reality for each individual that may or may not always be experienced as "overwhelming and always intense" (Hobson, 1993, p. 491). In fact, relationality would assume that "The world is [not] ordered by feelings..." nor do "... these feelings form the context within which the addicted person lives." (Hobson, 1993, p. 491). A relational alternative, by contrast, would assume that the "world is ordered" by the shared nature of all things and that addicted individuals (indeed all individuals) live in a concrete context of relationships, contexts, and choices.

Another pertinent example is the widespread phenomenon of *relapse*, and how it is now so universally conceptualized and accepted, relapse has become an "*it*"; that is to say, relapse "is treated like an object that can be expected to do the same thing to... [every addict] every time." (Bell, 1995, p. 10). However, a relational outlook assumes that each experience of the addicted individual is a nexus of mutually constitutive elements. This means that all important elements of the individual's life are in a meaningful relationship that results in endlessly diverse experiences for each individual at any given time. No experience among addicted individuals is fundamentally the same, since each individual shares a unique relationship among mutually constitutive factors; furthermore each experience is uniquely interpreted by the individual and others. "One way of putting this is that all people... experience interpreted realities or meanings rather than objective realities or objects." (Slife & Richardson, 2008, p. 18). Consequently, a relational

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approach would assume that "objectivity" is to be found in the "eye of the beholder", rather than in "separate worlds" assumed by abstractionism.

Take for example, the previous abstractionist case in point of the phenomenon of relapse. The relationalist would assume that since individuals are highly constitutive of their contexts, relationships, and choices, then one of the most fundamental features of relapse is the individual's personal interpretive meaning of the experience. The relationist would furthermore assume that the experiences of one individual or a group of individuals (as in research studies) is not necessarily generalizable, in theory or in practice, to all individual experiences. Slife & Wiggins (2009) clarify the distinction between the interpretive meanings of the individual and the meanings conferred by theory; they state:

> "Meaning here refers specifically to the meaning encountered in lived experience, rather than a more detached or abstractive meaning such as a theory or principle... meaning is [therefore] embedded in one's practical engagement with the world rather than in abstract [e.g., theory] or cognitive deliberation... " (p. 23).

This is not to say that the theories of relapse are "... irrelevant, but theory is not primary; the concrete context of lived practice is the more real and fundamental." (Slife & Wiggins, 2009, p. 10). Following this perspective, the relationalist would attend to the "concrete" experiences of the individual to inform theory and practice, rather than relying entirely on theory to explain the "meaning[s] encountered in lived experience..." (Slife & Wiggins, p. 10).

Situating the "lived experience" as the most fundamental aspect of addiction and the individual carries with it a number of important implications. Although, the

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therapeutic alternatives concerning experience will be reviewed more extensively in this chapter's last section, there is one therapeutic nuance worth mentioning here. It should be noted that a relational approach to the experiences of the individual carries with it the assumption that the individual's experiences inform the direction and quality of the therapeutic endeavor.

There are some, in the addiction sciences, who believe that relying too heavily on abstractions discovered in addiction research, rather than focusing on the "concrete" day-to-day experiences of the addict, carries with it the hidden danger of not only objectifying addiction but the addict as well (Acker, 1993; Anderson & Griffin, 2008; Critchfield, 2002). In fact, there is a growing concern that objectifying addiction results in a stereotypical view of the addict, which in turn underestimates how different each addicted individual, really is (Adams & Robinson, 2001; Bell, 1995; Buchman, 2007; DuPont, 1998). Griffith Edwards (1994), past editor-in-chief of the journal *Addiction* agrees that such objectifications may lead to mistaken notions of addiction:

> Much science is guided by the belief that the ultimate frontiers of understanding lie further and yet further away from the impossible crudities of the whole, real, painful human experience... Good science necessarily takes things to bits and the bad scientist then mistakes the bits for the whole. (p. 10).

Relationality, therefore, would assume that such hidden dangers, such as objectifying the individual, could, to a great extent, be avoided by not reducing individuals or their "human experience" to common themes and descriptions. For example, elsewhere in this dissertation (p. 85), loss of control, helplessness, and diminished agency have been referred to as the "cardinal manifestation[s] of addiction"

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(Miller, 1993, p. l8). In this example, *loss of control* is expected to emblemize every addict and indeed every addict in every context.

Relationality would, by contrast, assume that there are profoundly unique factors and meanings underlying that which is often expressed in theories or methods as the most basic reality. Additionally, it is the mutuality among contexts, relationships, and addiction factors which provide these unique themes and descriptions. Therefore, relationality would assume that individuals and their interpretive reality should always represent the foreground of therapy and the therapeutic relationship (Slife, 2005).

Our second abstractionist assumption is that the experiences of the addicted individual fit into a linear continuum that is reducible to individualistic entities and/or self-contained qualities. For example, experience in many addiction theories is thought largely to be a secondary behavioral effect rooted in primary causal conditions (Moss-Walton & McCaul, 2005; Pumariega, Rodriquez, & Kilgus, 2004). Such views often attempt to encapsulate individuals and their experiences into causal antecedents which precede experience. For instance, Hartling (2004) clarifies this aim by stating:

> Following these dominant theories, substance abuse is viewed individualistically, suggesting that the problem is located within the individual, who is deficient in some way—for example, ill-informed, weak-willed, immature, or easily influenced by others; or one who has poor decision making skills, low self-esteem, no self-control, or misperceives social norms. (Hartling, 2004, p. 199).

In this example, it can be assumed that underlying such behavioral and character descriptions are the more "objective" factors of biology (American Medical Association, 2008; Goldstein, 2001; Koob, 2007; Kreek, Neilson, Butelman, & LaForge, 2005;

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Kushner, 2006). For instance, hostility is preceded by intoxication, which is preceded by ingesting intoxicants, which is preceded by depression or anxiety, which is preceded by low dopamine levels, and so forth (Colin, Kosten, & Kosten, 2006; Massaro & Pepper, 1995; Sevy et al., 2006). Often the quality of linearity is assumed within experience since the elements of the addict's experience seem detached and/or sequential in their manifestation.

For example, Pumariega, Rodriquez, & Kilgus (2004) assume linearity exists among adolescent addicts since they seem to experience early drug involvement as discrete stages:

> Substance abuse among adolescents follows a fairly predictable progression, beginning with the recreational use of gateway substances such as alcohol and cigarettes, followed by marijuana and, eventually, other illicit drugs (especially cocaine or crack in the inner city). After initiation with such substances, individuals can progress to other illicit drugs such as opiates and hallucinogens. (p. 147).

Relationality, on the other hand assumes no ontological separation in the "lived experience" of the addicted individual. Under a relational perspective no particular context, such as a "stage" of abuse, is ontologically detached from any other context. Relationality would assume, therefore, that given the right context addiction could skip or stall in any number of so called stages. In fact, it is the nature of the shared relationships between individuals, their contexts and addiction factors that makes the addict's experiences all the more relevant and therefore valuable to a relational alternative to addiction.

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Take for example, the abstractionist's notion of linearity mentioned above. All three of the conceptual frameworks mentioned by this author: the disease, biopsychosocial, and life-process models, situate addiction as the final or near final link in a linear chain of causal determinants (Ball, 2007; Darke, 2008; Davies, 1996; Edwards, 1994; Engle, 1980; Peele, 1987). This implies that the lived experience of addicted individuals which includes "subjective" experience, e.g., emotions, perceptions, and choices, are somehow separate from the objective world, e.g., biology, the environment, or a flawed psychological nature. It is strongly implied, for example, that the choices of the individuals, i.e. contextual agency (see pp. 40-49), is an effect of prior antecedents such as inherited neurotransmitters, childhood abuse, or a particularly willful character. However, Slife & Wiggins (2009) clarify this point in their relational conception:

> ... such things as inherited traits, chemical imbalances, traumatic experiences, or habitual patterns do not strictly determine a person's particular pathology, behavior, or experience of the world. Rather these things contribute to the contextual limits and possibilities that the person encounters. (p. 21).

Adopting these views, a relational alternative of experience would embrace the assumption that addicted individuals and their lived experiences is a nexus of the factors, relationships, and contexts of the individual including the necessary context of agency. We have noted previously that recognizing contextual agency as an important and shared constituent of addiction brings with it the implication of greater responsibility for the addict. This in turn means that the addict's personal interpretations of their own experiences—that is to say, their personal and world view—has embedded within it the important factor of agency. In this respect, each individual is the agent (within contextual

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boundaries) of how they view past histories, present lived experiences, and future possibilities. The relationalist would, therefore, propose that informing and educating addicted clients concerning this interpretive dynamic could facilitate a clearer understanding of their agentic role in each lived experiences. For instance, addicts could be interpreting their world in such a way that leads to addictions, such as "I'm a victim" or "Nobody likes me". After all, a relational conception of addiction would also assume that the self-defeating ideas and experiences of the addict are mutually constituted in the stultifying *context of ignorance*.

Comprehending such a relational context as education could mean the difference between the individual staying stuck in a perception of victimhood or discovering the wellsprings of empowerment. The relationalist would assume that once addicts perceive that they, in fact, have a substantial measure of control, this new knowledge—which also constitutes a mutual context—may possibly lead them to chose behaviors that exemplify greater control of their lives and thus increased empowerment. For instance, therapy that includes education on how to make healthy choices may result in the development of growth-fostering relationships (Miller & Stiver, 1997) and may expand the individual's repertoire of such life-skills as "mutual empathy, mutual empowerment, and mutuality..." (Hartling, 2004, p. 199).

The third and final abstractionist assumption regarding the experience of the addict is that experience is, at its most fundamental, a phenomenon that results from interactions among separate contexts such as the brain, the psychological character, or the environment. For example, the Disease model situates the foundations of the individual's addictive experience in the structures and processes of the brain (Andreasen, 1984;

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Leshner, 1997; Nestler & Malenka, 2004; Olbrich et al., 2006; Redfish, Jensen, & Johnson, 2008). The Biopsychosocial model situates these experiences in the interactions of self-contained factors derived from biological and psychosocial sources (Engle, 1977, 1980; Griffiths, 2005; Kersting, 2005; Levant, 2004). And, the Life-process model situates the addictive experience not as a "... disease but rather a habitual response and a source of gratification or security that can best be understood in the context of social relationships and experiences." (Santrock, 2008, p. 471).

A relational conception would suggest there are a number of alternatives to each of these mainstream assumptions. To begin with, the relationist would submit that all three models situate the experiences of the individual as commencing in some self-contained structure, process, or property. This implies that each of these factors is not only necessary but sufficient to account for the experiences of the individual. For example, most advocates of the Life-process model concentrate on the experiences of addiction as a reflection of the *values* and *will* of the individual (Peele, 2001), which is "In contrast to the disease model of addiction, which focuses on biological mechanisms... (Santrock, 2008, p. 471). In this sense, the values and willfulness of the individual do not share a mutual relationship with the brain but are thought to be independent of such processes. In short, the will is not responsive to all contexts but only shares a relationship with certain contexts such as "social relationships and experiences" (Santrock, 2008, p. 471). This implies that a person's will is capable of operating independently of some contexts in which decisions are made—and one of these contexts is the biology of the individual.

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Although there are a number of perspectives concerning the will, the *will* in this sense is understood to mean the "mental faculty responsible for acts for volition, such as choosing, deciding, and initiating motion." (Honderich, 2005, p. 957). The Life-process model of addiction elevates this notion of *willful* actions much in the same way that the disease model elevates *biological* processes. That is to say they are both ontologically independent and thus sufficient to account for experience.

The relationalist would suggest that the experience of addiction for the individual starts neither in willfulness nor in biology but is situated in the shared nature of all significant factors. From this perspective the relationalist would take for granted that the brain shares an inseparable and mutual relationship with agency and visa versa. Such a relationship is understood best in the relational view of contextual agency. The concept of *contextual agency* indicates that choices cannot be made in a vacuum that is free from the influences of relationships and contexts.

One particular example, is the addict's experience of *impulsivity* (i.e., the failure to self-regulate or defer wants) which tends to increase as the drug addict continues to use in spite of escalating adverse consequences (Kreek, Neilson, Butelman, & La Forge, 2005; Potenza, 2007). In this example, the impulsive choices of the individual are responsive to and share a mutual relationship with the brain. This is to say, the more the context of the brain is subjected to the addicts continued poor choices, the more the brain reflects the mutually constitutive nature of the relationship. This is not to say, that the relationship is cause and effect at its foundation but each factors most basic meanings are reflected in the mutuality and simultaneity of choices, relationships, and context.

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This view of contextual agency as a mutually constitutive element of the individual's life has important implications for a relational approach to addiction. In fact, a relational alternative would presume that although addicted individuals exercise agency in a number of ways, their choices change in nature since the consequences of addiction are in relation to the contexts of behaviors and biology, among others. This means that agency is not a self-contained dynamic but is constrained or empowered according to the relational and contextual realities of the individual.

There is found, for example, within the concept of contextual agency the strong implication that *others* and the quality of their relationships to the addicted individual is an essential factor in the prolongation or recovery from addiction. In short, since *others* constitute an important context; a relational approach to addicted individuals and their experiences would assume that the relational roots of addiction and recovery are uniquely bound up in others and their shared experiences.

For example, one of the primary tenets of Alcoholics Anonymous assumes that every person trying to overcome addiction needs the human touch by way of a *sponsor* (Alcoholics Anonymous, 2001). In this case, a caring individual, i.e., sponsor, who already has a firm footing in recovery, volunteers to befriend an individual who is earnestly seeking recovery (Fagan, 1986; Rush, 2002). A relational approach would agree with the fundamentals of such an approach by assuming that the most meaningful of contexts that addicted individuals' experience is the lived experience of human relationships (Slife, Harris, Wiggins, & Zenger, 2005).

