

SIPT Manual

The Psychosynthetic Treatment of Addictions

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Addiction is a mental obsession that leads to a physical compulsion. Assagioli stated it succinctly in his first psychological law: "Images or mental pictures tend to produce the...external acts that correspond to them." 1

The most common addiction is alcoholism. The person's obsessive thoughts about alcohol activate the compulsion to consume alcohol. The mental obsession originates when the person discovers that alcohol relieves their vulnerability and makes them feel normal. The physical compulsion becomes extreme: if it were physically possible, the alcoholic person would never stop drinking. In Dante's *Inferno*, Cerberus in the realm of gluttony is the precise picture of extreme compulsion. 2

Cocaine, heroin, anti-anxiety agents (e.g., Valium, Xanax), painkillers (e.g., Oxycontin, Vicodin) and other drugs can also become addictive. In addition, there are addictions without alcohol or drugs, including eating disorders, gambling, and sex addiction, which follow the same dynamic of obsession and compulsion. (For convenience, we will refer to alcohol and alcoholics as a way to discuss the dynamics and treatment of all addictions).

The immediate question presents itself: why does a person become obsessed with alcohol? Most people can enjoy alcohol without becoming obsessed. What makes the alcoholic different?

To answer this, we need to review the theoretical models of addiction.

Models of Addiction

There are at least eleven theoretical models of addiction. 3

The Medical Model. The person has been consuming significant amounts of alcohol over a long period of time. Deprived of it, the person's central nervous system goes into a state of physiological craving (withdrawal). To suppress the craving, the person must continue alcohol consumption.

The Genetic Disease Model. The person has a genetic, bio-chemical predisposition to alcoholism. The predisposition is activated by the use of alcohol.

The Self-Medication Model. Perhaps due to trauma, the person experiences an intolerable degree of fear in daily life. He uses alcohol to soothe his anxiety.

The Dysfunctional Family Model. The person learned from people in his family that one copes with anxiety and/or depression by consuming alcohol.

The Psychosexual Development Model. The infant did not experience adequate nurturing at the oral phase of development and becomes psychologically fixated at that stage. The adult form of the oral fixation is the consuming of alcohol.

The Ego Psychology Model. Deprived of adequate nurturing and mirroring as an infant, the person has weak ego strengths and cannot tolerate the pressures of life. Alcohol relieves the pressure.

The Character Defect Model. An early model offered by the 12-Step program of Alcoholics Anonymous, it proposed that alcoholics are morally and characterologically "defective" and require alcohol to pacify their "self-centered fears."

The Instant Gratification Model. Alcoholics are people who have a low threshold for frustration and need instant satisfaction of their impulses. This impulsiveness is reinforced by the hurried pace and empty materialism of modern life.

The Trance Model. This is based on the pleasure principle. Once the brain has experienced the pleasure of intoxication, it stores the experience like a hypnotic suggestion and desires to repeat it.

The Transpersonal-Intoxication Model. Based on the observed connection between artists and alcoholism, this model's thesis is that the alcoholic "thirst" is really a spiritual thirst for expanded consciousness.

The Transpersonal-Existential Model. This model accepts that (1) the human condition is innately vulnerable and anxious and that, (2) alcoholics are people who experience this existential anxiety more acutely.

These models are greatly simplified. Their theme, though, is clear. Essential feelings of vulnerability cause or contribute to the development of addiction. This emphasis on vulnerability is verified for the authors by thirty years of clinical experience with hundreds of people in recovery. Patients repeatedly describe that the onset of their addiction was their first discovery that alcohol took away their fears and make them capable of functioning in life. Therefore, therapeutic attention must be given to the person's vulnerability in order help him recover successfully.

Early Treatment Principles

No therapist has the power to stop an alcoholic from drinking. Other factors - the family, the person's doctor, the employer, the use of rehabilitation centers - must be involved in the initial confrontation of the alcoholic. The therapist becomes significant when the actual drinking has stopped and the person has detoxified.

