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Addiction Research

Coming to Believe in a Post-Belief World: Mysticism, Recovery, and Clinical Applications of Step 2

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ABSTRACT

This paper examines the theological and existential tensions embedded in "Step 2" of the Alcoholics Anonymous 12-Step program within a clinical framework, particularly exploring the neurobiological, psychological, and spiritual dimensions of recovery from trauma, addiction, and chronic pain. Drawing on a multidisciplinary approach that integrates evidence from addiction medicine, Jungian psychology, post-Holocaust theology, Hasidic mysticism, and Eastern contemplative traditions, this paper explores how patients navigate the paradoxical nature of belief in a "Power greater than ourselves" within a fragmented and morally compromised world. Clinical research on spiritual coping, neuroplasticity, and existential distress is synthesized with mystical traditions to provide healthcare practitioners with evidence-based approaches to address the spiritual dimensions of suffering in clinical practice.

The paper proposes that embracing paradox rather than resolving it may activate neurobiological mechanisms associated with resilience and recovery, offering a clinical model for addressing spiritual concerns that acknowledges both the science of healing and the mystery of transformation.

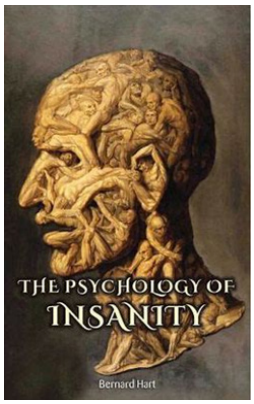
Keywords
Alcoholics Anonymous, Spiritual struggle, Post-traumatic stress disorder.

"We came to believe that a Power greater than ourselves could restore us to sanity" [1]. This assertion from Step 2 of the Twelve Steps simple on the surface becomes profoundly complex when filtered through clinical lenses of trauma, chronic pain, and existential distress. In healthcare settings, practitioners routinely encounter patients whose spiritual frameworks have been shattered by suffering, creating what clinical literature describes as "spiritual struggle" [2].

Jung's observation that "even the enlightened person remains what he is and is never more than his own limited ego before the One who dwells within him, whose form has no knowable boundaries, who encompasses him on all sides, fathomless as the abysms of the earth and vast as the sky" [3] reflects the psychological challenge patients face when integrating traumatic experiences into coherent meaning systems. This integration process has significant implications for treatment outcomes and recovery trajectories [4]. From a neurobiological perspective, chronic pain whether physical, emotional, or spiritual has the capacity to unravel one's sense of coherence, rewiring neural pathways in ways that reinforce maladaptive patterns. Studies have demonstrated a strong bidirectional relationship between chronic pain and major depressive disorder [5], with many patients describing what might colloquially be termed "insanity" a pattern of destructive cycles rooted in existential despair and neurobiological dysregulation. The neurobiological and psychological impacts of collective

trauma present additional challenges to recovery models. Research has demonstrated intergenerational transmission of trauma responses [6], with epigenetic changes documented in Holocaust survivors and their descendants. Such findings provide a biological substrate for understanding how historical catastrophe affects spiritual and existential beliefs across generations [7]. This paper examines how recovery frameworks, particularly the empirically-supported Twelve-Step methodology, offer therapeutic paradigms for addressing spiritual distress following trauma and chronic suffering. With specific focus on Step Two of Alcoholics Anonymous, the paper explores clinical approaches to facilitating adaptive spiritual meaning-making in patients experiencing existential distress, integrating insights from mystical traditions with evidence-based clinical interventions.

Pain, Insanity, and the Clinical Context

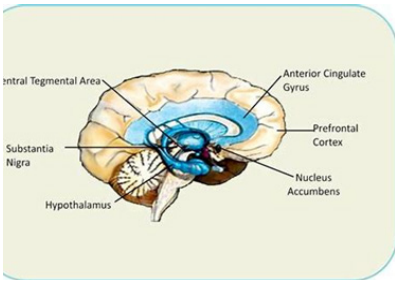


Clinical Conceptualization of Recovery and Psychological "Insanity"

In addiction medicine, the concept of "insanity" referenced in Twelve-Step literature has been operationalized as perseverative dysfunctional behavior despite negative consequences a pattern consistent with the neurobiological understanding of addiction as involving impaired executive function and dysfunctional reward circuitry [8]. As commonly understood in recovery contexts, "insane behavior is characterized by a belief that repeating the same self-destructive acts would somehow result in a different outcome" [1]. From a clinical perspective, this behavior pattern shares features with the perseverative cognition seen in post-traumatic stress disorder and complex trauma responses [9].

