Constructing Recovery from Addiction

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Reconstructing my understanding of addiction and recovery began for me in 1995, when the reality of client's presenting conditions and needs proved to be inadequately served by the constructs of the psychotherapeutic theories to which I had hitherto been exposed.

There was an inconsistency in the claims of psychotherapeutic cures of conditions that were being labelled as "addiction" or "alcoholism", when in fact the client had been displaying behaviours of temporary or controllable misuse. The chaotic descent into the life-threatening hell of dependence that was observable in some clients, relatives of clients and in the world around me (my practice was in Kings Cross) did not seem to be adequately represented. And because addiction was "off the map", the route to aiding recovery seemed unnavigable.

According to my constructivist learning tradition, I began to seek more clarity not just in literature but also through hours of interview with many people who had reached a desperate state of hopeless and destructive dependency and had since succeeded in rebuilding their lives to maintain a stable and acceptable mental health.

This form of research is sometimes called "modelling", wherein the researcher gathers detailed information about the subject's internal processes of reality construction, in terms of internally generated sensory representations, such as pictures, self talk and somatic markers of emotion, visceral activity and arousal. This "data" is then explored in how it holds together and operates sequentially and systemically, contained and directed within the individual's belief systems, motivating values and identity narrative.

Characteristic of people's language when they speak of these normally unconscious dynamic constructs of psychological self-governance is that they often offer descriptions in symbol and story, making information of this kind creatively transferable for other people's use in their own subjective meaning-making processes.

Modelling in a formal or informal way is used across the spectrum of experiential therapies, often going by different names. Its development into a scientifically informed art is largely credited to the developers of Neuro-Linguistic Programming where modelling the client's structures of subjective experience in sensory terms empowers their flexibility and awareness in how they structure and experience their reality, and therefore behave within the world. This increases their cognitive and somatic alignment to make congruent, teleological, or "outcome oriented", choices (Dilts, 1998).

This approach defines therapeutic purpose as facilitating an increase in awareness to the sensory feedback of experience that in turn informs greater flexibility in adaptive processes towards fulfilment of meaningful values (Wake, 2007).

Such a definition of healthy state is directly polar to the experience of the person suffering with dependency. Dependency states are characterised by rigidity in thinking and behaving, with a breakdown of the human cybernetic feedback-response loop, separating thinking from emotional and sensory experience, so that perceptions of self, others and the world are distorted (Gilligan, 1997).

Modelling can also be used to deconstruct and therefore digest at a deeper level, the constructs of a culture or theory base, discerning the patterns that make constructs

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applicable and effective in different contexts (DeLozier, Grinder, 1987). These “maps” are evaluated according to their usefulness in helping us navigate the “territory” of our experiential and relational life, in alignment with contextually sensitive priorities. So modelling recovery culture was also a part of my endeavour.

With these methods I set about to educate myself about recovery in addiction using the central question of Contemporary Psychotherapy – “What works?”

My solution-focussed bias, as a personality and practitioner, got big strokes from discovering that clients in recovery spoke more about the processes of health that they were constructing and maintaining than they did about the history or causes of their dependence.

On the other hand I found that many contrasting theories and constructs of what causes addiction, how it should be defined and the meanings we should apply to recovery, could confuse and alienate client and practitioner alike. Research has yielded disconnected parts of the elephant. An issue that ranges across so many individual, family and social systems has necessarily been approached by specialists from many fields, each with their own areas of illumination and blindness to the systemic nature of the beast.

Try as we might in our scientific endeavour, we cannot say definitely if, or to what degree the causal factors of genetic expression (not to be mistaken for ‘hereditary traits’) , social conditioning, psychological development and economic motivations are causal factors in the manifestiation of what is called addictive disease, in general or in individuals. But we can say that all these factors may have varying degrees of influence from person to person, and within different kinds of addictions, such as substances, sex, food or relationships.

All may need to be considered at some point in recovery from addiction as all four systems are impacted by the condition. A treatment that is rigidly attached to one causal theory (construct) or another would be bound to fail some sufferers at some time.