A case in point can be found in how the "objects" of addiction are often thought to be the most real aspects of addiction. This is to say, that even though the addict's

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current experience with the non-human aspects of addiction, (for instance, specific drugs, e.g., heroin, specific paraphernalia, e.g., needles, and specific places, e.g., cheap hotels) seems to dominate their experiential space (Minkoff, 1995); the ubiquity of *others*, in meaning and reality, is nonetheless universal and mutually present in all contexts (Reber & Osbeck, 2005). In fact, it is this mutuality which conveys the most foundational meaning to objects and their interpretation. A relational alternative would, therefore, assume that *quality of relationships* is an essential element in the addict's day-to-day experiences. In fact, many have noted the inescapable relationship and resultant connection between the addict's quality of relationships and the moral frameworks in which the addicted individual chooses to relate to others (Borsari & Carey, 2006; Jordan & Lewis, 2005; Livingston, 2009; Wiklund, 2008). As relationality assumes the ultimate significance of human relationships in the addict's lived experiences, relationality simultaneously assumes the implication of a moral perspective to each relationship.

This particular aspect is often referred to as the moral, existential, or spiritual dimension of addiction and adds yet another important alternative perspective of the addict's individual experiences. Galanter (2008) clarifies this particular facet by noting:

> Spirituality has been paid little attention in the contemporary psychiatric literature... [despite] findings on a national probability sample, that the large majority of Americans endorse that they are "spiritual"... Spirituality is defined by those deeply felt beliefs that give meaning to a person's life. Although spirituality can be embodied in a religious orientation, it can also be understood as commitment to broader ideals or to the welfare of others. Among patients who then attended AA, those who reported having a spiritual awakening were more

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> than three times as likely to be abstinent 3 years later than those who did not... (p. 1514).

More specifically, Wiklund (2008) focuses on the spiritual dimension in addiction by commenting:

> Spirituality is considered a driving force within, and the concept relates to self, others, and God and the relationships between them. The spiritual dimension is of great importance in both the addiction itself as well as in recovery and... should be considered when caring for addicted persons. (p. 2435).

Bearing in mind these viewpoints, there are a number of issues dealing with the lived experience of the addict that a relational approach of this kind may richly address.

For example, the lived experiences of existential anxiety and lack of personal meaning have each been cited as fertile ground in which addiction may take hold (Cornelius, 1989; Gordon, 2008; Flores, 1997; Wiklund, 2008). A relational alternative would assume that confronting such experiences includes the agentic possibility of meeting them in a variety of ways. Obviously, one such way is to seek relief from negative feelings of this sort by escaping into the stupor or diversion of addictive substances or behaviors. Grof (1993) submits "... none of these momentary solutions quenches the deep... spiritual thirst of our being for wholeness... (p. 1). A relational alternative to managing feelings of this nature might involve reaching out to others for their support, exploring ways in which a value laden approach to life results in greater personal meanings, and serving others to diminish self-focus (Frankl, 1984; Hilton, 2009; Grof, 1993; Josselson, 1996).

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Each of these approaches, and indeed any approach to such experiences, is tacitly undergirded by the assumption that all behavior is made up of "... qualitative distinctions that differentiate what is noble and base, significant and shallow, admirable and despicable.... (Taylor, 1989, p. 19), there are some choices "... thus deemed higher, fuller, or richer than stances that slough off responsibility, disregard human dignity, or decline to seek out avenues for fulfillment" (Richardson, Fowers, & Guignon, 1999, p. 285). A relational alternative to all lived experience would therefore include the context of matters commonly referred to as spiritual or moral. Indeed a relational approach would assume as Thoreau (1854) that "Our whole life is startlingly moral." (p. 117).

Determinism. This concluding section will address, from the theoretical and treatment viewpoints, the distinguishing ontological feature of *determinism* as it appears in contemporary conceptions of addiction. This section will involve the explication of determinism by addressing the abstractionist tenets of *causation*, *sequentiality*, and *vulnerability*. Concurrently, relational alternatives will be proposed to address issues within these particular ideologies recommending, in particular, the perspectives of *simultaneity* and *contextual agency* as more viable theoretical options. In doing so, traditional literature sources will be cited for insights into how determinism undergirds traditional theories while less conventional resources will be cited for examples of relational alternatives. I will thus argue for a relational approach to addiction that takes an atypical perspective on the issues of determinism and agency.

Within the feature of determinism lies some of the most challenging theoretical issues facing psychology (Bishop, 2007; Engs, 1990; Slife & Fisher, 2000; Slife, & Hopkins, 2005). In fact, Bishop (2007) comments that:

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> "... mainstream psychologists face a severe dilemma concerning determinism and freedom... [For example] agents are pictured as being able to form their own preferences and to make choices based upon these preferences at the same time as they are pictured as being completely determined by forces beyond their control. (p. 296).

Addiction science as well is constantly confronted with this seemingly conceptual impasse that Bishop (2007) has noted. In fact, the high relapse rates associated with addiction perhaps provide the most compelling reason to address the questions surrounding determinism and its alternative, contextual agency (Brownell, Marlatt, Lichtenstein, & Wilson, 1998; Fingarette, 1990; Maslansky, 2007; Peele, 2000; Peele & Brodsky, 1991; Reith, 2004; Szasz, 1974). After all, each relapse is accompanied by not only a multitude of seemingly overwhelming factors and but a myriad of choices made within the contexts of the individual's day-to-day experiences.

As we recall from Chapter 3, determinism is the view "... that all events without exception are effects—[i.e.,] events necessitated by earlier events. Hence any event of any kind is an effect of a prior series of effects, a *causal* [italics added] chain with every link solid." (Honderich, 2005, p. 208). In short, behaviors and conditions of the present can be traced or reduced to principal issues or prior circumstances which operate as causal factors. Furthermore, since every "link" is seen as "solid" it is also seen as "causal" to the preceding links (Honderich, 2005, p. 208).

Determinism and its reliance on causality is situated to a great extent in the age old medical belief that individuals are best understood if they are likened to machines, e.g., the heart is a pump, the liver is a filter, the brain is a computer, etc. (McEwen &

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Stellar, 1993; Schuman, 2006; Uchino, Cacioppo, Kiecolt-Glasser, 1996). Most prominent approaches to addiction are also grounded, to one degree or another, in a fundamental acceptance of this paradigm (Leshner, 1997; Shaffer, 2004; Shorter, 1997). This means that certain deterministic (and mechanistic) factors and conditions underlie the physiology, cognition, and behavior of each addict (Dackis & Miller, 2003; Leshner, 1997; Peele, 1987; Seale & Carney, 1991). After all, if machines do what they are designed to do—i.e., they cannot do otherwise—then humans may be similarly arranged in view of their mechanistic qualities.

Causation. Although there are numerous facets to the abstractionist feature of determinism, there is one particular aspect that seems especially relevant to addiction, the scientific precept of *causation*. Conventional causation, and its application in addiction theory, generally assumes that addiction is preceded by a number of important factors which are thought to be self-contained and sequential and therefore sufficient at some level of interaction to account for addiction (Leshner, 1997; Levine, 1978; Khantzian, 2003; Raistrick, 2008). For example, Gorman & Brown, (1992), cite such factors as "... a neurological deficit ...dysfunctional arousal processes... certain types of personality traits... [and] provoking events" as just a few antecedents for addiction to occur. (pp. 837 & 843). In similar examples certain factors are thought to not only predate addiction but also continue to strongly influence the course of addiction and any ensuing recovery as well (Redish, Jenson, & Johnson, 2008).

Conventional causation therefore means that other accompanying and simultaneous factors cannot be an influence in addiction owing to the unresponsiveness of what are thought to be prominent qualities. Consequently, some factors of addiction

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such as the imbalances of the brain are somehow more essential to addiction other factors, e.g., the choices of the addict. In this respect, such abstractions imply that "choices" are not really choices at all, because they are caused by imbalances and thus allow no possibilities. For example, Nina Volkow (2005), the current director of the National Institute on Drug Abuse, asserts "... addicted individuals continue to be stigmatized by the pernicious yet enduring popular belief that their affliction stems from voluntary behavior." (p. 1430). Burns & Bechara (2007) support such an assertion by noting:

> Research continues to elucidate the neural processes underlying how we make our choices, and much of what we know already about these brain mechanisms indicates that decision-making is greatly influenced by implicit processes that do not necessarily reach consciousness... much behavior that seems to be "free will" may be determined by the routine operation of a healthy neural mechanism. What happens when something goes wrong with this process elucidates this point further... [e.g.,] addiction... We might conceptualize this as a "hijacking" of the execution of willpower by an overactive impulsive system, where will becomes guided by the amygdala rather than by the prefrontal cortex. (pp. 263, 267, & 271).

In this example "brain mechanisms, implicit processes, [and] an overactive impulsive system" are causally implicated and thus determinative of "decision-making" prior to "addiction" (Burns & Bechara, 2007, pp. 263 & 267). Such views situate the brain as almost exclusively "... like a glorious machine" and could imply that "... human nature... [seems] necessarily fixed and unalterable..." (Doidge, 2007, p. xviii).

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However, Doidge (2007) and many others now believe "... we must rethink our model of the brain now that we know it is ever changing."(p. xix). The relationalist would agree that such metaphors as a machine or computer have long outlived their usefulness. In fact, the relationalist might assume that such descriptions are far more misleading than instructive (Slife, 2005). However, this is not to say that the brain is not a vital factor in the addict's decision to use, continued use, or ceasing to use drugs. But, as Slife & Hopkins (2005) remind us "... it is one thing to assume that decisions take place in the brain and quite another to assume that the mechanisms of the brain are solely responsible for those decisions." (p. 7).

Relational alternatives to commonly held assumptions of addiction. We have noted that abstractionism has led many novices and experts alike to view addiction as context-free, which in turn, emphasizes the provocative nature of a relational approach. Unlike abstractionism, relationality uses a totally different orienting framework to approach addiction than that of mainstream conceptions. The abstractionist framework, however, may have resulted in a number of "truisms" that have become reified into the overall culture of addiction (Peele, 1985, 2000).

We will examine a few of these "truisms" and their ontological assumptions and offer a relational alternative to each of them. Such maxims as; "... recovery is a never ending process" (Mack et al, 2003, p. 341), "... cure is an unrealistic hope... [and] requires lifelong treatment" (O'Brian & McClellan, 1996, p. 239), "persons are said to be alcoholic in personality whether they are drinking or not" (Flores, 1997, p. 167), and perhaps most the most telling of all "once an addict, always an addict" (Heyman, 2009, p. 65).

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First of all, we see that the abstractions implied within mainstream approaches convey a number of abstractions to the addict themselves. For example, the individual is abstracted from the hope of normalcy since "recovery is a never ending process" requiring "life-long treatment" (Mack et al, 2003, p. 341; O'Brian & McClellan, 1996, p. 239). The relationalist would situate either the occurrence or absence of "life-long" struggles with addiction amid the frameworks of relationships, contexts, and agency. Equally, the relationist would assume that while addiction is indeed a serious and life-threatening condition, recovery need not be "a never ending process" requiring "life-long treatment" (Mack et al, 2003, p. 341; O'Brian & McClellan, 1996, p. 239).

The relationalist would suggest that since context is a ubiquitous and influential accompaniment to individuals and their addictions, it can also be used to influence recovery outcomes. This dynamic is perhaps best captured in two basic perspectives of recovery addressed by Flores (1997). Flores contends that there are two fundamental categories of persons in recovery. First, there are those who are holding on to their own recovery so tenaciously that they are referred to as the "white knuckle society" (p. 279). And second, those that seemingly forget themselves, turn their attention to others, and capture the elusive quality of *serenity* (p. 279). The relationist would view these diverse approaches to recovery as important contextual indicators of the direction and focus of recovery. Flores seems to be saying that the context of perceiving one's self constructively coupled with the context in which the addict views and engages the world, may expand the possibilities from "life-long treatment" of self to life-long pursuit of meaningful relationships (O'Brian & McClellan, 1996, p. 239). For example, many scholars believe that the contexts of selflessness and serving others underlies much of the

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motivation that finds so many recovering addicts in the field of addiction counseling (Crab & Linton, 2007; McGovern & Armstrong, 1987; Shipko & Stout, 1992; White, 1998).

One obviously unintentional side consequence to the disease concept—which assumes certain genetics can be expressed as an "addictive personality"—is the commonly held belief of "once an addict, always an addict" (Flores, 1997, p. 167; Heyman, 2009, p. 65). However, according to relationality the addict is never exactly the same from one context to the next, from one year to the next. As contexts change, addicts and their addictions changes also. Often the change is insignificant but in some instance the change may be appreciable. This reinforces the relational conception that although addiction manifests a fair amount of consistency across contexts, neither individuals nor their contexts remain truly static.

Relationality would respond to the particular context of "once an addict, always an addict" by perceiving of the individual at this point as being stuck in a web of faulty perceptions (i.e., abstractions) or pernicious contexts. Such perceptions and contexts may include the personal contexts of e.g., attitudes, learning styles, and rigid interpretations of the addict's own experience, and the influence of broader contexts e.g., social trends and cultural aspirations. Schumaker (2001) for example, asserts that "the uncontrollable drive to acquire, use, or experience an object, activity, or substance" (p. 40) can be explained as just one more "consumption disorder [rooted in the contexts] of materialistic orientation, social alienation, and feelings of cultural inadequacy" (p. 41).The relationalist may therefore view addicts who are stuck in one particular "mold" of addiction as being "first and foremost addicted to their own assumptions" and also the

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assumptions of broader contexts such as social and cultural norms (Slife, personal communication, September, 2004).

Such dynamics are commonly expressed in addiction culture as "stinking thinking" (Wright, 2006). As Wright observes "Stinking thinking is so pervasive we often don't realize it exist. We think our stinking thoughts are facts, not arbitrary decisions based on faulty beliefs." (p. 63). A relational approach to this problem would presume that such "stuckness" is the result of a number of abstractions held by the individual and often reinforced by the broader culture of addiction. Take for example, the context of rigid interpretations. Many addicts interpret their current and historical experience with addiction from the contexts of victimhood, tragedy, regret, and feelings of irreparable damage (Frey, 2003; Morrison, 1989). They tend to abstract the experiences of the past and the possibilities of the future in to a single narrow view (Flores, 1997). Often the individual chooses this view in favor of perceived benefits or is perhaps unaware of other options (Boyarsky, 2002; Kerr, 1996).

