

Road Map to Recovery

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Clinical Philosophy

Position I

Patients are admitted to Caron Renaissance for treatment of substance abuse and/or other mental health issues. Caron Renaissance directly addresses the underlying character pathology that fuels the addictive process.

We, as a treatment team, need to identify the patient's dependency of choice, as substance abuse is frequently a symptom of other more entrenched dependencies. This identification, or assessment process, involves getting to know the patient from four major perspectives:

1. Developmental Status. The status of an individual is identified through behaviors, competencies, and attributes that demonstrate how a patient has integrated developmental themes over the course of his or her life. Disruptions to development can be manifested by regressive themes. Regression to narcissistic and dependent ego states, rather than progression to a more integrated, socially adaptable ego state is characteristic of many who are chemically dependent. Regressions that utilize primitive defensive structures, such as denial, aggressive outbursts or withdrawn isolation, frequently lead back to relapse and a return to active addiction.

2. Characterological or Personality Organization. The personality features and character structure of the patient need to be identified and addressed. Distorted perceptions and beliefs can leave the patient in chronic conflict with the world, continually misinterpreting relationships and situations. For example, one individual might vacillate between extremes in relationships, first overvaluing and then devaluing others, never able to maintain a stable perspective. Another might demonstrate total disregard for people, and even for his or her own health and safety. The end result is that an individual, trapped in a distorted belief system, is only able to have a relationship with him or herself. Without challenging the distortions and consequent behaviors, the patient will be unable to develop the interpersonal relationships necessary to recovery.

3. Affective Experience. The affective experience of an individual refers to how one experiences him or herself on a feeling level. Affective disorders, such as depression, mood or anxiety disorders, are often manifestations of regressive and dependent ego states. The patient will rarely recognize their experiences on a feeling level as being connected to developmental difficulties while moving through life's challenges. In addition, past traumas, whether chemically induced or by perpetration, can set the stage for trauma bonding and the tendency to exhibit an obsessive-compulsive process, exhausting the individual's psychic energy. Individuals in this state can experience extreme difficulty identifying or expressing their emotions, leading back to an over-reliance on others. People, especially in early recovery, can have overwhelming, confusing, or labile emotions. If not addressed, these affective states can trigger a return to the

addictive cycle.

4. Family-system dynamics. All families operate according to spoken and unspoken rules; family members adopt and adapt roles, communication styles, and boundaries. The dynamics of an individual's family system help explain the "authorized" experience of the family and, sometimes, the "chosen identity" of an individual patient. The dynamic of spousal child, family hero/scapegoat/lost child all put people at risk of being assigned a dependent role within the family system. As it is common for individuals to re-create the dynamics they experience within their families in other relationships as well - be they with friends, lovers, co-workers, and even therapists - the re-creation of dependent roles, and the resultant pattern of interactions, is specifically detrimental and can contribute to the relapse process.

While in treatment we, as a treatment team, must also identify the strengths and competencies of patients in order to help them confront the issues that serve as obstacles to the recovery process. When one develops identification with his or her own competencies or talents, they can come to serve as the regulators of anxiety, depression, or grandiosity. In fact, our operational definition of sobriety is the ability to manage emotions without a return to chemicals or other addictive behaviors. The goal is for the patient to build upon their strengths, work through their issues, and move from a dependent position to an interdependent position.

The dependent position, with its chief emotional components of feelings of entitlement or perverse grandiosity, fuels anxiety, depression, anger, and fear. An individual in this position believes success or failure is due to someone else's behavior or to circumstances that are imposed on him or her. Any encouragement of the dependent position reinforces and fuels the addict's delusional system: "If I take something from the outside and put it inside, I will feel, be, work better!" With this belief system in place, it makes sense to the addict that the external world is at fault or to blame for any unhappiness, problems or discomfort, and, by extension, to blame for the addict's behavior. Most patients have had this "fixed" delusional system for many years: "If only I had a better therapist, treatment center, roommate, job, set of parents, car, girlfriend, boyfriend, husband, wife, partner, boss - if only I could get that thing out there and incorporate it, I would be better!"

