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Using Experiential Dynamic Therapy with Addicted People[1]

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Abstract. Addiction has been conceptualized as a disorder that hijacks the person and is best treated by cognitive or behavioral intervention. It is better conceptualized as a disorder of emotion and attachment which responds well to therapies that build emotional literacy and capacity for connection. Experiential Dynamic Therapies (EDP), including Accelerated Experiential Dynamic Psychotherapy (AEDP), do just this and require minor modification for working with addictions. This article has three aims: (1) to examine the reasons why therapists have shied away from working with addictions, (2) to describe a model of experiential treatment that draws on the evidence base and contemporary theories of addictions and psychotherapy effectiveness, including neurobiology, and (3) to encourage experiential therapists to accompany these clients as they change their lives.

Introduction

Thirty percent of adults will have an alcohol related disorder, and 9% a substance use disorder (SAMHSA, 2018). Almost half of those with addictions also have co-morbid psychiatric diagnoses. Addictions wreak great damage, from medical

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(including pain, infectious, cardiovascular and liver disease) through financial, social and spiritual. The people close to the person using suffer too, losing support, experiencing stress and often violence. Society loses over $400 billion to productivity, criminal and medical fallout (Bouchery, 2012). Treating this population benefits many.

Addictions vary in severity and many different approaches help. Some 50% of people with problematic use will be 'in recovery' without help from either professionals or mutual support groups, and 40-60% of those with severe addiction will have good outcomes (Kelly, 2017). Obviously, those who struggle most have more complex problems, with genetic, developmental, medical, psychiatric and socio-economic contributors. These clients may need very comprehensive and long-term help. However, the therapeutic principles laid out here will contribute to all and transform many.

I use the term addiction to refer to alcohol and drug use as well as to the "process addictions:" sex and pornography use, binge eating, gambling and video-gaming. All these disorders involve a similar neurological signature: (a) engagement of the nucleus accumbens dopaminergic registering of salience, (b) engagement of the orbitofrontal cortex that interprets the reward within a complex social and historical context; and (c) dysregulation of the stress hormone circuit that reflects deviation from homeostasis and triggers corrective behaviors (Noël, 2013). These disorders show a characteristic syndrome of compulsive and stereotyped behaviors performed despite negative consequences and resisted only with a sense of anxiety and craving.

Good addictions therapy relies on factors common to all good therapy. A deep attention to the emotional experience of the person is needed for engagement,

motivation and change. A caring relationship can buffer and even heal the effects of adverse childhood experiences (Jaffee, 2017). An attachment-based, emotion-focused therapist may be the lifeline to a way of being with others that reignites universal needs and strengths that may have been repressed, hiding and dormant (Fosha, 2000), often due to traumatic experiences in development that may include neglect, maltreatment or frank abuse. A deliberate emphasis on, or privileging of, the positive affects aroused in a session is both an entry into understanding the allure of the addictive state; and a way of reinforcing emerging healthy connection and growth that must compete with the addictive behavior. These approaches are quite different from what has typically been taught and recommended for the addicted client.

It is important to emphasize that while gentle understanding and an attempted repair of traumatic development is essential, it is often insufficient. This is because addiction involves a compulsivity and a profound shift of values and identity. Over years, a once deliberate choice to use becomes more habitual. Short-term, drug-related goals become more prized and the people, places and things, as well as emotions, associated with use serve as triggers. Meanwhile, relationships and long-term goals wither. It will take a long time for internal change to be robust enough to withstand such triggers, and so therapy will need to facilitate external structure, support, skills and connections.

The Old Model of Addiction:
Focus on Cognitive and Behavior Change, Morality and Abstinence

Drug and alcohol use usually starts as a positive experience that is fun, social and experimental. Only rarely does someone lose control, and never intentionally. Yet when use transitions to addiction, the user is often judged immoral and weak.

Society has responded with constraint and criminalization, and treatment has developed within this context. The teaching was that the "addict" cannot be helped until they reach a "rock bottom" and must forever abstain. Treatment was been moralistic and paternalistic—done to the addict, not with them and certainly not led by them. Faulty thinking and behaviors are targeted with confrontational intervention and long-stay residential treatments. Incarceration was often accepted as appropriate, in order to help the addict experience negative consequences. Twelve-step approaches may work towards personality and behavior change through fellowship and spiritual growth, but start with a view of alcohol as an allergen and the person as having character defects and disregard a psychiatric prospective and medication as "an easier softer way." This justifies the withholding of life-saving medications such as methadone and buprenorphine. In parallel, simplistic neurobiological models depict a reward center hijacked by drugs and reducing a person to an impulsive and insensitive automaton. In fact, the dopamine pathways probed are merely one part of a nuanced system attempting to survive and thrive in a complex social world of conflictual reward possibilities.