We explored this particular relational dimension in Chapter 2 (pp. 43-46 this dissertation) as *contextual agency*. The relational assumption is that each person is both empowered and constrained to act and be acted upon in relation to the contexts in which they exist. In fact, each individual addicted or not, is the embodiment of such possibilities and limitations (Slife & Hopkins, 2005). On the one hand, many individuals "stuck" in a cycle of faulty beliefs and destructive behaviors (i.e., addiction) choose knowingly to do so (Peele, 1985, 2000). On the other hand, some have been surrounded by the contexts of hopelessness and ignorance for so long that opting out of "stuckness" seems a distant and mystifying alternative (Badiani & Robinson, 2004).Yet for others,

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choosing the contexts of humility, selflessness, love, and virtuous relationships has empowered them to seek a way out of the "entrapment" of addiction.

Relationality would propose that addicted individuals and their choices are at the most fundamental level, a nexus of these contexts. That is to say, addicts use an abundance of agency in all facets of addiction or recovery that are situated in a contextual reality. However, the relationalist would stress that the contexts of choice is inseparable from the contexts of either constructive or negative outcomes. For example, in some instances that choice may be as simple as choosing not to affiliate with the "people, places, and things" associated with prior substance use and dependency (Stalcup, Christian, Stalcup, Brown, & Galloway (2006). Stalcup et al. (2006) have found for example that certain environmental cues (i.e., triggers) that are conscientiously avoided increases the likelihood of sustained recovery. We will explore the context of agency considerably more in our section on determinism; however, for the present it is important to highlight the relational assumption that choice is indeed a necessary and ubiquitous context in the processes of addiction and recovery.

The sequential and simultaneous nature of relationality. Relationality would confer an alternative theme by simply assuming that the processes and phenomenon of addiction cannot be solely accounted for in presumably "causal" factors. The relationalist in this case would agree that some factors of addiction do, on the surface, seem to "pave the way" for other factors of addiction. Nonetheless, this does not preclude the simultaneous existence of accompanying contexts and relationships and their intertwined influence on the objects and events of addiction. However, most addiction

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theories highlight the sequential (i.e., deterministic) nature of addiction rather than the simultaneity evidenced through contexts and relationships.

Whereas many addiction scholars would assume that some sequence of causation is solely involved, (e.g., bad parenting in childhood leads to falling in with the wrong crowd, which may then lead to brain changes), the relationalist would hold that each of these events not only influence one another but also are influenced themselves by a host of simultaneous factors, such as culture, choices, etc. In other words, relationalists do not assume that influences stop with just the sequential (and assume that simultaneity cannot be causal and thus influential); the relationalist assumes that factors can be influential by virtue of their simultaneous (whole-part) relations. Consequently a host of important factors for the relationalist are overlooked by the abstractionist.

For example, many individuals initiate drug or alcohols use in their early adolescence (Anderson-Moore & Zaff, 2002; Blum & Nelson-Mmari, 2004; Garbarino, 2001). However, separating this particular phenomenon from other contextual and relational factors—i.e., focusing purely on adolescence's sequential nature—negates many significant factors that the relationalist would find essential for deeper meanings.

For instance, is the adolescent attuned to an accompanying context of a laissez-faire culture, one that rewards risk taking, elevates sensual experience, or reinforces a consumption oriented approach to happiness (Schumaker, 2002)? Or does the adolescent attend to a culture that compensates thoughtfulness, wellbeing, and accountability (Friedman, 2009)? Does the adolescent have the supportive networks of a caring family, helpful friends, or faith group that seems to carry with them some level of protective influence against abuse (Schaffer, 2004)?

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Such contextual supports appear to counter other sequential factors that have been shown to precede addiction, e.g., puberty, exposure to abuse opportunities in peer activities, and media influences that cleverly market the appeal of an excessively consumption oriented lifestyle (AMA, 2003; Cushman, 1995; Frank, 1999; Jordon & Lewis, 2005). And how are the individual's personal choices arrived at when expressing a particular preference? Each of these considerations, and a host of other accompanying factors, may enrich the meanings given to specific factors, such as adolescence, and reinforce the idea of simultaneous relationships and contexts.

Adolescence is just one example of how overly focusing on the sequential or objective nature of addiction may lead to hasty assumptions about what is most fundamental regarding the disorder. In this respect other simultaneous factors such as choice or personal intentions are diminished as "causal" factors. For example, Lende (2009) observes that "The disease model cannot incorporate intentions [or choices] except as outcomes of physical and psychological causes. Thus, our cultural way of thinking and our embodied way of thinking combine to produce a tunnel vision [i.e., abstracted] approach to understanding addiction." (p. 1). If, for instance, simultaneous relationships are neglected in favor of what is perhaps most apparent, then approaches to treating addiction are at risk of becoming a mere reflection of theoretical "tunnel vision" (Lende, 2009, p. 1).

Relationality provides a way in which the very "being" of addiction is brought to light through the acknowledgment of relationships and contexts. In fact, to focus on the "observed" qualities of one addiction factor or another, e.g., developmental phases, rather than to view all factors relationally is ignore the reality of unseen factors in addiction.

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Take a set of billiard balls, for example, that hit one another sequentially. Clearly they are influenced by one another sequentially as they transfer energy and motion to one another. Yet, they are also influenced simultaneously by other factors.

For instance, without the accompanying context of gravity they would likely fly around the room (and perhaps not even hit one another). What conventional causation does is it focuses on the sequential influences and overlooks the simultaneous influences (Slife, Yancher, & Williams, 1999). It may be assumed that the same problem occurs with the addicted individual, focusing on what events precede and overlooking the events that accompany.

Indeed, addiction factors in this respect are just as inseparable as events or experience, since they too share identity from one another and the whole of addiction. For example, the brain and its processes cannot experience the environment without an environment, and there is no environment without its shared relationship with the brain. Therefore, the relationalist would propose that the most meaningful approach to so-called underlying mechanisms is to assume the underlying mutuality of contexts and relationships involved in all addiction factors.

Perhaps Bruce Sapolsky (2002), the eminent neurobiologist currently at Stanford, best explains this by pointing out:

> One of the most important great truths that Western thinking has ever embraced is the reductionist credo... But its time for many braches of medicine to lurch away from the great truth of reductive medicine to another great truth: You can't understand a disease outside the context of the person with the disease... We've entered the gilded genomics era just in time to have to admit that most of our ills

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> have to do with extraordinary ungenomic things like your psychological makeup and patterns of social relations, your social status and the society in which you have that status, your lifestyle... Or that being isolated, anonymous, [and] lonely is demonstrably damaging to your health. (p. vii-xi).

The relationalist would agree in large part with Sapolsky (2002) and further assume that the underlying ontology connecting all genomic and "extraordinary ungenomic" factors is the inexplicable shared nature of their relationships (p. vii-xi). The relationalist would accordingly propose a number of philosophical—and thus methodological—alternatives to a deterministic approach to addiction. First, neither addiction nor the addicted individual is reducible to one or "... a causal chain" of determinants (Honderich, 2005, p. 208). Therefore, individuals and their addiction are best understood as "first and always a nexus of relations" (Slife, 2005, p. 4). This means that any therapeutic modality meant for addiction should be foregrounded in the dynamic relationships and contexts of the here-and-now rather than in presumably static or self-contained features.

Relationality would also propose alternatives that bring to the forefront such non-genomic factors as personally held attitudes, e.g., faulty assumptions within the addict's belief systems. Such faulty assumptions may be thought of as mutually constitutive elements of many important aspects of addiction such as social norms, i.e., the influence of others, family dynamics, and the assumptions of one's standing with God or a "higher power". By focusing on and attending to the individual's existing contexts, such as personal attitudes, belief systems, and relationships—rather than on isolated abstracts—

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the individual may be able to apply concrete strategies that foster a sense of living appropriately in the here-and-now.

This is not to say that relationality would situate neurology, psychology, or sociology on the back burner of theory and therapy, to the contrary, these are vital areas of concern. However, if they are to be best understood in relation to addicts and their condition they must be approached not as self-contained constituents of addiction but as mutually connected with one another and the contexts they are in. Indeed, the everyday lived experience of the addict may manifest itself in ways in which neurology, psychology, and sociology are indeed relevant to a relational approach. But, it is imperative, to a relational alternative, that each be viewed from the lens of relations and contexts not in the abstractionist connotation of self-containment.

Vulnerability. One particular implication inherent within theories of addiction is the notion that addictive behavior is largely attributable to factors that confer an inherent liability or vulnerability to the individual (Ainslie, 2008; Le Moal, 2009; Sarnecki, Traynor, & Clune, 2008). If, for example, an individual grows up in a family setting in which drugs and alcohol or some other behavioral addiction is evidenced, that individual is thought likely follow in the same path (Carnes & Delmonico, 1996; Trudeau, 2005; Wolkin, 1984). Thus, the factors that initiate addiction along with the processes which maintain addiction are thought to put the individual at some sort of disadvantage when exposed to addictive substances or behaviors.

Vulnerability therefore exists for the individual when prominent factors of addiction, considered more "objective" in nature, have the capacity to initiate change (i.e., causality) while others, considered more subjective, are merely post interaction

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effects. This means that some aspects are considered independent variables (e.g., the brain, our environment, our psychology, etc.) while others are considered dependent variables (e.g., behaviors, attitudes, choices, etc.). Indeed, most scientific approaches to addiction rigorously endeavor to keep both areas isolated to avoid corruption or confusion. In fact, accompanying contexts and relationships considered "subjective" are assumed to muddy the waters of already self-explanatory or causal features (Director, 2002; Edwards, 1994; Slife & Hopkins, 2005; Wiklund, 2008).

Vulnerability or predisposition to addiction is most often thought of as being conferred by factors either within the individual, e.g., genetics or willfulness, or within the environment, e.g., parental example or community norms (Peele, 2000; Raistrick, 2008; Robinson & Berridge, 2000). Such views inherently situate the individual's agency as somehow subsumed in more causal features, for example the intoxicants in and of themselves, low SES, hostility, personality or character defects, genetic flaws, and peer influence (Flores, 1997; Jellinek, 1960; Khantzian, 2003; Kuhn, 2006; White, 1998).

This view strongly suggests that the addict's role in their own addiction is diminished due to overwhelming forces beyond their normal volitional control (Peele, 1990). This is evidenced by the addict's failure to regulate the use of addictive substances or behaviors and their ensuing loss of control even in the face of adverse consequences (Alcoholics Anonymous, 2001; Jellinek, 1960; Khantzian, Halliday, & McAuliffe, 1990). For example, Redish, Jensen, & Johnson (2008) state that:

> ... addiction arises from vulnerabilities inherent in the decision-making system within the brain. Susceptibility to these vulnerabilities arises through an

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> interaction among the genetics of the individual, the developmental environment, the social milieu, and the behavioral experience of the individual. (p. 433).

Once more we see causation being manifested as the interaction of self-contained factors resulting in "vulnerabilities... susceptibility... [and eventually] addiction" (Redish, Jensen, & Johnson, 2008, p. 433). And once more we find that many experiencing addicts think of themselves as "... pawns of history, biochemistry, and fateful events. In this helpless role, they find themselves unwilling or unable to create new and useful opportunities for themselves." (Efran & Heffner, 1991, p. 64). The relationalist may consider that many addicts have "bought" into such abstractions (e.g., vulnerability) in which they unwittingly "empower" real and perceived factors with more influence than they in fact have. This perhaps confirms precisely what Slife (2004) meant when he referred to addicts as being "first and foremost addicted to their own assumptions." (Personal communication, September, 2004).

Contextual agency. By contrast a relational approach to this particular perspective assumes no foundational separation between the factors that presumably predispose addiction and the agency of the individual. This is not to say that an individual's introduction to addictive substances or behaviors happens in a vacuum. What relationality would suggest is that agency is just as a ubiquitous and important element of addiction as is the brain or the environment. This means that agency, as other important factors, is a necessary but not sufficient condition to initiate and maintain addiction. If this is so, and the relationalist would argue that it is, it would imply that agency shares the same relational space as the neurological, psychological, and sociological factors related to addiction.

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However, in the same sense that these aforementioned factors (i.e., biological and psychosocial) are mutually embedded within and defined by relationships and contexts, agency is as well constrained by some relationships and contexts while simultaneously opened up to possibilities by others. This particular approach, as we recall from Chapter 2 (pp. 48-51) is known as *contextual agency*. Contextual agency implies that choices and the freedom to exercise alternatives are not merely "in the head" of the individual nor are they situated solely in the contexts of the bio-psychosocial. But rather, agency co-exists as an interdependent and engaged factor with all other significant aspects of addiction rather than as an effect of natural or law like influences, e.g., physiology. As Slife & Hopkins (2005) explain:

> ... agency and biology are not identical or reducible to each other. Our biology is not solely a product of our will, and our will is not solely a product of our biology. [Such an] "Embodied agency" [i.e., contextual agency] means that agency occurs in and through the context of the body, or the body occurs in and through the context of the agent. (p. 23).

Certainly, relationists such as Slife & Hopkins (2005) would agree that such an agentic approach could bring to the field of addiction a new and invaluable understanding about the day-to-day challenges of the addict seeking recovery. Moreover, a thorough grounding in the precept of contextual agency may enable the individual to see themselves in different light, rather than as "... pawns of history, biochemistry, and fateful events." (Efran & Heffner, 1991, p. 64).

For example, the guideline of contextual agency may help addicts struggling with recovery to see and understand how some contexts do in fact limit their choices.

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However, the relationist would assume that within these contexts of limits reside possibilities as well (Slife & Wiggins, 2009). Vulnerability then in this sense is not sufficient to initiate addiction because of its shared relationship with the individual's choices. This can be illustrated by referring to one of the most challenging issues that face addicted individuals and the professionals that help treat addiction, sexual abuse. In fact, "The majority of women and a significant minority of men who seek treatment for substance use disorders report a history of physical and/or sexual abuse" (Charney, Palacios-Boix, & Gill, 2007, p. 93). Young (1995) has stated, "One of the greatest unacknowledged contributors to recidivism in alcoholism and other addictions may be the failure to identify and treat underlying childhood sexual abuse issues" (p. 451). Abuse from this perspective is seen as rendering abused persons as somewhat vulnerable to addictive behavior that proceeds from an effort to mitigate the painful memories of their abuse. However, relationality would assume that even such a risk factor as sexual abuse is always situated in a multitude of contexts and relationships.