Once detoxified, the alcoholic is technically a person in the recovery process. But an alcoholic without alcohol is now exposed to the pain of life without his "medicine" and will return to alcohol for relief from his vulnerability. This

accounts for the many early failures in alcohol treatment. "Relapse" - the return to drinking - is an unfortunate but typical part of the early recovery process. Neither the patient nor the therapist should be disheartened by relapse. It is understandable in view of the enormous life-change the alcoholic is beginning.

Early therapy should be psychoeducational. The recovering person needs to be taught new ways of thinking and behaving. The individual therapist may be capable of accomplishing this if he sees the recovering person frequently during each week. If this is not feasible, then the therapist should be sure to have the person engage in the 12 Step program of Alcoholics Anonymous or another group psychoeducational process. The success of the 12 Step programs is that they offer an accepting community in which the cognitions and behaviors of sobriety are repetitiously taught. For example, when the recovering person notices that he is again obsessing about alcohol, he is taught to call another person in the 12 Step program - a "sponsor" - and to tell the sponsor about the impulse to drink.

If the person accepts the 12-Step guidance, he literally begins to build a new sub-personality - a "sober" person. He doesn't yet feel like a sober person, but he accepts that he must imitate the thinking and behaviors of a sober person in order to save his life. He thinks and feels "as if" he is a sober person.

This "sober" sub-personality needs to become a source of psychodynamic conflict in the person: the new sober sub-personality must compete with the old, established alcoholic pattern of thinking and behaving. In psychosynthetic terms, he is learning how to identify with (i.e., direct energy toward) his sober self and to disidentify (withdraw energy) from his alcoholic self. If successful in building the new sub-personality, the person in recovery will literally hear the two sides - the new sober sub-personality and the old alcoholic one - arguing in his mind.

Psychosynthetic Psychotherapy

When this new sober sub-personality is minimally established through psychoeducation and/or a 12 Step program, psychosynthetic psychotherapy can begin.

Immediately, the psychosynthetic understanding of inner energies and the cultivation of new inner self-images can be used to reinforce the new sober sub-personality. Therapeutic imagery can potentiate the person's identification with the sober sub-personality by imaginally rehearsing sober thinking and sober behaviors in the various scenes of his current life. He can also utilize imagery as a negative reinforcement - imaginally rehearsing what his life will become if he returns to alcohol: in the 12 Step programs, they call this negative reinforcement "thinking through a drink." One patient wanted help in remembering that, driving drunk, he had almost killed a little girl. Talking about it made him feel uncomfortable, but when he actually imagined images of killing her with his car, he began to sob. In his tears, he renewed his commitment to staying sober.

It is also at this stage that the study of his vulnerability should begin. Despite everything he has learned in early recovery, it will be intolerable feelings of vulnerability that will cause him to relapse, to return to alcohol.

The alcoholic numbed his emotions for many years. In early recovery, he will not know how he feels, and he will not be a good reporter of his feelings to his therapist. He will need the therapist's help in developing a basic vocabulary for his emotions. Later on in this process, Assagioli's emphasis on the power of self-observation - cultivating awareness - will become central to the naming of emotions, urges, impulses, etc., but for now the therapist must be the observer and name emotions for the newly sober person.

Fight/Flight Symptoms

To assist the therapist in discerning the patient's vulnerability, the following lists of fight and flight symptoms can be helpful. These lists describe the typical fight/flight patterns in the recovering alcoholic. As the therapist hears some of the listed fight/flight symptoms in his patient, he will be hearing the disguised forms of vulnerability.

Fight or flight are of course the two primal instincts of any human being when he feels unsafe and vulnerable: the recovering alcoholic will display many intense symptoms of fight and/or flight. The patient will not be able to describe the subtleties of vulnerability, but he will be able to tell you that he wanted to beat up his boss (fight) or that he ate a gallon of ice cream (flight) after his girl friend argued with him.