The Contemporary Paradigm:
Emotionally Focused, Collaborative, Harm Reduction

From the start, the experience of intoxicant use is determined by the individual's emotional state and response in a particular social context (Zinberg, 1984). We use substances to augment happiness, minimize sadness and aloneness, manage fear or stop reflecting on how we feel at all. Use becomes more habitual as this reinforced response is neurally encoded as social associations, reward expectations, memories and nostalgia. This process disrupts the central role

emotions play in representing and responding to environmental change (both internal and external). Our emotions become more dislocated from triggers, reflective thought and action. We can appear labile, undifferentiated and ineffective.

Research over the past few decades has demonstrated that successful outcome of addiction therapy depends on the therapeutic alliance, positive reinforcement of change, a focus on psychiatric co-morbidity and improved emotional regulation (Kellogg, 2012). Attachment and emotional processing are now seen as central organizing principles of brain function, social function, reward and motivation. The brain is an organ of exquisite subtlety. The reward pathway signals expectation and salience, and augments learning within multiple networks that serve to maximize survival and adaptability in a complex social world. When we consider addictions from this mature perspective, compassion, encouragement, partnership and pro-social relationships seem obvious strategies.

Harm Reduction Psychotherapy and Emotional Focus

The desire to manage intolerable emotional states, avoid pain and take shelter is understandable. Compulsion and eager anticipation of use can serve as such shelter. Since the 1970's, therapists aware of this have modified their approach to engage clients more effectively. Khantzian (1997) has beautifully articulated the Self Medication Hypothesis, and more recently Andrew Tatarsky (2003) has integrated this wisdom with relapse prevention, stage of change models, motivational interviewing, mindfulness and harm reduction. Contemporary approaches recognize that therapy is a collaborative and individualized process offered in the spirit of relief and understanding that encourages any positive change, any reduction in drug

related harm, which may include abstinence. Therapeutic goals should come from the client and may often start as a desire to cut down their addictive behaviors and have less negative consequences, an understandable goal which may be achievable. When a client states an intention to stop drinking completely, it is worth checking that this is actually their desired goal or is what they think they should say as following a false path will lead to disappointment. The ability to refer back to a genuinely agreed goal—agreed as deeply as possible at the time of making it—allows the therapist to refer back to them, and counters a client's urge to place the conflict between them and the therapist.

By acknowledging that drug use serves a purpose, one can approach the user with respect and curiosity and ask the questions "what does the drug do for you?" "what are the pros of use?" "what would be lost if you stopped or cut down?" or "any sense of what feelings are you getting away from when you use?" These questions are validating and engage the clinician and therapist in a serious effort to inquire and relieve the underlying reasons why people are still using despite everything. Clinicians must offer paths that help patients gradually feel these warded off emotions—be they fear, pain, aloneness, boredom, powerlessness—underlying the compulsive use of a retreat.

From this perspective, addiction is an opportunity. Within the compulsion lies an inarticulate but crucial emotional part of the person, suffocated within a compulsive cycle of self-soothing and regret. This part yearns for relief but has relied on methods that bring hardship, shame and aloneness. If we can help the person connect to and love that part of themselves and find a way to express themselves that is effective and social, then the addiction presents a pathway to a new identity (Kellogg, 2005). It is an opportunity for growth, connection and transformation.

Case Example One:
Working with Positive Affects Aroused in Addiction Behavior

Steven associates his methamphetamine with coming out as a gay man, and a new sense of sexual confidence. He had been very awkward as a kid, and had had no intimate relationships outside of drug use experiences.

Th: (*discussing the methamphetamine-fueled sexual experience).* It sounds fantastic...so intense to feel such confidence. Do you feel it now, that confidence and power? Let that fill you. **[I am deepening a positive experience and not worrying that it is sexual or drug-related, for we are in my office doing therapy.]**

Cl: It's a great feeling - here *(pointing to his chest).*

Th: Stay with it. It is a terrific feeling of confidence.

Cl: It feels a bit weird to do it with you.

Th: It's great to have this feeling here with you! I really enjoy this feeling of connection and confidence together here! Can you stay with that feeling? Just be with it and with me, as much as you can… *(He smiles, a tad nervous but maintaining eye contact).* Do you feel how you're looking at me - that's new to feel so connected, right?

Cl: Yes. I find it so hard to do. Crystal gave me a lot of confidence.