At the outset, relationality would address this challenging issue by first assuming that each addicted individual is a relational nexus of many factors, contexts, and relationships. This implies that no one feature or circumstance of the addicted individual, even as terrible as a history of sexual abuse, is a self-contained entity sufficient to initiate addiction. As we have noted many times, throughout this dissertation, many such factors can often appear overwhelming and causal. Nonetheless, when viewed from a relational perspective even sexual abuse shares its most fundamental meanings with contexts and relationships. Specifically, individual's present thoughts, feelings, and attitudes are a nexus of meaningful contexts and relationships in which their history is experienced.

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One of the mutually constitutive relationships that individuals share through their sexual abuse is the contexts of the past, present, and future. In this respect, the individual's past history, (i.e., sexual abuse), current experiences (e.g., shame and betrayal), and future expectations (e.g., forgiveness and recovery) are all bound together in the dynamic here-and-now. This means that the traumatizing events of the past are mutually constituted not only in the present but in hoped for future. Slife & Fisher (2000) clarify this somewhat complex idea:

> How one interprets events and renders judgments depends on one's memories and prior information. Memories and information from the past exist completely in the "now". Indeed, this is the reason memories are subject to the vagaries of present moods and circumstances... they occur in the present to be influenced in the present... Indeed, neither the past nor the future can exist for us experientially except in the present. (p. 97).

From this perspective the past is not purely an objective feature of reality nor is it a purely subjective interpretation of real events but exist as an interpretive reality in the present. This is not to say that the occurrence of sexual abuse is something that the addict can just dismiss or wave away with the attitudes and actions of the present. It is to say that the most fundamental meanings of past events are transformed in our present context, which includes the context of agency.

For instance, contextual agency would assume that as abused individuals choose healthy and virtuous relationships the contexts of the present will change and in turn their recollections and attitudes of the past and their hoped for expectations of the future will change also. Just as Heraclitus (535 BCE-475 BCE), the pre-Socratic philosopher

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proclaimed that “You cannot step into the same river twice”; the addict as well stands in the present moment which is an ever changing, non-linear, and constitutive experience.

Although the relationalist cannot predict perfectly how current choices may impact each individual’s attitudes about their abusive history there is scholarly support that the attribute of forgiveness is one element of healing the wounds of the past through the choices of the present (Gall, 2006; Snyder & Heinz, 2005; Thomas, White, & Sutton, 2008; Tracy, 1999). In the final section, I hope to argue there is an abundance of non-traditional approaches to addiction, as the feature of forgiveness will illustrate, that when combined with relational approaches offer viable alternatives to the addiction therapy.

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Chapter 5: Toward Therapeutic Application of Relational Alternatives

Relational Treatment

Introduction. In this final section I will introduce a relational approach to the treatment of addiction. The following section is not intended to be a specific modality but rather a general proposal of possibilities available within the constructs of relationality. To a large extent, relationality is more of a repositioning of emphases rather than an outline of distinct practices (Slife, Harris, Wiggins, & Zenger, 2005). There is existing scholarly support, nonetheless, for these relational alternatives in both traditional and non-traditional sources of literature.

However, this section is not meant to expressly treat any particular addict but is intended solely as an example of what a paradigmatic shift in addiction treatment may involve. In this sense relationality does not serve as a "black bag" of tools and prescriptions that presumably conveys insight and thus unlocks the individual from addiction. Thus, the main focus of this dissertation is intended to rekindle the primacy of relationships in the healing processes in addiction. Therefore, relationality should be viewed as more of a reorganizing of priorities in the treatment of addiction, rather than a step by step model.

This disclaimer of sorts is derived from two basic premises: First, this may be one of the few attempts, thus far, to address addiction from the perspective of a relational ontology. Consequently, I would hope this is viewed as a preliminary investigation that merits expansion in the future. And second, as previously mentioned relationality represents more of a philosophical foundation for approaching the lived experience of the addicted individual rather than a new psychological theory or structured treatment

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modality (Slife, Harris, Wiggins, Zenger, 2005). In fact, according to prominent relationalists, the very core of any psychotherapy rest on the assumption that since individuals are situated in a dynamic nexus of possibilities, treatment should likewise reflect the contextual and relational uniqueness of individuals and their disorders (Slife & Wiggins, 2008). Thus, relationality would assume that confining the treatment of addiction to a specific blueprint or protocol objectifies individuals much in the same way that abstracting the "objects" of addiction (e.g., physiological factors) objectifies theories.

For that reason, the relational alternatives offered hereafter have more to do with the actual day-to-day experiences and relationships of addicted individuals rather than the "objective" particulars of their disorder. As Howard Schaffer (1986, 2004), the current Director of the Division of Addictions at the Harvard School of Medicine has said:

> ... the addictions as a circumscribed field of endeavor rest upon a foundation of philosophy... Our analysis of the extant literature reveals that the specific objects of addiction play a less central role in the development of addiction than previously thought, and it identifies the need for a more comprehensive philosophy of addiction... (pp. 285 & 367).

It is hoped, therefore, that the alternatives presented here will enable the reader to see the relational bridge between the individual, the "objects" of addiction, and the contexts and relationships in which each exist. In short, gaining a "more comprehensive philosophy of addiction" requires that neither individuals nor their accompanying factors can be meaningfully separated from their surrounding contexts and meaningful relationships (Schaffer, 2004, p. 367).

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Re-envisioning the treatment of addiction: An overview. As we found in Chapter 1, addiction has been treated in so many ways that this diversity has become stultifying rather than enlightening (Acker, 1993; Mendola, 2003; Shaffer, 1986).We have noted in past chapters such "diversity" may be somewhat illusory since most approaches are derived from one general philosophy, that of ontological abstractionism. Still, even seemingly diverse theories, with their similar ontologies, can be confusing. In view of this, this final section will simplify (perhaps even oversimplify) the relational alternatives to addiction treatment by focusing on three key areas of interest:

1. The relationist would first approach addiction by generally reorienting the theoretical and therapeutic emphases, from one of fore-grounding addiction as largely self-contained—and therefore understandable through abstractions—to one of foregrounding addiction as largely contextually and relationally responsive—and only meaningful through relationships and contexts. A few of the relevant topics to be covered under this heading are; the paradigmatic shift, the therapeutic relationship, re-evaluating treatment goals, and the relational meanings within the language of addiction (e.g., addiction, recovery, and relapse).

2. Reorientation of the treatment approach necessitates a paradigmatic shift not only on the part of therapists and their conceptualizations but also on the part of the addicted individual and their misplaced assumptions. This calls for a strong emphasis on a relational, perhaps experience-oriented education of the addicted individual. As the therapist and others develop a relationship with this person certain ideals and values might arise that possibly will help the individual to see the protective benefits of healthy contexts and virtuous relationships. Among the

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issues to be covered are: relational approaches to individualism, the "good life", stigmas, and the values of humility and forgiveness

3. The final issue to be addressed is the significance of agency in addiction and recovery from addiction. Accordingly, the relationalist view accentuates the here-and-now lived experience of the addicted individual rather than there-and-then factors, e.g., bad decisions in the past, traumatic histories, shame, or physiological liabilities. From this perspective the individual's present contexts and relationships, e.g., present choices, are emphasized. Agency in this section is situated as a powerful constituent in the recovery of addiction and the continuance of healthy relationships (which is foundational to recovery). Some of the aspects connected to this section are; contextual agency, the mutually constitutive nature of the past, present, and future, virtuous relationships, and victimization and empowerment through choices.

In addressing these three topics, the five distinguishing features, i.e., context, reduction, identity, experience, and determinism, will be used periodically to explicate the relevance of each relational alternative.

Reorienting the therapeutic emphasis. Offering an alternative philosophical foundation for addiction carries with it the implication that a paradigmatic shift in theories will naturally be accompanied by changes in the contexts of treatment as well (Schaffer, 2004). For example, relationality would presume that addicted individuals will manifest the most meaningful and concrete properties of their experiences in a real world setting, e.g., the therapeutic venue. These insights, interpretations, and feelings cannot be located in textbooks, professional journals, or within popular addiction culture (which

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often permeates treatment facilities), but are to be found in the contextual and lived relational realities of the individual. These existing realities in fact form the foreground of a relational alternative to addiction therapy whereas theories, methods, cultural connotations, and even the past history of the individual represent the background of the therapeutic enterprise. For example, classical psychodynamic theory situates *resistance* in therapy as "The instinctive opposition displayed toward any attempt to lay bare the unconscious." (Campbell, 1996, p. 626). Relationality, on the other hand, would see such an approach as an abstraction of the more real here-and-now context of therapy. In other words, instead of reducing the individual's experiences to "... some intrapsychic flaw (e.g., one-way thinking)" the source of therapeutic failures comes as a result of "...relational disconnections" (Comstock, 2004. p. 91).

Take for example, the addicted individual that thinks they can "go it alone". That is to say, they believe they are capable of overcoming addiction without the concern and help of others, not to mention treatment. This form of resistance is wide-spread in the addiction community (Flores, 1997; Miller & Rollnick, 2002). First, the relationalist would assume that the individual did not get addicted in a vacuum and that there is no likelihood that they will recover in a vacuum. In fact, the relationalist would assume that relations of all kinds and qualities are intricately woven through every aspect of addiction and recovery. Second, the relationalist would assume that some interpersonal relationships are more vital than others.

For instance, family ties are some of the most significant relationships which can be drawn upon in the healing process. However, "The addictions field has traditionally viewed the family as an obstacle to successful recovery, neutral at best, and enabling and

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perpetuating the addiction at worst." (Garrett et al., 1999, p. 367). The relationist, on the other hand, would see the family or other close relations as a key component to a healthy recovery. For example, how individuals often "conduct family business" is at times built upon faulty assumptions and even myth (Bardill, 1977; Coletti, 1994; Fernandez, Begley, & Marlett, 2005; Kaslow, 1996; L'Abate, 1994). Consider the assumptions that men are expected to conceal their feelings or women are to be submissive and defer to the man's point of view. The relationalist would be attentive to such assumptions and strive to address them through the contexts of learning and discovery.

For example, the relationalist may respond by influencing the therapeutic relationship in such a way that addicted individuals and their families become more attuned to the relational aspects of kindness, equality, and awareness of the others feelings. Perhaps the relationalist would choose to use family sessions as a way to display how a safe atmosphere provides a context in which truthful feelings are shared and even welcomed. The relational alternative, therefore, is to give resistant clients and others the experience of good relationships which may perhaps open their eyes to the possibility of other such relational opportunities, such as those within family surroundings.

Relationality in this sense places its primary emphasis on present contexts and human relationships such as family, friends, and health providers rather than on abstracted factors. Slife & Wiggins (2009) bring this to light by stating:

> Still, for the strong relationist abstractions are only valuable as they facilitate healthy engagement with and understanding of clients in their particular contexts. In order to avoid subordinating the concrete particulars of context to the

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> generalities of abstraction, relationists take care that the abstractions they use arise out of the experience of concrete particulars. They avoid merely imposing a favorite or even an implicit, pre-session theory on the context. Indeed, relational particulars are allowed or encouraged to ‘‘rupture’’ the deepest of therapeutic conceptualizations. (p. 22).

This emphasis on the concrete and particular may be one of the most difficult preliminary alternatives for the therapist to enact since most practitioners, especially novice practitioners, defer to a number of accepted theoretical concepts and comfortable therapeutic strategies (Schaffer, 1986, 2004). The therapeutic relationship, according to relationality, is therefore figuratively "turned on its head" in lieu of the reorientation of priorities, values, and assumptions. As the relational therapist understands, it is the relationship that directs therapy, not the treatment provider or the methods they employ. Buber (1964), one of the most acclaimed Jewish relationists, warns "Help without mutuality is presumptuous; it is an attempt to practice magic. The psychotherapist who tries to dominate his patient stifles the growth of his blessing." (p. 395). Again we are reminded "All entities have a shared being and mutually constitute the very nature of one another." (Slife & Wiggins, 2009, p. 18), including therapists and their clients.

This, in fact, is why relationality requires that the "... concrete particulars of context" shape the overall therapeutic setting and therapeutic relationship as well (Slife & Wiggins, 2009, p. 22). Reprioritizing treatment can be best thought of as acknowledging the fundamental nature of relationships while theories, particulars, and strategies are coalesced into the therapeutic setting. This fundamental or "first things first" approach permits both client and therapist alike to focus on issues which need attention, while

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steering clear of issues which can become entangled in abstractions which are not easily accessible in the moment.

For example, the actual subject of substance abuse may be deferred temporarily as more pressing and "foundational" issues are brought to the forefront e.g., a relationship crises involving abuse of spouses or children, or significant others. In other words, from the relational perspective, the substance abuse "trees" should not be focused on to the extent that the contextual "forest" is lost. Indeed, the relationist would predict a relapse, no matter how thorough the rehabilitation, if the relational context is not itself "rehabilitated." This approach is clearly the exception in current treatments, which are primarily focused on the substance abuse itself and the loss of control it conveys (Alcoholics Anonymous, 2004; Jellinek, 1965; Stevens & Marlett, 1987). A few cogent examples may provide the reader with a greater understanding of how this relational foregrounding may occur in the context of therapy.

First, relationality assumes that no two addicted individuals are meaningfully alike, i.e., their most fundamental being is derived from the infinitely diverse contexts and relationships in which they live. This is not to say that relationships of similarity do not exist or are not valued, they in fact are. For instance, gender, race, SES, and faith orientation are but a few factors of similarity that many will share. However, it is the infinitely diverse relationships and contexts that these factors are situated within that confer the difference and depth of each factor.