Fight

Mental Patterns of Fight. Rigidity, obsessiveness, lack of creativity, black and white thinking, judgmentalism, intolerance, fanaticism, hypervigilance, arrogance, manipulateness.

Physical Patterns of Fight. Hypertension, headaches, gastrointestinal disturbances, chronic muscle tension, rigid diets, body armoring, workaholism, forcing body to exceed limits (e.g., risk taking, extreme exercise).

Emotional Patterns of Fight. Constricted affect, rigid control of feelings, grandiosity, fake performance of feelings, denial of vulnerability, overly aggressive, rageful, domineering

Spiritual Patterns of Fight. Self-righteous, fundamentalism, dogmatism, attempts to control other people's inner lives, negation of spirituality.

Flight

Mental Patterns of Flight. Chronic refusal to decide, numbed mental processes, disconnection, dissociation, self-depreciation, victimized thinking, unthinking acceptance of others' opinions and demands, indifference, inability to focus, self-pity, self-absorption.

Physical Patterns of Flight. Low energy, compulsive TV watching, repetitive self-soothing, overeating, immobilization, avoidance, isolation, lack of self-care.

Emotional Patterns of Flight. Helplessness, hopelessness, emotional flooding, guilt and shame, unworthiness, co-dependence.

Spiritual Patterns of Flight. Magical thinking, narcissistic theology, nondirected, superficial spiritual dabbling, emptiness, lack of relatedness to a larger vision of life, lack of trust in his own experiences, lack of meaning or purpose.

When a pattern of fight and/or flight is recognized, the therapist can then investigate the incident that triggered the fight/flight reaction. Predictably, the incident will reveal a vulnerable moment.

The patient who wanted to beat up his boss was asked to go back into his memory and to see what triggered his impulse to fight. He saw in his memory that his fight reaction was the result of a mild criticism from the boss. The patient who ate a gallon of ice cream saw in his memory that his flight reaction was triggered the moment his girl friend's appeared bored with him. Gaining recognition of the impact of criticism or inattention moves the therapy toward the core issue of vulnerability itself, rather than staying focused on the incident with the boss or girl friend.

The Balance and Synthesis of Opposites

In psychosynthetic terms, we can view fight and flight as polarities, as two extreme and opposite reactions to vulnerability. There is nothing inherently wrong with either polarity in a specific situation. The mental pattern of arrogance (fight), for example, may be helpful when we need to assert ourselves. The mental pattern of self-depreciation (flight) may be helpful when we need to go along with a group decision. Problems in living develop when we habitually utilize one extreme or the other and have no capacity to consciously choose when to use them.

The goal is not to get rid of the polarities, which would be impossible anyway, but rather to use the positive aspects of their energies. Assagioli's insights into the balance and synthesis of opposites is an ideal and remarkably nonjudgmental way to work with these polarities. He notes that "psychological life can be regarded...as continual effort, conscious or not, to establish equilibrium." 4

In the example of arrogance and self-depreciation as opposites, we can say that a positive aspect of arrogance is personal pride, and that a positive aspect of self-depreciation is humility. Assagioli suggests that if we could synthesize these positive aspects of arrogance and self-depreciation, i.e. if we could synthesize the energies of personal pride and humility, we would be cultivating dignity - a highly desirable quality. 5

This psychosynthetic understanding of the refinement and transformation of inner possibilities leads the patient toward skills that will serve him again in his spiritual development. We will address this later in the article.

Emotional Development in Recovery

The therapist's focus on the patient's experiences of vulnerability will in time help the patient to recognize those vulnerable moments for himself. With this increased self-knowledge as the groundwork, the patient then needs to learn

new, healthier responses to his moments of vulnerability, rather than continue in patterns of fight/flight reactivity.

The therapist should not assume that the patient will know any healthy adaptive responses. The patient was using alcohol all the years when others were learning how to cope with the anxieties of being alive. There is a formula: the age at which the alcoholic began heavy drinking is the age of his present emotional development. For example, if he was drinking heavily by age sixteen, your patient may be chronologically forty-two but he is emotionally a sixteen year old.