Using someone else's behavior as one's regulator of emotions is doomed to fail. Addiction serves as a way of regulating a patient's emotions, and in this sense, it is similar in process to the dependent position. Both addiction and the dependent position provide a substitute for developing the capacity and the necessary competency to regulate one's own internal emotional processes.

The interdependent position reinforces and fuels the addict's recovery by merging the patient's internal dialog with the logical consequences of his or her behavior. This includes success and failure, experienced positively or negatively. When patients experience honest, realistic views of their self-worth, and begin to assume responsibility for their own behaviors, it facilitates the development of personal integrity, which we define as the congruence between one's inside world and outside world. One begins to see oneself as a part of a larger whole. An interdependent position requires individuals to discard the delusion that outside sources are

responsible for one's actions, and yet, accentuates the reality that we do not live in isolation and that individual choices affect the environment and our lives.

Position II

Addiction is a functionally autonomous process! External stressors, jobs, relationships, money, trauma, parenting styles, and family of origin issues do not cause addiction. However, some relationship and family of origin issues can interfere with the internal personal resources an individual needs to draw upon to effect recovery. Therefore, outside concerns, especially family of origin issues, are relevant to recovery, but not to addiction. Families and friends can either serve to contribute to their loved one's recovery or to the perpetuation of the disease.

If a patient in early recovery is blaming external situations or exploiting family of origin baggage, how can he or she truly believe that addiction is a functionally autonomous process? When a patient gets into blaming, they are coming from a dependent position, and the likelihood is that he or she still harbors, perhaps unconsciously, the fantasy that if these issues are resolved, then one can drink, drug, or engage in other self-destructive behaviors successfully again. Therefore, family, group or individual therapy sessions should proceed very cautiously, especially when discussing family of origin issues, due to the potential to reinforce the dependent position and its concurrent externalizing of responsibility for life's successes or failures.

Paradoxically, the very process of exploring family of origin issues can open the door for the patient to discover the ways in which he or she has developed habits of externalizing and assigning responsibility to others. However, this process is only valuable as a means of confronting, reframing, and reversing patients' ideations from externalizing to internalizing. In short, patients must be moved from taking others' inventories to developing the ability and motivation to take their own. Unless attention is paid to these points, the dependent position will be reinforced.

Position III

Parent as codependent is the normal position for parents. To provide for, to protect and defend, are normal, healthy, God-given instincts that are integral to parenting. These same instincts are also basic in spousal, significant other, and close family relationships. The disease of addiction perverts and distorts the healthy process of defending and protecting, and can produce, as a result, the unhealthy behaviors of rescuing and enabling. These behaviors serve the dependent addict, and tend to perpetuate the addictive process.

Without guidance or external support, families can adopt many of the same defense mechanisms as the addict, and assume roles that keep the addict in a dependent position. For this, and other reasons, some professionals view addiction as family-centered, and family members, like the addicts themselves, can engage in a recovery process. Recovery for families often means going

against one's own instincts in order to allow the addict to experience the consequences of his or her behavior. We, as a treatment team, believe that it is important to address and challenge the family's perceptions and behaviors. This is a much needed and healing process, yet can be difficult. We believe that the skills necessary for recovery must be taught and consistently supported. For most families this is not instinctual. Many families choose to engage in their own therapy with a knowledgeable professional, while others participate in self-help groups such as Al-Anon and Families Anonymous. These groups offer important tools and support, and allow family members to feel okay about themselves as they redefine what it means to have a healthy and loving relationship with a recovering or active addict.

But remember, addiction is a functionally autonomous process. Families do not cause addiction. The significant people in an addict's life are often filled with feelings of guilt, anger, or confusion. Some even project those feelings, and believe that we, as professionals, are judging them as unfit or think that they are actually to blame for the addiction - something they may have heard from the patient. As a treatment team, we believe in giving families an enormous amount of support, clarification and validation. Families are not responsible for the addiction, but can be of great help in the recovery process. Our goal is to develop a therapeutic alliance with family members. The value we place on the relationship between families and the patient cannot be underestimated.