For example, some therapeutic communities focus on offering treatment to special populations that share many apparent similarities, e.g., gender, age, level of education, and the absence of co-morbid mental disorders. In fact, there are presently an abundance

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of therapeutic boarding schools for high school age individuals (which regularly address addiction issues) and admit only those who meet specific criteria of similarity. It can be safely assumed, however, that only few of these institutions actually position contexts and relationships as the key to discovering the deeper meanings which undergird relationships of similarity (Gass & McPhee, 1993; Gauld, 1993, Kimball, 1993; Lowe, 2004; Russell, 2004; Slife, Mitchell, & Whoolery, 2003). Positioning contexts and relationships as the central approach to addiction may be manifest in a number of ways. For example, the relationalist would assume that in a therapeutic boarding school—where similarities in gender, age, and education seem to dominate the environment—the underlying contexts still provides the deeper meanings for each.

For instance, many therapeutic schools use the "solo" experience as a way for students to focus and understand the mutuality and simultaneity of the "inner" and "outer" contexts (Schoel, Prouty, & Radcliff, 1988). The solo experience can be anything from 15 minutes of silence and contemplation in varying locations to overnight experiences in remote areas where students are given the opportunity to be separated individually from a centralized camp group (Kelly, 2006; Russell, 2000).

In these settings students are physically detached momentarily from the contexts of modern comforts and conveniences, and also free from the distraction of others. Students become acutely aware of how surroundings and inner states are shared in the present not as detached entities competing for attention but as the relational "moment". Bell (1995) points out how solo therapy facilitates some participants in their need to "... overcome their fears" while others may "... want to learn to feel their fear, physically, when appropriate, and respond in a way that does not put them at risk [i.e., substance

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abuse]" (p. 15). Such experiential interventions, if done with a relational ontology in mind, are ways in which the deeper meanings of context can be exposed in spite of apparent similarities.

However, this appears to be the exception rather than the rule in most approaches to addiction given that contexts and relationships appear only as "add on" features to what is thought to be more fundamental (Slife 2005). Indeed, Gifford & Humphries, 2006) report that:

> Disregard for context has led to some psychologists making pronouncements on the 'universal features of addiction' (among many other features of human existence) on the basis of how small samples of white, middle-class under-graduates have filled out a questionnaire. (p. 356).

The relationalist would therefore propose that therapy will, by necessity, be intrinsically and meaningfully different and importantly similar for each addicted individual. That is to say that therapy for each addicted individual will be responsive to the particular needs of the individual while attending to the dynamics of similarity.

While most approaches to addiction seem to be focused on the consistencies and similarities among addicted individuals, the relational approach also addresses the contextual differences and relational inconsistencies embedded within each individual's experience. For instance, the relationalist would tailor treatment to not only reflect gender and ethnicity – potential factors of consistency – but a host of other contextually unique factors e.g., family of origin, SES status, health, faith, friendships, and faulty assumptions that are intricately interwoven into addiction.

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These factors and others must inherently undergird the therapeutic intervention to capture the ebb and flow of each addicted individual. Take for example, the case study of a young girl graduating from high school as the valedictorian and National Merit scholar (Hartling, 2004). Hartling (2004) describes the case:

> "With an outstanding academic record and a promising future ahead of her, no one would have predicted that this successful, self-disciplined, conscientious young woman would find herself in a hospital room during her first week of college, her life on the line after a single night of heavy drinking. (p. 197).

Such a case illustrates the baffling nature and mystifying reality that accompanies the use of substances in such a destructive and meaningless way. Theories, methods, and even insight on the part of the therapist or the patient cannot begin to understand or rehabilitate the addicted individual without considering and revitalizing relationships.

For example, the relationalist would assume that an overall non-judgmental attitude from the therapist has the potential to regenerate feelings of self-worth and self-efficacy in the recovering individual. In fact, a relational approach to treatment would assume that preconceived judgments, labels, and other stereotypical abstractions are not conducive to healthy and virtuous relationships. Even the "common" or accepted language in which theories are explicated, insight is expressed, and methods are brought forth are abstractions of deeper and more meaningful relationships.

Thus, the relational therapist understands and minimizes the tendency to rely on language alone, while remembering the reality that "Language is necessarily abstract and impoverished, in this sense, especially in comparison to the richness of practice or lived

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experience." (Slife, 2005, p. 14). As Adame & Knudson (2007) professors at the University of Miami assert:

> The difficulty in escaping the mental health system may have stemmed in large part from the fact that many felt that they were alone in trying to escape the system and that their protests fell on deaf ears. When the survivors initially left the mental health system, most still felt trapped in the language of psychiatry; and their friends, family, and employers often spoke in terms of mental illness and health as well. Thus, one reason that recovery from the mental health system is so challenging is the isolation, loss of community, and loss of voice that many ex-patients experience upon discharge from the hospital. (p. 167).

As these authors illustrate, the subtle nuances of language, and thus its abstraction from context, can often undermine the environment of trust, accountability, and the feelings of belonging that are so vital to good therapy and recovery.

For example, most therapist and the facilities they practice in abstract—through the language of reduction and determinism—the addicted individual to number of codified descriptions, diagnoses, and cultural connotations (Adame & Knudson, 2005; American Psychiatric Association, 2000; Edwards, 1994; Gifford & Humphries, 2006). The language most often used, e.g., the terms addict, recovery, and relapse, for instance, carry special meanings and implications in the context of a treatment facility. A fictional case study may help to shed light on how the language and practice of abstraction are evidenced in a typical admission of an addicted individual into a treatment facility. Relational alternatives and scenarios will be offered in response to this particular case study.

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Treatment by way of abstractionism: A fictional case study. The following individuals depicted are purely fictional and their experiences are drawn strictly from imagination and scores of documented case histories. However, the case represented here is largely typical of many who find their way into an inpatient treatment facility for drug and alcohol dependence (Bergman et al., 1998; Flores, 1997, Ray & Ksir, 2004). The subsequent example illustrates how an admissions counselor—who, in general, are the first to meet the client—may create an opening history and assessment profile from an initial intake interview.

Although intake interviews may vary slightly from one facility to the next, they generally use similar formats and procedures (Brems, Johnson, & Namyniuk, 2002; Hoffman et al., 1995; Rasting & Buetel, 2005). As we will find these standardized approaches may lead to the abstraction of addicted individuals and their experiences. For the sake of brevity, this example will be somewhat abridged and will primarily focus on relevant concerns.

Jane D. is court ordered to enter a 28 day treatment facility as part of a plea bargain to reduce her conviction of felony drug trafficking to felony procession of a controlled substance. Jane's first encounter at the treatment facility is with the admissions counselor. The ensuing account may be typical of what might be condensed from the counselor's interview notes, and subsequently turned over to Jane's therapist following the interview:

> Jane is a 22 year old divorced female with no children. She reports being a poly-drug user with a penchant for cocaine, ecstasy, and crystal meth but will use anything when her favorites are unavailable. Her paternal grandfather was an

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active alcoholic and died of liver cancer at the age of 59. Jane has been diagnosed and treated, at one time or another for, bulimia, ADHD, depression, and bi-polar disorder. She now meets six out of the seven DSM-IV criteria for Poly-Substance Dependence (304.80) and meets all the criteria for Major Depressive Disorder, Recurrent (296.3x).

Jane appears, presently, to be appropriately oriented to time and place. She reports no medical issues but has, in the past, been prescribed Concerta for the ADHD and Celexa for the depression. When pressed she admits to using Ativan the last several days in preparation for admission. The downer was obtained illegally on the street.

Jane has numerous legal issues, to lengthy to cite. She was expelled in her sophomore year from a prominent private school when marijuana was found in her locker. Upon expulsion, Jane was sent to a "wilderness" program to iron out some of her "childish rebellion" and address an eating disorder. Not long after she returned from treatment she was caught stealing from her parent's liquor cabinet on several occasions. Jane was subsequently home schooled.

Upon completion of the home schooling she received her GED just a month shy of her 18th birthday. Her grades were all in the "gifted" range. In the interim Jane was diagnosed with early stage "high risk" Human Papillomavirus (HPV), was treated, and vaccinated with Gardasil. After this incident Jane's father set up several sessions with a Nun from their local parish to try a spiritual approach to Jane's destructive behaviors. This approach seemed to be working well as Jane reported that she and the "sister" got along well and communicated openly and

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honestly. In fact, Jane said that Sister Angelica was the first person she had ever really confided in. Jane left home when she was 19.

As part of this interview and assessment the counselor also reviews a number of administrative issues. For example, Jane is told to read the Health Information Privacy Act, become familiar with the facility schedule, the rules for patients, and finally signs a number of consent forms. The final words of advice from the admissions counselor as she walks Jane to the therapist office is "The sooner you admit your powerlessness and who you really are, the sooner you will progress in your program, at least that's how it was for me nearly six years ago".

The abstractionist approach. The abstractionism outlined in this case history is attributed to a number of practices grounded in the assumption that individuals are best understood when they are separated from their contextual and relational aspects. For example, the individual's history is often recorded as deterministic reductions that are assumed to capture the most important factors of Jane's past, present, and future possibilities.

From this perspective, the Jane in the here-and-now is understood and identified by a handful of historical "facts" likely taken out of context. Such factors as drug history, the suggestion of hereditary involvement, past psychiatric history, legal problems, etc., are foregrounded as the most vital factors of her past, without concern for the multitude of contexts in which these factors occurred. Indeed, this history of sorts is thought to be as real and reliable in identifying Jane's entire life as a snapshot is able to identify her appearance. Moreover, the admissions counselor, a no doubt well-meaning individual, has abstracted Jane's future possibilities into the narrow confines of abstractionists'

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constructs and labels (acknowledgement of powerlessness and addict identity). This is fact, may be far removed from Jane's interpretive reality. A relational alternative would assume that reorienting the overall therapeutic emphases to one of relationality will do more for the Jane that really counts, i.e., the Jane in the here-and-now.

The relational alternative. First, a relational approach to this fictitious scenario would proceed from one vital assumption: contexts and relationships do matter and they are indispensable if addicted individuals are to be attended to compassionately and for treatment to be provided by the best possible means. For example, the intake counselor in the preceding illustration is relating primarily on an abstractionist level since much of the interview assesses Jane as an object with objective features. Observations which are guided by diagnostic criteria cannot be expected to comprehend or appreciate the underlying influence of contexts and relationships. As Bell (1995) notes "Abstract thinking is privileged over embodied knowing... It is "common" practice in theorizing, and is a tool of the Western European intellectual tradition." (p. 10).

The relationalist would therefore offer an approach in which the addicted individual, in the moment, is seen as uncommon, unique, and evolving in response to the quality of contexts in which they exist. For example, the alert relationalist would be attentive to relational aspects such as the individual's communication skills or lack thereof. An individual's access to virtuous relationships depends significantly on the ability of client and therapist to connect through language both spoken and unspoken. In such a case where this process is impeded by difficulties in conversing, the relational therapist may opt to direct the therapeutic goals accordingly. In this manner there is no one set therapeutic aim; but such aspirations will flow from the qualities of the

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therapeutic association. Special populations, especially those with limited function in mind and in body should be approached and related to in the contexts in which they live their day-to-day lives.

Abstracted factors, although useful in many instances, do not constitute the most important qualities of treatment. This is not to say that abstractions such as historical factors, events, behaviors, and even diagnoses are not important, they have their place. Indeed, abstractions are clearly permitted and are no doubt unavoidable from a relational perspective. Still they are not treated as ontological in the theoretical orientation or therapeutic practice of addiction treatment. What this is saying is "that these beliefs [abstractions] are secondary to and ultimately should be in the service of facilitating something more basic – complementary and intimate relationships." (Slife, 2005, p. 20). For example, the admissions counselor and indeed the entire staff would understand that relationships are not only an important aspect of addiction and recovery; ontological relationships are the defining feature of each. Slife & Wiggins (2008) explain:

> Relationships, especially interpersonal ones, are the most crucial aspects of life and living. At our core, we are relational beings—we exist for relationship... In psychology, this means that literally everything is about relationship ultimately. Our very identities do not stem solely from what is within and carried from context to context. Our identities are constituted by the unique nexus of our relationships in the past, present, and future. (pp. 19-20).

This perspective may be applied in several practical ways within the institution. Initially, since the admissions counselor is often the first person to have contact with an incoming client, they would need to understand "... it is more important and meaningful

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for the client [and the counselor] to experience or practice good relationships than it is to describe or think about how to have good relationships in therapy" (Slife & Wiggins, 2008, p. 23). In this respect, the admissions counselor may reorient the admissions process entirely to reflect this ideal. For example, instead of treating Jane as an object to be understood through the lens of apparent factors and diagnostic criteria, the counselor could reorient the first meeting to promote the experience of healthy and virtuous bonds. Such relational details as making Jane feel comfortable in an anxious setting, inquiring about family, friends, likes/dislikes, and the counselor's availability if Jane should ever need her are but a few ways in which to de-objectify Jane. In this sense the formation, nurturance, and protection of healthy and virtuous relationships are central to the rehabilitation of the addicted individual.

For certain, at least from the relationalist view, "Movement out of disconnection requires looking at what both the client and the therapist bring to the relationship at any particular point." (Comstock, 2004, p. 91). In this respect, theories, methods, and other abstractionist assumptions are not excluded; but merely form the structural backdrop of less structural entities such as interpersonal relationships and contexts. It is then, and only then, such theories, methods, and other abstractions have relevance in therapy. The following is a rendering of what could have transpired if Jane were admitted to a facility that understood how important these concepts are.

Treatment by way of relationality. This fictional example depicts how a paradigmatic shift to a relational ontology may transform therapeutic relationships, treatment objectives, and the language of addiction:

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I met Jane D. in the parking lot a few minutes before our appointment and welcomed her to our facility. Once her luggage was safely locked in my office we toured the building and grounds for the next forty five minutes. First, I introduced her to everyone we came in contact with, including two young female residents who were writing letters in the atrium. Second, I had previously asked them to be there at that time to meet Jane and offer to be her unofficial guides for the next several days. The two girls felt honored and trusted, and Jane was relieved to have peers show her around. Third, I actually got this idea from our last in-service training where we discussed how, "... relationships, not individuals, are nurtured and guided. [And that] Treatment goals are not so much about individual fulfillment as they are about relational caring and true intimacy." (Slife, Mitchell, & Whoolery, 2003, p. 26).