Kelly et al. [10] found that acknowledgment of powerlessness (Step One) correlates with decreased activation in brain regions associated with craving and impulsivity. Furthermore, longitudinal studies demonstrate that "coming to believe" in a power beyond oneself (Step Two) is associated with increased activity in prefrontal regions involved in cognitive control and decreased activity in limbic regions associated with stress reactivity [11].

The psychological transition from Step One to Step Two from acknowledging powerlessness to believing in the possibility of restoration represents a critical juncture in the recovery process. This transition has particular relevance for patients whose conception of divinity has been shaped by historical trauma or personal suffering. For these individuals, the traditional image of a benevolent, omnipotent deity may seem untenable in the face of their lived experience of suffering. These neurobiological correlates suggest potential mechanisms by which spiritual frameworks facilitate recovery. For clinicians, understanding these mechanisms provides insight into how to support patients whose spiritual beliefs have been challenged by traumatic experiences [12].



The 12-Step Program and Jungian Archetypal Theory: Clinical Implications

The historical and theoretical connections between the 12-Step program and Jungian psychology offer valuable insights for clinical practice. Carl Jung's correspondence with Bill Wilson, co-founder of Alcoholics Anonymous, explicitly acknowledges the role of spiritual experience in addiction recovery. Jung wrote to Wilson that the alcoholic's "craving for alcohol was the equivalent on a low level of the spiritual thirst of our being for wholeness, expressed in medieval language: the union with God" [13]. From a Jungian perspective, the 12-Step process can be understood as an archetypal journey that parallels the universal hero's quest.

This journey includes:

Confrontation with the Shadow: Step 1's admission of powerlessness represents the clinical recognition of what Jung termed the "shadow" the disowned and repressed aspects of the self that drive compulsive behavior. Research indicates that acknowledging the shadow aspects of personality correlates with reduced denial mechanisms and improved treatment outcomes [14].

Archetypal Higher Power: Step 2's "Power greater than ourselves" aligns with Jung's concept of the Self archetype the organizing center of the psyche that transcends yet includes the ego. Neuroimaging studies show that patients who develop a relationship with a personally meaningful Higher Power demonstrate increased activity in brain regions associated with emotional regulation and decreased activity in regions associated with self-referential processing [15].

Ego Surrender and Integration: Steps 3 through 12 align with Jung's individuation process the progressive integration of conscious and unconscious elements of the personality. This integration process has neurobiological correlates, including enhanced connectivity between the default mode network and executive control network [16]. In clinical settings, understanding the archetypal dimensions of recovery can inform treatment approaches. Patients often describe their addiction in terms that reflect archetypal possession being "taken over" by forces beyond conscious control. The 12-Step framework provides a structured path for naming, confronting, and integrating these archetypal energies.

Jung's concept of the collective unconscious the repository of universal human experiences and patterns helps explain why standardized recovery programs like AA can be effective across diverse cultural contexts. The archetypal patterns activated in the recovery process tap into neurobiological systems that transcend individual or cultural differences [17].

The concept of "spiritual awakening" in Step 12 parallels Jung's description of the transcendent function the emergence of a new psychological attitude following the tension of opposites. Clinically, this emergence often manifests as what Tonigan [18] documented as "quantum change experiences" sudden, transformative shifts in perspective that correlate with sustained recovery.

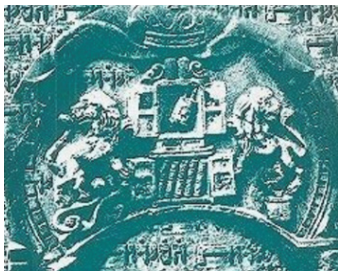
For healthcare providers, recognizing these Jungian elements can enhance clinical interventions by:
Framing recovery as an archetypal process rather than merely symptom management and acknowledging the role of the symbolic and numinous in psychological healing. Facilitating the integration of shadow aspects that drive addictive behavior and supporting the emergence of new identity structures that transcend addiction. Empirical research supports the efficacy of this approach. Kelly et al. [10] found that AA participation leads to greater rates of abstinence compared to other treatments, with the development of a relationship with a Higher Power serving as a significant mediating factor. Similarly, Tonigan's [18] research demonstrates that spiritual awakening experiences conceptually aligned with Jung's transcendent function predict # Coming to Believe in the Post-Belief World: Mysticism, Recovery, and Clinical Applications of Step 2.