Psychotherapists often display a sense of threat from the neuroscience of addiction, mistakenly believing that this dismisses the considerable developmental influences on mental health such as attachment and trauma. On the contrary, neuroscience validates what psychotherapists have intuitively known regarding the impact of early experience and brings new ways of demonstrating the measurable impact of cognitive and affective systems on brain function.

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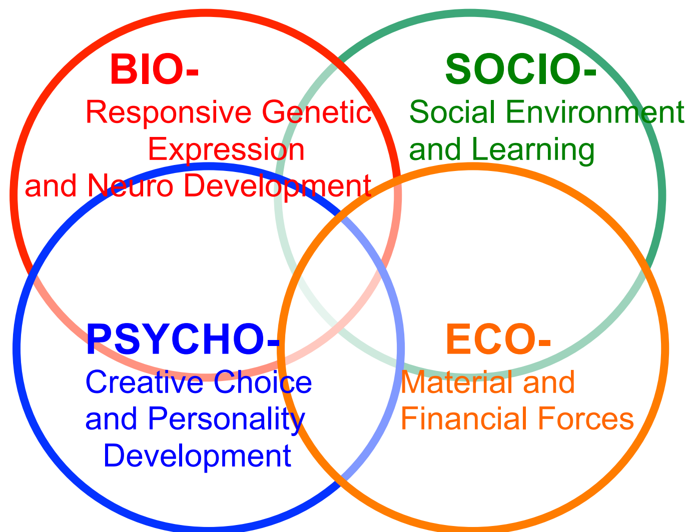
A Bio-Socio-Psycho-Eco Model



The good news is that neuroscience has progressed to demonstrate a greater plasticity in brain recovery than previously believed – in fact, the emergent picture of the potential for individual recovery looks a lot like the paradigm that we overly optimistic psychotherapists have been working in for a long time! (Kandel, 2000)

The recent convergence of neuroscience with psychotherapeutic research gives us a clear indication of why some approaches work in the treatment of addiction and other conditions of rigidity and compulsion. It also shows us how and why some psychotherapeutic activities actually heal the physical organ of the brain. The brain is like a muscle, not physically but metaphorically, getting stronger if it is exercised. Increased use in particular cognitive and creative activities results in greater brain cell development in the required areas of the neural structure, a process called neuro-genesis (Rossi E. 2002).

Unsurprisingly, these revelations from the experts are distinctly relevant to the processes of reconstruction of reality that were described by those in recovery who I had interviewed.

The rest of this article focuses on one aspect of the patterns revealed in constructing recovery, which is the individual's changes in the processes of building and managing constructs of *time.* Research suggests that a common feature in the constructing patterns of individuals with dependency and rigidity conditions is their comparative inability to think about and construct a relationship with time in the way that people with more healthily adaptive patterns do (Bendura, Damasio, 2002).

The results of inadequate or unhelpful constructs with time can be life-shaping.

There are three categories of time construction that I will explore here in connection to recovery and successful psychotherapeutic intervention that facilitate the mental and emotional processes of reconstruction, thus stimulating neurogenesis.

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1. Constructing time as a sequence of causally related events

An ability to construct a linear sense of time wherein sequences of events are related in cause-and-effect systems is vital for a person to develop a guiding sense of their behaviours having consequences.

Substance Dependent Individuals reveal a greater incidence of deficit in these constructing abilities (*ibid*), resulting in an obvious obstacle to impulse management and decision-making. This can help us to understand how those around the addicted person can exclaim “Can’t he see what he is doing?” This explanation of what is sometimes called “future myopia” answers “No. He cannot”.

This may be in part why addiction and anti-social personality disorder are so often perceived in the same person, as both diagnoses perceive a marked deficit in the person’s ability to make these sequential connections between actions and their consequences for themselves and others.

Attempts at persuasion or confrontation are shown to be ineffective and sometimes detrimental to engagement with any treatment for dependency (Moyer et al, 2002). One thing that various successful treatment approaches have in common, from Motivational Interviewing to 12 Step based treatments, is that they engage the client in processes of experientially reconstructing recent events in the client’s life that have been identified by the client as unwanted.

Exploration of step-by-step sequences of behaviours and decisions that lead to these undesirable consequences challenges from within the addiction construct that the use of drugs, drink, sex, abusive relationships, food are problem-solving and needed. Reclaiming the steps of the experience reveals in sensory references that their use is motivated by wishing to solve problems of uncomfortable emotions or thoughts, when in fact use, abuse or misuse lead to greater experience of what is being internally and externally avoided.