We then met the kitchen staff who promised to feed her healthy and delicious meals. In fact, the head cook told Jane to please let them know of any special dietary considerations and they would try to fulfill them. We also visited the garden area where Jane shyly hinted that she and her grandfather once grew a "fabulous garden".

During the visit to the "great room" Jane commented on the facilities beautiful grand piano and how she had endured six years of piano lessons. I asked if she would play something for me and she consented by playing a complex piece from Mozart and a popular theme from a movie. I found it amazing that this young girl at such a desperate time in her life still has the presence of mind to play so skillfully. I think I will try to enlist Jane in a little music therapy in the evenings when Mrs. Jones in room 318 becomes anxious and depressed. This may be a way to initially deemphasize Jane's preoccupation with herself while caring for someone else. (The

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therapist involvement of Jane with another member of the therapeutic community illustrates the relational dynamic of decentralizing her experiences. In this way, Jane feels and experiences the mutuality and connections of everyday reality and also what a virtuous life may feel like). I did however, notice her hands trembling and will investigate this issue in the intake interview.

The following are my impressions and overall assessment. Jane is a 22 year old divorced female with no children. She appeared extremely nervous when I first met her but seems to have now calmed down somewhat. She shared with me that she is perplexed at how her life seems to have become so unmanageable. We talked briefly about her family and her divorce but I won't write that up at present. Perhaps, in the contexts of your therapy it will come out differently. In any case, we can compare notes later on that particular issue.

Jane told me with, with tears in her eyes, that she became disaffected from her family at age 13 and shortly thereafter even from her friends at school. Since that time she is "clueless" why everyone has "abandoned" her. Jane's most enduring family relationship was with that of her grandfather who passed way when she was 12. She expressed that her father and mother were always too busy to care about her and that her "grandpa" filled the void. According to Jane "grandpa" drank himself to death in an effort to numb the pain of loneliness after his wife died. When she was 13 she took her first drink, smoked her first joint, and had her first partial experience with sexual relations.

Jane confided that her parents never really defined what they expected out of her except that they wanted her to be a "high achiever" with "low maintenance" (her

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father's favorite saying). However, she found the pressure of having to outshine others too stressful and she said "I turned my juice to being indulgent, spoiled, and untrustworthy". This approach seemed to work in getting more attention from her parents; however, according to Jane, the attention was never good. Her father sent her to pastoral counseling where she met and formed a caring relationship with Sister Angelica. Jane and the Sister got along fine for some time and then Jane terminated the relationship due to her "serious and passionate involvement with Tom", a young man 4 years older than she was at the time.

Jane expresses that she has always had problems with feeling like she belongs, having a sense of purpose, and distinguishing good people from "not so good people". According to Jane her biggest fear now is that she will not be able to remain "clean" when she is released. I simply reassured her that everyone follows a different path to healing and that a healthy recovery is within reach once we learn how to participate in actual relationships in a caring and altruistic way. Perhaps, if the right moment comes I will share with her some aspects of my own path to understanding the nature of these themes.

We will brainstorm, in our next staffing, ways in which Jane can better understand the connection between her impulsive and unwise decisions and the unmanageable and detrimental nature of her personal relationships and current contexts. I am sure that our entire community here will help facilitate each of our treatment goals.

Her present condition as far as clinical issues are concerned is as follows. Jane qualifies for poly-substance dependence diagnosis. We also talked about the sadness

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> and hopeless that has pervaded her life as of late. She is in the midst of a serious legal situation. And, she is currently taking Ativan for nervousness. Which reminds me, her last dose was nearly two days ago which probably accounts for the tremors. Please make sure that she gets in to see our medical director ASAP, we don't want her situation complicated by nasty withdrawals or the possibility of seizures.

Although, this illustration is designed to highlight a reorientation of ideals and practices, it most certainly is only the "tip of the iceberg". There are no doubt hundreds of clinical applications of relationality that would fit well within the treatment of addiction. The main idea here is addicted individuals are more apt to respond positively when caring and healthy relationships are experienced.

Theories, methods, observations, and factors are there to help shore up these relationships but they in no way define the identity of individuals or primarily direct the course of their treatment. In this respect the teaching of "social skills" and even strategies to avoid relapse cannot be equated with experiencing good relationships. Ideally, in fact, good relationships are to be derived, on the spot, in light of the particular issues, e.g., Jane's first hours at the facility. From such a viewpoint everyone is teaching everyone else in the here-and-now of how to have a healthy relationship. In this way, Jane (and countless others) may benefit from actual experiences with others and their experiences with others in an altruistic way. As the Association of Experiential Education's motto attests "Tell me and I will forget. Show me and I may remember. Involve me and I will understand." (Ancient Chinese proverb).

In the next section I will argue that not only are relational perspectives available to treatment providers, it is equally available to the individual. In fact, addicted

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individuals would not be expected to overcome their addiction without either knowingly or unknowingly using the fundamental assumptions found with a relational alternative.

Reorienting the addicted individual. As I have argued throughout this dissertation addicted individuals and their behaviors are often conceptualized as self-contained entities, essentially separated from the contexts in which they exist. For example, addiction is presumed to be within the individual, acquired from deterministic factors, and largely unresponsive to varying contexts. By this perspective, it can be assumed that the core identity of the addicted individual is also thought to be internal, determined, and largely unchanging.

This perspective and no doubt the tenacious nature of addiction may account for the personal and cultural assumptions that once an individual has addiction it is assumed life-long even if the symptoms are in remission (Heyman, 2009; Jellinek, 1965; Leshner, Valliant, 1982, 1995). Thus, for the individual and society as well "The expression 'Once an addict, always an addict' has become the mainstream view." (Heyman, 2009, pp. 65-88). The relationalist would presume that this belief, in part, may have derived from a number of abstractionist assumptions.

For example, "... some of our deepest problems both as individuals and as a society are closely linked to our individualism" and its connotation of self-containment (Bella, Madsen, Sullivan, Swidler, & Tipton, 1985, p. 142). There are numerous connotations of the term *individualism* but the one referred to in the previous quote is the individualism that assumes individuals are "autonomous... prior to society... [and] maximize their own self-interest (Bella, Madsen, Sullivan, Swidler, & Tipton, 1985, p.

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143) and "... the self is the only or main form of reality." (Coles, 1980, p. 137). Slife & Wiggins (2009) explain further:

> At its most basic, individualism refers to the outlook that the individual is most important: the individual should be independent and self-reliant; the individual's goals, desires, and wishes take precedence over those of the family, group, or community; the individual's preferences or autonomy should not be restricted by external moral systems based on tradition or religion. Relationships can be important to the individualist as long as they contribute to and do not interfere with the individual's goals and liberty to reach those goals. (p. 18).

If, therefore, individualism assumes persons are autonomous, prior to society, and self-interested: The relationalist would counter that reliance on others, a shared identity with society, and being other-involved reflects a more accurate representation of reality. Indeed, the relationalist could call upon an abundance of scholarly support for the assumption that the individualism, spoken of here, is an impediment to recovery (Flores, 1997; Hughes, 2007; Mickel & Liddie-Hamilton, 1997; Schumaker, 2001; Stewart & Reynolds, 1996). For example, it is probably safe to say that the addicted individual, from a behavioral viewpoint, mimics the individualism spoken of previously. Individualism, in this sense, is more of a collection of behavioral traits rather than an ontological reality.

Additionally, the addicted individual is often considered to be the epitome of self-centeredness, selfishness, and self-indulgence (Bateson, 1972; Cushman, Schumaker, 2001, Flores, 1997). However, if the individual's frame of reference is altered through the experiencing of good and fulfilling interpersonal relationships, then they will begin to

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view “the other” not as a burden to be avoided but rather a possibility to be invested in. For example, the relationalist would suggest that recovering individuals seek to uplift others in treatment, as well as seeking out service opportunities within the community, e.g., soup kitchens, food banks, community beautification, etc. In this way, the unhealthy aspects of individualism are eclipsed within the contexts of helping, nurturing, and providing comfort for “the other”. Perhaps the relationalist would also suggest that the individual in recovery needs to learn The Golden Rule and practice its precepts “Do unto others, as you would have them do unto you.” (Derived from the King James Version of the Holy Bible, Matthew 7:12). All this, of course, can only be done in the contexts of other-centered approaches to human relationships.

Relationality would assume therefore that all therapies and strategies should personify the ideal that supportive and virtuous relationships strengthen the possibilities of a life without the need or desire for damaging relationships, i.e., addictive substances and behaviors. Take for example, the AA admonition that all beginners in recovery should have a sponsor to guide them through the first several months of anxiety, temptation, and doubt (Alcoholics Anonymous, 2001). The relationalist would see the wisdom in such a practice since a lack of knowledge or simple unawareness on the part of the hopeful but inexperienced recovering addict constitutes a precarious context.

However, the relationalist would also be alert to the possibility that such approaches can become centered on more structured models of recovery, i.e., becoming more abstract than relational. For example, sponsors are expected to help recovering novices in working sequentially through the 12 Step Program. The relationalist would assume, however, that the healing available to those in recovery is embedded within good

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and meaningful relationships, not necessarily within the structures or time frames of programs. Once more, it is important to stress that programs, theories, and methods, merely form the backdrop of human relations. It is the sponsor's and other's relationship to the client is foregrounded as a healing end in itself. The sponsor and client can reinforce this ideal of meaningful relationships by cultivating intimacy, trust, and gratitude, rather than developing their expertise or proficiency in abstract designs or practices (Caldwell & Cutter, 1998). Sponsors and indeed all those helping the recovered addict, can help reorient newly recovering individuals in three very basic but powerful relational ways, which I will review: 1. by virtuous example and motivation; 2. by relationships of belonging; 3., by sharing spiritual or transcendent experiences with the recovering addict.

Relationships of virtue. The caring and well-seasoned therapist and sponsor are in a position where they (and others) can exemplify the peace and reconciliation available within virtuous and enduring relationships. In this respect, the mutuality of the relationship also implies that not only does the client benefit from associations with caring individuals, e.g., therapists, sponsors, and family, that these individuals are the beneficiary also through the relational dynamic. In many cases, the relational communion experienced within such associations may represent the healthiest relationship the client has ever experienced.

A truly relational experience of this nature may kindle a desire within the client to search out and develop other relationships of virtue, while strengthening existing connections. Because this is such a vital step towards recovery; sponsors, therapists, family, and without a doubt the addicted individual, might receive training in how they

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might each benefit from developing and improving healthy relationships. This "training" would naturally be situated as an adjunct to the actual experiencing of relationships. After all, it is not only the addicted individual that seems to be stuck in abstractionist assumptions but often everyone that is involved in recovery efforts. Once again this brings to light the belief that a bottom paradigmatic shift is often required when dealing with the intractable nature of addiction.

However, trainings, programs, and specific interventions are not ends unto themselves but rather serve as affirmations to the recovering addict's development of a moral sense and obligation. Such a moral sense and feelings of commitment underscore the relational nature of our being and our connection to others. A moral sense and obligation in this context implies that the addicted individual is capable of recognizing and responding accordingly to "... values and virtues... in the contexts of a meaningful cosmic order" (Richardson, Fowers, & Guignon, 1999).

Consequently, recovering addicts are able to establish, through their relationships with others, a moral compass that reflects among other things; the "dignity of difference" shared among all peoples (Sacks, 2002, p. 209); the sanctity of virtuous relationships, (the fundamental path to recovery); and the shared values that are constitutive of good relationships. Yet again, this requires a paradigmatic shift of a relational nature, from a self-serving or static morality to what Bella et al. (1985) refers to as a "moral ecology" (p. 46). In this sense, the addicted individual becomes aware, through various relational dynamics, "The web of moral understandings and commitments that tie people together in community" (Bella et al., 1985, p. 335). This is not to say that the individual in treatment must be inculcated with an avalanche of moral perspectives and ideals; this will

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come over time as the individual witnesses, first hand, the morality of human relationship and then embraces an acceptable moral framework.

Naturally, the relational therapist is there to provide guidance and the benefit of experience but acquisition of a moral perspective must be approach relationally. That is to say, he or she does not preach or lecture the virtues of a moral life and then expect the addicted individual to incorporate them into a moral life (Slife, Mitchell, & Whoolery, 2003). This is not foregrounding relationships; this is foregrounding principles. For example, the relational therapist may, on occasion, enlist clients in a treatment facility to participate in a group service project, e.g., assisting with chores in a homeless center, beautifying an old cemetery, or a donating blood. The opportunities and the resultant possibilities are endless. The point conveyed by relationality is that indoctrination in principals is secondary to immersion in virtuous relationships.

Relationships of belonging. Therapist, sponsors, and others can play an active role in relational therapy by experiencing with recovering individuals the kinship available in relationships of belonging. In this way, recovering persons leave their life of isolation and self-interest, and contribute in meaningful ways to the benefit of others and the community. Where they once lived a life in the margins of communal connections they are now at least able to witness the mutual benefits of a clean, sober, and relational life. Slife & Wiggins (2009) state:

> We all need to ‘‘belong’’ and be part of something greater than ourselves, such as a community. Indeed, the relationist makes the bold empirical claim that people who belong, are part of some greater communal whole, and are loved and loving in this community will rarely darken our psychotherapy doors... The good life,

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> from this view, is the life of good relationships and the central imperative of psychotherapy is to help clients relate well and love completely.
>
> (p. 20).

As we see, the relationalist would place a great deal of emphasis on exemplary relationships and interpersonal experiences as valuable contexts to move the addicted individual to a point where they may truly discern the "good life" from just a good time (Slife & Wiggins, 2009, p. 20).