Concept	12-Step Model	Jungian Psychology
View of Higher Power	Personal God or Higher Power (undefined)	Archetypal Self (collective unconscious)
Source of Addiction	Moral and spiritual failing	Imbalance of psyche / loss of meaning
Healing Mechanism	Surrender to Higher Power	Individuation, inner integration
Role of the Ego	Needs to be surrendered	Must be integrated (Shadow)
Spiritual Practice	Prayer, confession, community	Active imagination, dream work
End Goal	Spiritual awakening & sobriety	Wholeness / psychological integration

The Absurdity of God and Theological Frameworks in Clinical Contexts

In clinical settings, patients often articulate spiritual distress using theological language that reflects profound ambivalence toward the divine. The holocaust poet Paul Celan's "Psalm" offers a powerful expression of this ambivalence: "No one moulds us again out of earth and clay... Praised be your name, no one" [19]. This articulation of divine absence what might be termed "the theology of the void" has clinical parallels in patients' expressions of abandonment, betrayal, and cosmic injustice. From a psychological perspective, Jung's analysis in *Answer to Job* provides a framework for understanding these expressions not as pathological but as authentic encounters with the paradoxical nature of the divine. Jung proposes that the enlightened individual remains limited before "the One who dwells within" unfathomable, limitless, paradoxical [3]. In clinical terms, this dynamic is mirrored in the therapeutic alliance, where the clinician like the divine other must hold both presence and mystery for the patient struggling with existential questions. As demonstrated by Heim and Nemeroff [20], early life trauma creates neurobiological vulnerabilities that can manifest in adulthood as dysregulated stress responses. Similarly, collective traumas such as genocide create population-level vulnerabilities that clinicians must consider when treating affected individuals and their descendants [21].

The legacy of historical catastrophes like the Holocaust has fundamentally reshaped both theological discourse and clinical approaches to spiritual distress. George Steiner [22], reflecting on Exodus 4:24, provocatively suggests that the Jewish people may have "thrust upon [God] the labors of justice and right anger" (p. 149), implicating God in human suffering. This theological perspective has clinical implications for how patients conceptualize their relationship with the divine in the context of suffering.



In clinical contexts, patients from groups with histories of collective trauma may present with what Solomon [23] terms "existential distress" a condition characterized by profound questioning of previously held beliefs about meaning, justice, and spirituality. Steiner [22] observes that events like the Holocaust fundamentally disrupt patients' spiritual frameworks, challenging clinicians to address not only psychological symptoms but also existential concerns. Clinically, this disruption often manifests as spiritual struggle, a condition associated with poorer mental health outcomes and increased suicidality [2]. Pargament's [24] research demonstrates that negative religious coping (viewing suffering as divine punishment or abandonment) correlates with increased depression, anxiety, and PTSD symptomatology. Conversely,

positive religious coping (finding meaning and connection through spiritual frameworks) correlates with post-traumatic growth and resilience [25].

The integration of spirituality into evidence-based treatments requires careful clinical assessment and cultural competence. Mystical traditions both Western and Eastern offer conceptual frameworks that some patients find helpful in processing trauma and suffering. Hasidic mysticism, especially in the teachings of

Hasidic Mysticism and Eastern Traditions: Therapeutic Applications

Rabbi Nachman of Breslov and Rabbi Mordechai Yosef Leiner of Izbica, insists on the possibility of encountering the divine precisely in the vacuum of apparent absence [26,27]. Leiner's commentary on the concept of "Makom" (place) as a divine name identifies God with the very ground of being, even when all else fails (Leiner, *Mei HaShiloach*). The divine is conceptualized not as an external force but as the concealed presence within every experience, even suffering. This teaching that "there is no place devoid of Him" functions not just as mystical poetry but as theological resistance to despair. These concepts find parallels in Eastern mystical traditions, particularly within Advaita Vedanta and certain schools of Mahayana Buddhism, where the divine is conceived not as a personal God but as impersonal absolute reality (Brahman or Sunyata) [28,29]. In these traditions, suffering and ego-attachment obscure the realization of the already-present ground of being. The spiritual practice involves recognizing union with a Reality that transcends duality even the duality of God and self.

From a clinical perspective, these mystical frameworks align with several evidence-based therapeutic approaches:
Meaning-Centered Psychotherapy: Developed by Breitbart et al. [30] for patients with existential distress, For clinicians working with patients experiencing spiritual distress following trauma, several evidence-based interventions show promise:

Spiritual Assessment: The HOPE assessment [31] provides a structured approach to understanding patients' spiritual resources and concerns, enabling clinicians to integrate spiritual frameworks into treatment planning.

Dialectical Understanding: Teaching patients to hold seemingly contradictory beliefs simultaneously such as acknowledging both divine absence and presence can reduce cognitive dissonance and facilitate meaning-making [32].