There are five important goals in this stage of the therapy.

Two are concepts that should be taught and discussed until the patient can integrate them.

The first concept is "feelings aren't facts." This is borrowed from the 12 Step programs. It establishes that, although you may feel unsafe and vulnerable in a certain situation, it does not mean that you are actually unsafe. The concept tries to modify the trigger between vulnerability and fight/flight. It tries to calm down the patient's instinctive reactions and to increase the patient's ability to choose his responses to feeling vulnerable.

The second concept is the normalcy of shifting feelings. The normal moment-to-moment flow of changing thoughts and moods can feel too unstable to the person in recovery. He needs to understand and be reassured that the flux of change is normal and not a cause for worry. His years of alcoholism have prevented him from learning this fact of emotional life. He may, for example, report that he got very upset and didn't know what to do. The "normal" person knows that he or she can get upset and that he or she will survive it. The recovering alcoholic interprets being upset as a danger signal and an indication that he can't live without alcohol.

The third goal of this stage of therapy is teaching stress management skills. These are the healthier responses to feeling vulnerable. In general, the skills will be variations on meditation and imagery, but they must

be pragmatic skills that the patient can do anytime, anyplace. Yoga postures will not be possible on the bus, but a simple breathing technique will work well and go unnoticed. Many of our patients like this simple phrase which they repeat silently in their mind: "_____ (their first name), let go." In the post-traumatic stress of Manhattan since September 11th many patients use this phrase as they enter the subway, cross a bridge, ride in an elevator, or see a plane in the sky.

There are many stress management skills. In the psychosynthetic spirit of working collaboratively with a patient, the therapist and patient can experientially try out many skills and discover which ones work best.

The fourth goal of emotional development is the need for a second recovery. It is the need to recover from trauma. In the authors' experience, the majority of alcoholics have significant trauma in their early years of development. This second recovery is not typically dealt with in drug and alcohol treatment centers, but needs to be part of the psychotherapeutic view of recovery from addictions. This second recovery is of course a long-term process. It is aided by the repeated corrective experiences the patient can have with a psychosynthetic therapist who sees the "alcoholic" as only a sub-personality in a much greater view of who the patient is.

The fifth goal is the recovery of intuition. Intuition originates in a place of deep wisdom and knowing in human nature. It is an aspect of the psychosynthetic concept of the higher self. By helping the patient to re-discover their intuition, the patient gains another tool in transcending their fight/flight reactivity and instead has a wiser level of mind available to deal with vulnerable moments.

Spiritual Development

Deriving from the 12-Step programs' emphasis on spirituality, many alcohol treatment centers encourage some form of spiritual development as part of the recovery process. The word "spirituality" is carefully chosen to distinguish it

from religion. Spirituality is a series of expansions of identity in which the person realizes that he is participating in a larger life than his separate, anxious, self-absorbed personality. This "larger life" may be described as God, but the 12 Step programs are careful to say "God as you understand God."

Psychosynthesis offers many advantages at this stage of recovery. Through Assagioli's elegant integration of psychological and spiritual insights and methods, the psychosynthetic therapist can assist the patient toward discoveries of higher consciousness without the need for any pre-formed ideas about spirituality. Assagioli saw higher consciousness as an obvious fact: "We consider that the spiritual is as basic as the material part of man." 6

By discovering, through direct experience, the patient's natural spirituality, the patient can form his own spiritual understandings. He may search out many schools of spirituality, but the psychosynthetic therapist has helped the patient to have his own experiences as his guide. The primary methods in psychosynthesis for spiritual development are (1) a thorough understanding of Assagioli's map of consciousness, (2) the cultivation of awareness, of the "I-space," (3) the learned ability to disidentify from negative and self-defeating patterns, (4) the meditative use of transpersonal symbols, (5) the confidence that a higher, saner aspect of our nature - our higher self - is guiding our evolution.