It is probable that many recovering individuals are faced with an abundance of "good" and well-meaning "advice" on how to access the "good life" and the capture a sense of belonging and even love. But being a "... part of some greater communal whole" (Slife & Wiggins, 2009, p. 20) requires a moral awakening on the part of the addicted individual that may not be recognized by some as vital to recovery (May, 1991; White, 2005). For Christopher (2005) this relates to what he terms as the individual's moral vision; he observes "Moral visions refer to the constellations of cultural values and assumptions that constitute our understanding of the nature of the person and of the good life." (p. 222).

This harkens back to the foundation of the relationally good life; a sense that others count and that our shared associations require sacrifice, concern, and values. In a relational alternative to addiction treatment this may equate to the abandoning of potentially destructive associations such as unvirtuous people, places, and things (Miller & Rollnick, 2002). Indeed, individuals in recovery no doubt must shift many priorities in the re-envisioning of their relational life. This is a reality that Slife & Wiggins (2008) recognize as central to quality relationships; they comment:

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> Therapists can and should help clients consider how their values, choices, words, and general manner of being impact others and the quality of their relationships. Indeed, the best therapeutic option may sometimes be for the therapist or client to choose an option that is personally unsatisfying [such as changing friends], yet serves the client's relationships best (e.g., work through the difficulties in a marriage, give up a pleasurable hobby to have more with family). (p. 20).

Belonging in this sense carries with the obligation to put relationships with others before self not only in the theoretical sense but the practical sense of everyday living and relating.

Relationships of spirituality and transcendence. Concerned others provide a way in which the individual starting recovery can experience the transcendent or spiritual qualities found within all virtuous relationships. For example, the bonds, friendships, love, and longing to be in relation that develops over time within the intimate boundaries of the sponsor/client relationship are not observable qualities but exist in the relational space between individuals. Indeed, the relational "space" between individuals "is filled or reverberates with [the] all-important... relationship (Josselson, 1996, p. 5). In fact, Josselson (1996) cites Bowlby (1988) who situates the above relational ideal as indispensable to good mental health counseling, he asserts "... the idea that the adult need for others is a sign of *regressive dependency needs* is one of the most dangerous ideas promulgated by modern psychiatry" (p. 4). This is not to say, that overcoming addiction is easy or simple, it is to say, that some parts are certainly more accessible to change than others. Indeed, reverberating within the relational space are particular virtues that promote feelings of acceptance and trust.

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For example, concerned others including therapist, sponsors, and family may come to experience the virtues of humility, forgiveness, and sacrifice (among many others), as everyone endeavors to work with clients in the midst of their trials, challenges, and differences. These character virtues are recognized not as ends in themselves but as contextual means to reach the ends of worthwhile affiliations. For example, one may forgive everyone including themselves of wrongs endured but until one has the "spirit of forgiveness"; such proclamations are of little value, according to the relationalist (Slife, Mitchell, & Whoolery, 2003, p.22). Indeed, the bonds of caring kinships must be constituted in virtuous thoughts, considerate actions, and selfless motivations or they will wither and die (Peele, 1975; Robb, 2007; Ulrich, 2008; Walker & Rosen, 2004).

In this sense, the "outward" appearance of character virtues are of minute worth unless they are in relation with the transcendent changes of the addicted individual progressing from self-interest to self-denial, self-indulgence to self-constraint, ambivalence to compassion, etc. (Hilton, 2009; May, 1988, 1991; Walters, 1996). Relational feelings of acceptance, safety, and love, so important in the risking of "self" for good relationships, are shared constituents in the transcendent transformation of the addicted individual.

The relationalist would therefore assume that honest exchanges, truthful confessions, and appropriate sharing are each contextual manifestations of transcendent or spiritual connections. The relationalist would note, however, that such transformations do not follow a preconceived pattern or time table but rather occur in the ebb and flow of contexts. Indeed, this occurrence may be considered more process than event; however, the relationalist would not rule out the possibility of great change in a short period of time

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due to the diversity of individuals and the limitless nature of contexts, choices, and their attendant possibilities (Gordon, 2008).

Certainly, all those involved with the individual in recovery (including the individual themselves) need to develop a heightened sense of the power of humility to transform self-centered relationships into those of virtue and mutuality (Jay & Jay, 2000). Indeed, the relationalist would assume that the expansion of a real and practical sense of humility is essential to not only to coping with the intransigent nature of addiction but also the complexities and differences that are associated with the overall human experience. Slife & Richardson (2008) remind us:

> A relational ontology requires us to cultivate a sense of humility and a deep appreciation of enduring human limitations (Richardson, 2003), something that Woodruff (2001) terms 'reverence' and argues is a cardinal virtue in its own right... That kind of humility entails both a need and an obligation, from time to time, to consult the perspectives of others and to register the impact of their core ideals as fully as possible. (p. 710).

This "... kind of humility" (Slife & Richardson, 2008, p. 710) will also help the sponsor, others, and the client from appearing too dogmatic or confrontational, two qualities known to be correlated with resistance and relapse in the therapeutic community (Flores, 1997; Miller & Rollnick, 2008). For example, sincere humility can prevent the illusion of the power differential between therapist and client obviating power struggles or intimidation of the client. This too is enacted by relational therapists in their overall humble attitude and treatment of the client as a relational equal.

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Recall the humble way in which the relational therapist in the fictional case study approaches Jane. Her approach was not to abstract Jane into so many theoretical descriptions and diagnoses but rather to let their relationship "unfold" as the contexts of trust and safety were infused and reinforced. Additionally, the relational therapist did not use her academic knowledge or personal successes to assert her expert status but was content to await the right contexts for such disclosures to be shared. Humility within the constructs of relationality is an acknowledgement that much of life is a mystery that unfolds in countless relationships and contexts in which the sponsor, the client, and significant others are but unpretentious participants (White, 2007). Crucible

Reorienting perspectives of agency. This last section on relational approaches to treating addiction addresses one of the most relevant issues in the field, that of agency. The matter of agency, in fact, has been recognized as a recurrent theme in the study of addiction for over two hundred years (Brodie & Redfield, 2002; Jellinek, 1965; Rush, 1814; Valliant, 1982). The term agency, in its simplest form rest on the assumption that "... humans have free-will, choices, or possibilities "... [i.e.,] they could have acted or thought otherwise." (Slife & Hopkins, 2005, p. 7). Agency, in respect to, has been debated from two basic and seemingly polar opposite perspectives, each of which is abstractionist in their approach.

First, agency is considered only as a social construction and does not exist in reality (Burns & Bechara, 2007; Peele, 1990). This view reduces the phenomenon of agency to materialistic factors rather than the nexus of material and non-material entities, i.e., the object has primacy over the subjective. In fact, Vohs & Baumeister (2009) report "Belief in addiction is tantamount to a disbelief in free will, at least in the circumscribed

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behavioral sphere involving the addiction." (p. 231). Views of this nature rely on the scientific constructs of empiricism, reductionism, and determinism to makes their case (See Chapter 2). The second perspective situates agency as the freedom to choose (i.e., freewill) regardless of contexts such as the "inner" and "outer" environment of the individual (See pp. 95-104). In this case agency is abstracted from the material contexts. That is to say, that agency, a fundamental human trait, is sufficient from context to context to account for addiction, i.e., the subjective has primacy over the objective. Both views as we found in Chapter 3 are built upon similar abstractionist assumptions.

The purpose of this section, therefore, is to explicate a third perspective known as contextual agency (See pp. 175-179) and apply them to treatment ideals and alternatives. Contextual agency assumes the subjective and the objective are mutually constitutive of one another. This means agency is best understood when contexts and relationships are taken into consideration, i.e., they are thought to be ontologically inseparable. This also implies that choices are not made in a void but are shared constituents with biological, psychological, and sociological factors. As Valenstein (1996) asserts "it is impossible to understand consciousness and thought [e.g., choices] without considering the psychosocial context that not only shapes the content of thought, but also the physical structure of the brain" (p. 140).

For example, the brain, the mind, the environment, and agency exist as meaningless concepts without taking into account the mutuality and contextuality of each (Restak, 1991; Valenstein, 1996). In fact, none of these factors can exist without the other, and none has meaning without their shared relationships (Slife & Hopkins, 2005). In this case, addiction shares an intimate and mutually constitutive relationship with each

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of these factors. The lived experience of the individual represents the nexus where each of these "parts" constitutes a meaningful relationship—in the case of addition a destructive relationship with the individual.

Agentic alternatives. Consider, for example, the choice of the addicted individual to seek help in overcoming addiction. Hardiman (2000) observes that a "... willingness to change" is one of the "... Key elements in Recovery." (p. 80). But this willingness is not a self-contained choice; it is always situated within a number of other contextual features that enable us to understand the inherent meanings situated in those choices. Indeed, choices are not abstracted from one another nor are they abstracted from the contexts in which they are made.

In short, if persons inwardly expresse a desire to escape from the compulsive behaviors and destructive consequences of addiction their contexts will offer depth as to the nature of such decisions. For instance, help-seeking behaviors are regularly found in the contexts of negative consequences such as health issues, deteriorating relationships, legal problems, and the shame and guilt which accompanies these and other factors (Gendel, 2004; Livingston, 2009; Massaro & Pepper, 1995; Maxmen & Ward). Specific contexts of those seeking help from alcoholism are also known to be "...older [individuals], more likely to have completed school, worked at a full-time job... more likely to have experienced the termination of their first marriage, and more likely to have a positive family history of alcoholism" (Dawson, Grant, Stinson, & Chou, 2006, p. pp. 827-828).

The relationalist would assume these factors did not cause the individual to enter treatment, but the individual's agency, as other factors, are to some extent responsive to

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the contexts in which they exist. Conversely, the relationalist would also point out that these particular contexts will also be responsive to the choices of the individual. The relationalist would propose that this is a sequential as well as simultaneous phenomenon.

Obviously, not everyone suffering from addiction chooses to enter treatment. Once more, this brings to light that individuals "... could have done or thought otherwise" even in similar contexts (Slife & Hopkins, 2005). The relationalist, therefore, may assume that the factor of agency is a mutually constitutive element in persons refusing or accepting help in recovering from addiction. Although each addicted individual comes from a diverse assortment of relationships and contexts each shares contextual agency. But, how what are the contextual differences at the beginning of addiction rather than those at later stages?

For example, if an individual, fourteen years of age, chooses friends who use drugs and alcohol, the fourteen year old has created an influential context in which decisions are influenced at the age of fifteen. What if these choices are made in the presence of other contexts such as the absence of a stable and loving family environment, in a social system that reinforces the belief that material consumption provides fulfillment while spiritual beliefs are of little worth? Each of these contexts has been mentioned as being strongly correlated with the initiation of drug abuse and an increased likelihood of addiction (Anderson-Moore, Zaff, 2002; Blum & Reinhart, 1997; Critchfield, 2002; Lerner & Steinberg, 2004).

In lieu of this, the relational approach would seek to be aware of the circumstances of the individual and how these factors may be relevant to poor choices, such as abuse of intoxicants or destructive relationships. For example, environmental

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factors such as relative family values, poor parental example, and relaxed cultural norms may create a ripe atmosphere for experimentation, rebellion, and even skewed values that are constitutive of addiction.

In the case of cultural norms; the "Culture of Honor" shared among some males has been linked to alcohol abuse and aggression (Cohen, Nisbett, Bowdle, & Schwarz, 1996, p. 946). Relationality would assume that growing up in such an environment represents a cultural ideal in which some may choose to participate. Overcoming such faulty assumptions, through relational approaches would naturally be a context worth examining and unraveling.

Perhaps the therapist could use group therapy as the setting to overcome the destructive influence of such cultural "norms". Possibly in this approach, individuals with such assumptions could be invited to participate with others in the group in sharing ideas that promote more honorable and virtuous means to express masculinity, courage, or bravado. For example, individuals with this skewed perception may be challenged to coach and mentor a youth sports team. Conceivably, the imperative to relate well, set a good example, and provide "adult supervision" could enable individuals to see the positive alternatives to their own flawed assumptions of "Cultures of Honor" (Cohen, Nisbett, Bowdle, & Schwarz, 1996, p. 946). Such honorable choices would also be assumed to supplant customs and social norms that create negative possibilities.

Addicted individuals in treatment rarely recognize customs in society as an influence in their addiction; but they often identify pain in the present or trauma in the past as the cause of their addiction (Davies, 1992; Flores, 1997; Kurtz, 1985). Although the relationalist would accept the influence of such contexts they may also challenge the

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individual to choose to think differently about these conditions. For example, the individual may choose to use traumatic experiences in the past to relate to others or provide assurance to those in similar situations. In this way individuals are able to reconcile, or make peace with the past, by attending to the quality of their relationships in the present.

In such an approach, addicted individuals do not merely reshuffle or rationalize the events of the past; they simply accept that the past represents a learning opportunity that is mutually constitutive in the present. In this way, traumatic events in the past do not remain as static or painful memories but are part of the fluid depiction of the present. What were once thought to be disastrous and tragic events from the past are now transformed into valuable lessons that reinforce the implementation of positive relationships, healthy contexts, and wise choices. What were once monumental failures of character become distant reminders of the consequences of unvirtuous relationships, precarious contexts, and unwise choices (Hilton, 2009).

Moreover, the therapist may recommend that others with experience in dealing with such factors may take the opportunity to help this particular individual in "re-envisioning" the past. This provides, yet another chance, for individuals to experience the give and take of virtuous relationships. Such a reconstitution of the past shifts the self-involved energy used for victimhood to energy shared in virtuous relationships. Thus, relationality is more about forming the present and the future—through virtuous and helpful relationships—than settling the unfairness of the past. This means that choices in the present always reframe the qualities of the past, and the expectations of the future.

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In this respect, contextual agency is experienced in the present as a nexus of the past, present, and future (Slife, 2005). Simply put addicted individuals make choices based on the mutually constitutive nature of their present interpretations of the past, present, and future. For example, William Bennett, former U. S. Secretary of Education (1985-1988), admitted that for many years, including his years as Education Secretary, he was addicted to cigarettes. However, when Bennett was called upon in 1988 to be the "Drug Czar" he immediately quit smoking, citing the incongruity between the new position and his addictive behavior (Peele, 2000, p. 606).