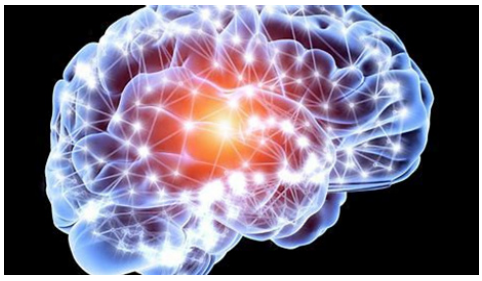
Narrative Reconstruction: Helping patients construct coherent narratives that incorporate traumatic experiences into their spiritual frameworks promotes post-traumatic growth and resilience [33].
Mindfulness Practices: Research by Davidson et al. [34] demonstrates that mindfulness practices derived from spiritual traditions reduce activity in brain regions associated with rumination and increase activity in regions associated with emotion regulation. Clinically, these interventions help patients move from rigid, absolutist spiritual frameworks that cannot accommodate suffering toward more flexible frameworks that acknowledge paradox and uncertainty [35].

Integrating Paradoxical Faith in Treatment

Case Presentation: A 67-year-old male patient presented with treatment-resistant depression, alcohol use disorder, and chronic pain. His clinical presentation was complicated by intergenerational trauma, as both parents were Holocaust survivors. The patient reported spiritual struggles including anger toward God and inability to engage in religious practices that previously provided comfort.

Intervention: Treatment integrated motivational interviewing, cognitive-behavioral therapy for depression and pain management, and spiritually-integrated psychotherapy. The clinician helped the patient explore paradoxical faith constructs from his own religious tradition, particularly the Hasidic concept of divine presence even in apparent absence.

Outcome: Over 16 weeks of treatment, the patient demonstrated significant reductions in depressive symptoms (BDI-II score decreased from 29 to 14), improved pain management, and achieved sobriety. He reported decreased spiritual distress and renewed engagement with religious practices, now understood within a framework that could accommodate his traumatic history. This case illustrates how helping patients integrate paradoxical spiritual frameworks can facilitate recovery from complex conditions involving both physical and existential suffering.



Neurobiological Correlates of Spiritual Recovery

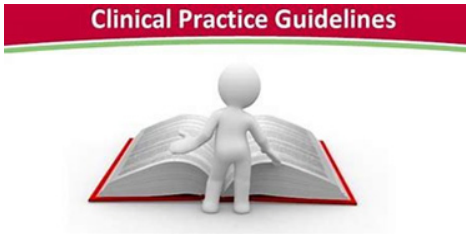
Emerging research provides insight into the neurobiological mechanisms through which spiritual frameworks may facilitate recovery from trauma and addiction:
Default Mode Network Modulation: Spiritual practices have been

shown to modulate activity in the default mode network, which is hyperactive in both depression and PTSD [12].

Improved Cognitive Control: Longitudinal studies demonstrate that spiritual practices improve top-down regulation of emotion, potentially counteracting the impaired prefrontal function seen in addiction and trauma [36].

Enhanced Neuroplasticity: Regular engagement in contemplative practices increases BDNF levels, potentially facilitating the neural reorganization necessary for recovery from trauma [37].

Stress Response Regulation: Positive spiritual coping is associated with improved HPA axis regulation, counteracting the dysregulated stress response characteristic of trauma and addiction [38]. These findings suggest potential neurobiological pathways through which paradoxical faith constructs might contribute to recovery and resilience.



Clinical Recommendations

Based on current evidence, the following clinical recommendations emerge for healthcare providers working with patients experiencing spiritual distress following trauma:

Conduct comprehensive spiritual assessments that explore both resources and struggles. Integrate patients' spiritual frameworks into evidence-based treatments rather than addressing spirituality as a separate domain. Help patients develop tolerance for ambiguity and paradox rather than seeking definitive theological or philosophical resolutions. Recognize that spiritual recovery often parallels psychological recovery in being non-linear and characterized by ongoing integration rather than complete resolution. Attend to potential neurobiological mechanisms of spiritual interventions, particularly their effects on stress regulation and cognitive control.

Conclusion

For clinicians working with patients affected by personal or collective trauma, understanding the role of paradoxical faith constructs offers valuable therapeutic insights. The integration of spiritual frameworks that can accommodate suffering without minimizing it may facilitate neurobiological, psychological, and existential healing.

As demonstrated by emerging research, helping patients develop spiritual frameworks that embrace paradox rather than demanding resolution may activate neurobiological mechanisms associated with resilience and recovery. For healthcare providers, this approach offers a clinically sound method for addressing the existential concerns that often complicate recovery from trauma and addiction. Future research should continue to explore the neurobiological correlates of spiritual meaning-making and develop manualized interventions that integrate paradoxical faith constructs into evidence-based trauma and addiction treatments. As healthcare providers increasingly recognize the clinical relevance of spiritual concerns, interdisciplinary collaboration between medical professionals, psychologists, and spiritual care providers will be essential for developing comprehensive approaches to healing that address the full spectrum of human suffering.

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