Constructing time in this way also affects the dependent person’s ability to perceive of a future that can be happier without the substance/behaviour/relationship in which they currently are invested. Processes known in Ericksonian Psychotherapy as Pseudo Orientation in Time develop the client’s ability to construct various alternative futures and the resources and actions required to make them a reality (Erickson, 1954/80).

These kinds of interventions have blossomed into many different schools of Erickson-influenced practice, such as Brief Solution Focussed Therapy, Motivational Interviewing, Neuro-Linguistic Psychotherapy and Constructive Psychotherapy. 12 Step approaches to treatment offer this by affording the individual exposure to a number of other people who have achieved what the client wants, demonstrating its possibility, and by revealing the various narratives of others in recovery as step-by-step actions that can result and maintain sobriety.

Such facilitations exercise the client in the imaginative and evaluating processes required in decision-making, a key life-skill that people in recovery spend much time developing and appraising. William James, great-grandfather to constructivism, identified as early as the 19th Century that deficits in decision-making were causal to much individual misery. Regaining clarity in recognising and navigating “choice-points” (Gawler-Wright, 1997), also serve in greatly reducing the occurrence of “relapse” – when a lapse in healthy behaviours

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spirals into a chain of compulsive actions that swiftly reduce the client to a state close to the pre-recovery experience of self-destruction.

This attention on constructing cause-and-effect sequencing should not be mistaken for a psychoanalytic search for insight into historical causes for dependency. Insight oriented psychotherapies have been “spectacularly unsuccessful in changing substance abuse” (Miller et al, 2003). Some in recovery may however experience benefit from such therapeutic intervention at later stages of recovery when they are searching for meanings in their construct of personal narrative.

Possibly the bias against psychoanalytic intervention at the beginning of recovery is because orientation into remote and confused memories further dissociates the client from contemporary acts and their consequences. Successful engagement in recovery almost invariably involves the client’s ability to reclaim their power in self-determination (accepting paradoxically “powerlessness to control usage”) by regaining the construct of foresight and the act of choice that is only available in the “now”.

2. Constructing time as the “experiential now”

One of the most widely documented phenomena of dependency conditions, and most commonly reported to me by the people in recovery, is the loss of cognitive recognition of emotional and visceral feedback. This is not just so in dependency of those substances which would be expected to have an anaesthetic effect but also those dependencies on processes such as gambling, internet chatting and compulsive relationships (Alexander and Schweighofer, 1988).

Accompanying this loss of experience in the moment is a racing and obsessive mind whose thoughts are almost always placed somewhere other than the here and now. This state of dissociation that has long been recognised in the psychotherapeutic lexicon has emerged in neuro-scientific literature within “Somatic Marker Hypothesis” (Damasio, 1999).

Dependency is marked by a lattice of non-sense schemas, what is known in CBT as “stinking thinking” and in 12 Steps as “junk-talk”, that argue for continued use of, or obsession with, the subject of the dependence (Lewis, 1994). Such cognitive activity necessitates a denial and distancing from affective activity until there exists just one label for all emotional and visceral experience. The label will usually be a variation on the word “craving” – “must get”, “need to”, “can’t live without”. Attempts to identify other feelings are experienced as “numb” (Gawler-Wright P. 2000/01).

The schism between cognitive labelling and somatic experience within the dependency process is identified variously in different recovery paradigms. The client’s experience is that they only have one limited set of somatic experiences – craving and satisfaction of craving, with an acutely diminished repertoire of satisfying behaviours.

Increasing the internal relationship and communication between in-the-moment somatic experience and cognitive processes of identifying and responding to the huge variety of somatic signals and events is central to many successful treatment paradigms in addiction recovery. Mindfulness, Self-Relations, Systemic Neuro-Linguistics, CBT and 12 Step based therapies engage the client in processes of what is called in Ericksonian Psychotherapy “proper naming” of subjective experience.

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Again these various approaches revolve around the client's ability to make meaningful and useful constructions to navigate appropriate responses to internal events.