The authors' clinical experience shows that true spiritual development must be rooted in direct experience. Patients who have adopted a spiritual or religious perspective but have not directly experienced its truths gain no benefit from it when a crisis comes along. Spiritual development must come from lived experience.

The issue next arises: what is a spiritual experience? People can have many non-ordinary experiences, and yet the experiences do not necessarily contribute to their spiritual development: people in recovery have experienced many altered states of consciousness via drugs, and yet none of these altered states has helped them to develop spiritually. After the examination of many Eastern and Western spiritual experiences and maps, the authors found in *The Divine*

Comedy an elegant and comprehensive view of higher consciousness. 7 Dante's Pilgrim experiences two types of higher consciousness - the guiding wisdom of Beatrice, and the liberation from the personality into states of illumination. Wisdom and illumination in turn lead the Pilgrim to unitive consciousness, to the final merging of his individuality into "l'amor che move il sole e l'altre stelle."

The authors found it intriguing that all of the Pilgrim's illuminations are expansions of consciousness into the energy field. Dante utilizes many descriptions of radiance and light to describes these expansions. Although considered a "Catholic" poet, Dante in fact was presenting a model of spiritual discovery remarkably in line with the Taoist view of the universe as an interpenetrating field of living energy.

Clinically, the authors have utilized the Dantean concepts of guiding wisdom and the illumination of energetic reality as ways to help patients along the spiritual journey. The first concept - guiding wisdom - is identical to Assagioli's concept of the higher self. Psychosynthetic techniques related to the higher self activate the innate center of guiding wisdom in the patient. Illumination of energetic reality is not within the standard psychosynthetic methods, but Assagioli's model of consciousness is clearly an energy model, and in his archived notes he has this bold notation: "In India, God was Mind, Consciousness. In Christianity, Love is emphasized. But God is energy, and the religion of the next century will be the study of energy."

To assist patients in exploring the energetic realm of reality, the authors have incorporated Qigong methods in their practice. The methods are applied in the psychosynthetic attitude of an open, scientifically-minded exploration of the spiritual dimension of human nature. Assagioli clearly sets the standard for this attitude: "...we hope to see developed...a science of the Self, of its energies, its manifestations, of how these energies can be released, how they can be contacted, how they can be utilized for...therapeutic work." 8 (Assagioli, 1965, p. 194).

The patient's spiritual search may go in many directions over the course of his life. The psychosynthetic therapist can be the one who, as Assagioli put it, "leads the person to the door." 9

Summary

The following steps summarize a psychosynthetic approach to the addictive process and the path of recovery:

1. Addiction is an obsessive-compulsive cycle driven by the need to suppress vulnerability.
2. All people are vulnerable, but people who feel a greater degree of vulnerability are drawn to addiction as a remedy.
3. The first step in recovery from addiction is detoxification. Then psychoeducation and psychotherapy are possible.
4. The first task in psychoeducation and psychotherapy is the building of a sober sub-personality.
5. Since the addiction was suppressing vulnerability, the end of addiction will cause vulnerability to be a primary problem again. People in recovery begin to heal by recognizing and respecting their vulnerability.
6. The patient's continued recovery is based on developing new, healthier responses to vulnerability.
7. This vulnerability, however, cannot be effectively responded to on a long-term basis by the ego level of the self, since the ego-level of self is at the very root of vulnerability.
8. Advanced recovery therefore requires the development of an expanded, spiritual sense of identity. Such spiritual development is a normal aspect of adult development.
9. Psychosynthesis offers insights and practices that can introduce the patient to their innate spiritual dimension.

The treatment of addictions is a complex process but well worth the effort. Even in the many frustrations of dealing with people in recovery, the therapist should remember this single point: addiction can be completely cured. People can lead the rest of their lives without addiction. The therapist gets the opportunity to participate with the patient in the transformation of suffering into a purposeful life.

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