Position IV

Sobriety, as opposed to abstinence, is an adult undertaking. It takes an integrated, mature, emotionally accessible psyche to respond to life's events without picking up a drink or drug, or engaging in other addictive and destructive behaviors. While in treatment, there is only a short period of time in which to initiate and foster psychological development in our patients. Our goal is for patients to develop consistent internal frameworks to emotionally process their lives' events. This is accomplished by asking them to stretch into adulthood from their childlike dependent position.

1. We consistently ask the patient to take responsibility for whatever is happening in his or her life.

Again, the development of personal integrity begins with patients accepting that the choices they make in responding to life's events, made consciously or unconsciously, are entirely their own and bring about consequences that they themselves create.

2. We have the patient earn before receiving, whether emotional support, financial support, spiritual support, or physical support.

Addiction is sustained by the unconscious fantasy of life without consequences. Recovery is the acceptance that one is responsible for consequences earned, be they experienced positively or negatively. Anything given to the addict before it is earned simply serves to reinforce the dependent position and fuels the unconscious and childlike magical thinking that one is

somehow entitled to things and is pardoned for the logical consequences of one's actions. When parents or partners do for loved ones what they could do for themselves, they are deprived of an opportunity to develop appreciation for themselves. It is this appreciation that will come to serve as the regulator of anxiety or depression. This ego or identity enhancing development cannot be handed down verbally, theoretically, or otherwise experientially from one person to another. It must be internalized through an individual's direct experience.

3. We ask patients to assume adult responsibilities while in treatment, including work and homemaking for themselves and others.

Work and home responsibilities are part of the therapeutic process. Having been in a chemically dependent, or alternatively dependent, position, with its regressive or childlike process, the adult addict has little or no stable sense of the world of adult responsibility and may view it as being harsh, overly demanding or without joy. When patients engage in blaming their environment for their problems, they are frequently expressing these views. Our therapeutic process asks that patients have direct experience with the calming and ego building world of adult mastery. We continually expect patients to rise to the level of adult responsibility, from simple self-care to appropriate work within the community.

4. We ask patients to do unto themselves and others as they would have others do unto them.

This well-known saying has some unique applications in treatment. Not only are patients given the understanding that they help themselves by helping others, but by actively engaging in this process, can reverse the effects of previous dysfunctional relationships. Patients can change the past - or how they are experiencing the past - through changing their current behavior. For example, those that may have come from dysfunctional families can parent others in the way they wish they had been parented, and thus internalize the parental ideal. When patients practice being their preferred parents, they internalize an ego structure which can regulate anxiety and depression, find balance between the alternating feelings of grandiosity and inferiority, and produce the ability to internally give solace and comfort without self-pity and false pride.

As one's internal dialogue becomes healthier, one becomes capable of joy without mania, of feeling good rather than grandiose, of feeling calm rather than numb; one has realized integrity of thought and deed, of intellect and behavior, and one is capable of caring for others without care taking. In order to have this come to fruition, we, as a treatment team, employ the therapeutic tool of psychological relapse. A patient's success in recovery depends on success with negotiating through crisis after crisis and developing the necessary internal resources to effect lasting change.

- The patient repeatedly experiences firm boundaries set by family, friends, peers, and therapists. The dissolution of rescue fantasies begins. *The dependent position is challenged.*

- The patient begins to experience his own strengths and weaknesses, rather than those of others. The patient becomes oriented to his or her own insides...painful, but anxiety reducing and

sobering.

The dependent position is weakened.

- The patient begins to perceive that it is him or herself that is responsible to regulate his or her own internal affairs. The magical thinking of a child begins to give way to reality based adult perceptions.

The dependent position deteriorates.

- The patient experiences the development of personal integrity, and begins to practice the principles aligned with 12-Step programs. The adult child is reoriented to the world of responsibility, living in communion with, and demonstrating consideration for, others.

The dependent position is disintegrated and re-integrated as the interdependent position.

- The patient experiences the repeated crisis of psychological/spiritual relapse and finds resolution without returning to chemical dependency or to other addictive and destructive behaviors. He or she is now able to build a stable and functional self-identity, which enhances feelings of positive regard, self-worth, and genuine acceptance that recovery creates the opportunity to earn a full and rewarding life.

The interdependent position is strengthened and becomes a way of life.