Common to the clients that I work with is the rediscovery of what I call "the taboo value", an undeniable yearning for a misnamed outcome, coded as a demonised emotional state that the client perceives as intolerable. The constructs of self-condemnation and shame (such as "attention-seeking", "pathetic", "raging") that have been built around an important somatic signal of an irrefutable human need (such as "belonging", "safety", "freedom") keep the client from finding genuinely satisfying meanings and behaviours in response to strong, positive motivations or the variety of emotional experience.

Dissolving these inaccurate and unhelpful constructs also involves deconstructing beliefs around the client's ability to cope with the range of experiences that life brings. Common to the addiction mindset is the self-identity that one cannot possibly bear pain or uncomfortable emotions. Well-meaning relatives, carers, and even therapists, can collude with this sense of incompetent self by supporting a notion that dependency should not be challenged if it exposes the client to other unresolved feelings or stresses.

Recovery involves an acceptance that sometimes life hurts like hell, but human beings are equipped to respond constructively to even the most profound trauma, loss or regret and to grow in strength through the process. It is the avoidance of uncomfortable feelings, an abandonment of life's process in current time, which causes the perpetuation of pain.

Reconciling the psychic relation to the full range of somatic experience, from pain to joy, engages naturally healing physiological processes (Rossi, 2004). When such processes become frozen in time by the block to growth that the dependence cycle creates, the self becomes stunted at the age of the onset of dependency, increasing the illusion that the dependent person can only manage by avoiding developmental challenges.

As constructing skills to process sensations and emotions within the experiential now is such a key foundation in the building of recovery, it makes sense that psychotherapeutic constructs built on more Eastern epistemological principles such as Buddhist Psychology and Systemic Modelling (Fenner 1995) have had much to provide in the explanations of why some things work in recovery and some other theoretical bases do so more sparely.

3. Constructing past/present/future as a meaningful narrative of self

Before reaching for recovery, the dependent person has been locked into a Sisyphus-type cycle rolling over many chapters of regret, abuse, trauma and loss. The high incidence of addiction in adult-children of parents with addiction suggests that deficits in attachment through neglect and growing up in a high-stress environment predispose an individual to having the gaps in personal functioning that addiction so easily fills (Shore, 2003).

The destructiveness of the dependency cycle as a coping strategy results in repetition of earlier injuries, such as abandonment, narrated by echoing choruses of worthlessness and failure. The decline in personal care and safety that accompanies dependency can bring added incidence of violence, accident and sexual or emotional abuse.

Many clients present for treatment with a shopping list of anxiety conditions, esteem issues, unresolved trauma and failing relationships. It has to be said that many of these experience a momentum of alleviation of other presenting conditions without a need for the therapy they first signed up for, once the commitment to recovery has been made and

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inner resources are remobilised through the interruption of the dependence cycle. It is as if the recovery construct in itself triggers an unstoppable healing process.

This is often accompanied by a great need to talk to others about their addiction and recovery experiences, to stretch the muscles of their learning capacities in new studies and activities and a need to reconnect with the interdependent social system. Spiritual reconnection is also a core feature in many people's experience of recovery and their identity reconstruction.

Whether through therapy or through other means, the person in recovery usually has a story to make sense of and to tell. Continuing mental health that is increasingly less susceptible to relapse is fortified by the construct of a meaningful and satisfying self-narrative, that encodes regrets into teleological learning episodes and enables an ethical valorisation of past struggles (Rose, 1996).

12 Step approaches offer this through a fellowship of people in recovery whose naturalistic storytelling engages the listener in imaginative meaning-making, revealing patterns of sameness and difference within individual narratives. The 12 Steps, as in other constructive therapeutic approaches to recovery, offer the individual, family and group simple and tried methods for dealing with past mistakes and committing to an enlightened future.

Such stories have in turn enlightened my practice and my personal growth. Clients in recovery have served as exemplars to me for a conscious and values-driven life. The recovery community is resplendent with hugely successful individuals, as well as a high population of charity runners, foster parents, bone marrow donors and other quiet heroes. This reframes the identity construct of "addict" or "alcoholic" into the badge of one who has been to the edge and made it back, with the accompanying humility and gratitude that such a journey affords.

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