This does not imply that the William Bennett as Secretary of State could not quit smoking and that somehow the William Bennett as the Drug Czar was inexplicably able to quit. This simply illustrates that our choices are in some ways responsive to the contexts in which we live. By this token, the individual's lived experience is much like the narrative of a story where the plot can be changed from moment to moment (Yancher, 2005), rather than the deterministic actions of one domino hitting another. In this respect, an individual's choices can alter the sequence and quality of events much in the same way as an author inserts or deletes particulars as they write.

This has important implications for relational alternatives, simply because it awakens the individual to previously unrealized possibilities while simultaneously alerting them to existent responsibilities. Slife & Hopkins (2005) find that "... agentic factors, such as exerting one's will to consciously withhold certain behaviors, can be just as effective as biological factors, such as drugs, in predicting even the neurological outcome of treatment for obsessive-compulsive disorder (p. 138). This implies that such approaches could be also be useful in addiction considering addiction is often viewed as a

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constellation of obsessive thoughts and compulsive actions (Schwartz & Abramowitz, 2003; Shaffer, 1994).

The preceding explanations are not intended to imply that overcoming addiction is simply a question of "mind over matter", quite the opposite. The relationalist recognizes and gives due respect to factors such as the brain and the environment since they also constitute with the mind the lived experience of the addicted individual. However, agency is accorded an influential relationship with a wide variety of contexts and relationships. In this respect, the relationalist would assume that certain choices in certain contexts enable addiction while other choices in different contexts may help to loosen its grip on the individual.

For example, loneliness, disappointments, and anger are often considered as contexts that facilitate addictive behavior (Flores, 1997; Gorski & Miller, 1986). This is not to say that a person is destined to use addictive substances if they experience these conditions only that these conditions are frequently found to be constitutive of choices that lead to substance abuse. Once more, this highlights the difference of virtuous relationships and contexts as a constituent of recovery as opposed to the relationships of self-indulgence and the contexts of self-interest as constituents of addiction.

The relationalist would therefore approach such negative contexts not by offering management strategies to overcome loneliness, disappointments, and anger but rather developing with the individual relationships that are conducive to belonging, fulfillment, and serenity. For example, therapists may situate individuals in various contexts where they are able to see, more clearly, how their relational attitudes and assumptions facilitate contexts of opportunity and choice. What the therapist hopes is that relations of trust,

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humility, and openness form supportive contexts in which the individual is able to see themselves differently, perhaps for the first time in many years. Such approaches may afford the individual the opportunity to violate long standing self-conceptualizations as being hopeless, innately flawed, and a victim (Grof, 1993; May, 1991).

For example, this is regularly addressed in group therapies where the individual establishes relationships of exploration, discovery, and mutuality. In this way, the individual is able to see themselves in others and to have others see themselves in the individual (Flores, 1997; Miller & Rollnick, 2002; Velasquez, Maurer, Crouch, & DiClemente, 2001; Yalom, 1925). Sometimes individuals are encouraged to express themselves in different ways so that they have viable alternatives to the various "scripts", "street smarts", and "games" that seemingly served them in the past (Phelps & Nourse, 1986). This may help individuals out of their "stuckness" that is more often than not built on a foundation of faulty assumptions.

The final illustration of contextual agency concerns choices made in the context of a belief in the transcendent other, such as a Supreme Being. The relationship of individuals with a Supreme Being or Higher Power has been cited as providing both the means and the motivation to overcome significant weakness, adversity, and suffering (Grof, 1993; Hilton, 2009; May, 1991). Indeed, the relationalist would no doubt assert that a sustained recovery for the addicted individual is dependent on the quality of many unseen connections, whether they are of a spiritual nature or are situated with the relational space of the human experience. At times these unseen connections are experienced in the midst of competing feelings or contexts e.g., despair and hope, sorrow and joy, or peace and conflict.

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Individuals who profess and share a relationship with a Supreme Being have perspectives and beliefs that not only hold them accountable to others for their choices and underlying intentions but they are also answerable to a "source" which to them provides a sense of mission and life purpose [and] a reason to live more virtuously" (Slife, Mitchell, & Whoolery, 2003, p. 16). This is not to say that all individuals seeking recovery, with such beliefs, fit easily into standard religious frameworks. Indeed, some may reject the confusion and competitive nature attributed to organized faith groups. Ideally, addicted individuals "seek and ultimately find a certain truth of [their] own—a special happiness, and a true peace and serenity" that is known to those who have faced a life threatening condition such as addiction (Morrison, 1989, p. ix). This personal realization is the "moral vision" referred to in the last section (Christopher, 2005, p. 222). "Moral, in this sense, has less to do with rules concerning what is right or wrong as with our deepest understanding of what good, worthy, and desirable." (Christopher, 2005, p. 222).

The relationalist would strive to share such a morality with the addicted individual by choosing to do the right thing, for the right reasons, in the right context (King, 1998). In this way recovering individuals need not constantly refer to categorical sets of principles for each situation they encounter but defer to transcendent impressions or feelings that derive from a genuine love for the "other" and an abiding relationship with the god of their understanding (Alcoholics Anonymous, 2001).

Once again, however, this is not so much an experience that can be taught as one that is "caught". In the words of Arthur Henry King (1998), a noted scholar and theologian, "... if we aim at fulfillment, we shall never be fulfilled... If we aim at

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salvation [recovery?] we shall never be saved. These things are indirect, supreme results of doing something else, and the something else is service, it is righteousness, it us trying to do the right thing, the thing that needs to be done at each moment. (p. 265).

We have learned that the issues of agency is a complex but yet basically understandable construct. This is to say, agency is infinitely more relevant and comprehensible, especially where addiction is concerned, when it is approached from a relational ontology (Slife & Hopkins, 2005; Slife, Mitchell, & Whoolery, 2003). Contextual agency, in fact, is the relational response to conceptions that either minimizes the actuality of agency or positions agency as a reality that is the same from context to context. Therefore, a relational approach to both the theory and treatment of addiction must proceed from the assumption that choices are made within the shared contexts of the addicted individual. Such a perspective, indeed, places a heightened sense of accountability on the individual while simultaneously opening up a myriad of possibilities for theories and treatments.

Conclusion. As we have been reminded countless times throughout this dissertation there is no small spirit of competition and even contention among the mainstream approaches to addiction (Schaffer, 1985, 1986, 2007). We have also noted that even though these approaches seem contradictory they are, in fact, united at the level of ontological assumptions. The fundamental approach to addiction science, from its earliest origins, have sought to separate the objects of addiction, e.g., the substances and biological entities, from the subjective aspects e.g., the contexts, relationships, and choices of the individual.

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Now more than ever in the history of addictionology, concepts and approaches lean heavily on these abstractionist assumptions. Schwartz & Begley (2002) observe:

> Surely there is something deeply wrong, both morally and scientifically, with a school of psychology whose central tenet is that people's conscious life experience (the literal meaning of the word *psych*) is irrelevant, and that the intrinsic difference between humans and "brutes" (as Watson had candidly put it) could be safely ignored. (p. 6).

Such approaches, according to the relationalist, inherently keep addicted clients and their "... conscious life" at "arms length" both therapeutically and more importantly, personally (Schwartz & Begley, 2002, p. 6).

If mind and mood altering substances and behaviors are designed to keep individuals in their "comfort zones" and thus, removed from the realities of everyday experience, then modern approaches to addiction have similar effects. In fact, most approaches to addiction skip the most real aspects—i.e., the individual and their accompanying relationships and contexts—and concentrate on abstracted features such as behavior out of context, chemical imbalance, psychological defects, and environmental influence (Engle, 1977; Jellinek, 1965; Leshner, 1997; Prentiss, 2005). These abstracted ideals can be found within various programs, methods, constructs, and strategies that are meant to somehow enable the individual to live productively in the real world without ever using the real world in the approach!

Relationality, by contrast, situates individuals and their behaviors as a nexus of possibilities and constraints with the contexts of relationship and choice. From this primary view the "objects" of addiction are only meaningful when placed in the context

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of relationships and choices. This implies that objectivity and subjectivity only exist as a "...interpretive reality" of the individual (Slife, 2005, p. 166). Treatment is approached accordingly: People and their concrete experience are foregrounded; theories, programmatic dynamics, and criteria are back grounded. John Donn (1572-1631) expresses succinctly the underpinning of relationality when he asserts "No man is an island" (Meditation XVII). Thus, the connected nature of the addicted individual is focused on in therapeutic endeavors rather than the disconnected elements of interest.

This is accomplished through relationships of virtue, contexts of acceptance, safety, and choices made in the contexts of awareness and humility (Slife, Mitchell, & Whoolery, 2003). Only by immersion in these relationships does the addicted individual become conscious of the alternatives available. This is not to say, that relationality offers smooth sailing for the addicted individual, to the contrary. Relationships of virtue guarantee, a consistent mix of trial and error, and no guarantee that suffering, in general, will abate immediately or completely.

Indeed, relationality would see suffering and discomfort as an important contextual relationship that may often accompany virtuous relationships. These may in turn instill a yeaning to have a life that is consecrated to others regardless of the sad or demanding circumstances this may bring. In this respect; learning, motivation, and action stem from one dynamic, that of the virtuous relationship. Of course, the individual path to and through virtuous relationships is by necessity different for each individual. But this should not be of any great concern for therapists or addicted individuals, since the motives and means for a life of meaning, cooperation, and love is intrinsically and simultaneously provided through virtuous relationships.

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Appendix

Table A1

Table of Distinguishing Features. This summarizes the abstractionism versus relationality comparisons shown in Chapter 2.

Comparative features	Abstractionism	Relationality
Context (pp. 18-22)	<u>The best knowledge stems from separating or abstracting the object of interest from its context.</u>	<u>The best knowledge is derived by understanding the object's relation to its context.</u>
	• Contextual factors are separated and eliminated, as much as possible (e.g., *laboratory*), to minimize distortion of the phenomenon of interest.	• The phenomenon of interest is most real when considered in relation to contextual factors (e.g., *field studies*).
	• Subjective contextual factors, such as biases and values, should be particularly minimized to get at the truth.	• Bias and values are inherent in knowledge.
	• Context is situated as background to more important foreground features. Foreground features are self-contained and need no context to have meaning.	• Context and relationship features are situated in the foreground of importance and meaning.
	• The best methods are traditional methods that control and eliminate subjective factors.	• The best methods incorporate a nexus of dynamic factors, including subjective factors.
Reduction (pp. 22-25)	<u>Reduction assumes that some features of reality are more fundamental than others.</u>	<u>Relationality assumes reductions are inevitable but not inherently more fundamental.</u>
	• Reductions prioritize the more fundamental factors	• Contexts and relationships are fundamental to meaning.
	• Some components are more basic than, and thus causal to, others.	• All components share a mutual constitution with other factors, with no one factor more "basic" than others.

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Comparative features	Abstractionism	Relationality
Reduction (pp. 22-25) cont.	• All components of the causal chain are self-sufficient.	• All factors of significance are necessary but not in themselves causally sufficient.
	• Individuals and their behaviors can be reduced to diagnostic labels.	• The complexity and mutuality of individuals and their behaviors resist reduction to mere labels.
Identity (pp. 25-31)	• <u>The identity of individuals and their disorders are viewed as self-contained entities.</u>	• <u>The identity of individuals and their disorders are viewed as an evolving nexus of mutually constituted factors.</u>
	• Identity is based on relationships of similarity (e.g., universals, laws, traits).	• Identity is comprised of both relationships of similarity and relationships of difference (e.g., contextual differences).
	• Identity is prior to relationships and is only affected by relationships if "incorporated within."	• Identity exists only in the presence of shared relationships and can fluctuate for that reason.
	• Identity remains autonomous and static despite the evolving and emerging world around the individual.	• Identity is not static or autonomous but reveals a changeable quality that is dependent on and evolves through relationship and context.
	• Identity is formed by contextless and unchangeable laws of nature.	• Identity is a synthesis of dynamic factors, relationships, and contexts.
	• The goal of development is self-sufficiency and independence.	• The goal of development is virtuous relationships.
	• The self is the most crucial aspect of life, living, and identity.	• Relationships are the most crucial aspect of life, living, and identity.
Experience (pp. 31-45)	<u>Abstractionism claims that objective reality and subjective experience are independent from one another as "separate worlds".</u>	<u>Relationality asserts that experience is neither objective nor subjective but an interpretive reality or meaning</u>
	• The objective world is the most reliable indicator of reality (not personal values and beliefs).	• Personally held beliefs about and interpretations of the world are important sources of meaning

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Comparative features	Abstractionism	Relationality
Experience (pp. 31-45) cont.	• All experience, according to abstractionism, is distinguished as subjective representations of more real entities, viz. the brain; the value of subjective experience is therefore utilitarian.	• All experience is interpretive and therefore is neither objective nor subjective.
	• "Subjective" experience does not yield the most fundamental or accurate knowledge.	• The "lived experience" of persons (i.e., subjective) contains the most fundamental meanings.
	• The best diagnostic criteria rely on laboratory and objective conditions.	• The best diagnostic criteria rely on "real world" contexts and relationships.
Determinism (pp. 45-50)	Abstractionism assumes that self-contained things relate to one another through cause-and-effect and thus deterministic relations.	The relational alternative to determinism is *contextual agency*, the assumption that possibilities exist within the limits of context.
	• Prominent determining abstractions are causal or caused by natural law.	• Relationality asserts that "cause" is determined by the interaction of mutually constitutive factors.
	• Causation is considered a sufficient condition for whatever effect occurs.	• Causation is considered a necessary condition for whatever effect occurs.
	• Isolated antecedents are the "causal links" in behavior.	• Antecedent factors in behavior are not isolated from one another or from present or future factors.
	• All identities are victims of prior events or laws	• The choices (i.e., possibilities) of the individual are not solely dependent upon prior events or laws.
	• Cause-effect interactions obviate moral considerations.	• Relational possibilities require moral considerations.
	• The "there-and-then" (preceding events and past contexts) contains the most fundamental information about the present.	• The "here-and-now" (current context and in progress contexts) contains the most fundamental information about the present.

Note. Underlined comparisons provide an overview of comparative qualities.

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