Th: Sure. Of course it did. But what's it like to have that confidence here….no crystal needed? **[I am bridging the confidence and intimacy, previously obtained only during methamphetamine use and ascribed to that, to this new context, and pairing it to a sense of connection—without sex or drugs—that he always wanted.]**

The core of motivational interviewing is an embracing of the ambivalence inherent in giving up something important, and a tolerance of the shifting willingness to change (Miller, 2009). Starting with an acknowledgement of the positives of use, using reflective listening to bring curiosity where there is feigned certainty, *rolling with resistance, rather than confronting it,* the dyad explore the pros and cons before the interviewer asks permission to offer any opinions or advice. Further developments include eliciting specific change talk, improving the capacity to sit with ambivalence and working with the loved ones to utilize similar empathy-based approaches.

Understanding the "Addictive Personality:"
Emotion Regulation and Homeostasis

People with addictions can show alterations of empathy, impulsivity, anxiety and affect regulation which makes it hard to establish and maintain a therapeutic relationship, a crucial mediator of change. Many clients with addictions present as emotionally demanding, labile or antagonistic, or with antisocial features. These can be temporary states, acquired or exaggerated by the ups and downs of drug use, a reaction to the judgment of others, and the impact of pursuing short-term emotional avoidance rather than more long-term social pursuits such as work and love that can seem undesirable or out of reach.

Development of addiction occurs at the end of a winding developmental path that is influenced by genetics, quality of nurturing or damaging relationships in childhood, and drug exposure. Early childhood neglect increases rates of addiction in adolescence and adulthood. Risk is mediated by genetics and, importantly for therapists, the buffering effects of positive relationships and social connection

(Collishaw, 2007). There is a clear genetic risk for developing addictions via increased novelty seeking and reduced harm avoidance (Vanyukov, 2003), antisocial behavior (Gerra, 2004), liking of the drug experience, and proneness to depression and anxiety (Jaffee, 2017). There are also genetic factors for resilience. Stress, mediated by the hypothalamic-pituitary-adrenal axis (HPA), helpfully enhances memory consolidation and protective response, and is felt in an emotional experience, either encouraging avoidance or approach. However, chronic stress is harmful, leads to chronic hypo-responsiveness, impaired learning and a stereotyped response, as well as sense of powerless, depression or anxiety. People become flat, reactive and impulsive. Endorphins (our body's own opioids) calm the stress system, buffer pain and danger perception and bring a sense of serene calm that permits effective focus and response (Koob, 2007). All drugs of abuse increase endorphin release—opiates, alcohol, cocaine, nicotine, as does sex, comfort and warmth. So, for someone chronically stressed, endorphins are a compelling experience, signaling something profoundly important for survival and, therefore, rewarding: arresting and worth learning to do without thought. Addiction's on-and-off cycles of over-stimulation and withdrawal will dysregulate stress and emotion systems, dislocating them from the social and interpersonal context, which we see consistently in clients presenting with addiction, irrespective of childhood experiences. Most people present initially looking like they have had trauma.

This intimate interplay between emotion, trauma and addiction explains why people with trauma and despondency find drugs so compelling. Many people with trauma describe their use as the "missing piece that made me feel normal for the first time." By adulthood their habit of retreating into the addictive experience may have become established and normalized, but the downside of this avoidance is an

erosion of affect recognition, tolerance and application to the problems of living. Meanwhile, the phenomenon of tolerance means that more of the drug must be consumed to obtain the same effect or stave off withdrawal.

Obstacles to Emotional Exploration:
Anxiety, Dissociation and Risk of Relapse

In treatment, clients may have little idea of the alternatives to this way of managing and meeting affect and become quickly overwhelmed by anxiety as affects are experienced. Sometimes this is visible as somatic anxiety, other times is expressed as dissociative or visceral anxiety, more so in clients who have PTSD. Sometimes it is very difficult to perceive anxiety as clients shift rapidly into habitual coping modes. Use after the session might be the first indication that affect was aroused. Indeed, exposure to emotional stress, especially those that are associated with traumatic memories, activates the HPA and autonomic systems and predictively correlates with relapse (Sinha, 2001). For this reason, therapists have tended to avoid raising affect in the sessions, but if they are trained in emotion-focused techniques then they understand these are learning opportunities. *If the emotion is not aroused in the session then it will still be aroused by life outside, but without the opportunity to transform the experience.* Treatment must go deeper into the moment that is triggering, undoing and reconsolidating memory, helping the client learn new ways of being with the emotions, building tolerance and capacity for anxiety, affect, and mixed feelings, and let go of a limiting self-soothing that perpetuates aloneness.

Damaged Ability to Process Emotions and Impulsivity

Alexithymia was described in the 1970s (Krystal, 1979) and refers to the way clients with addictions and trauma can find it difficult to describe their emotions. This disables their capacity to know and reflect on their own internal states, understand motivations and reactions of other people and be interpersonally effective. These attachment deficits are acquired in childhood. Neglectful or mistreating parents are less validating, show less prototypical facial and vocal expressions of anger, fear or happiness and are poor at perceiving the feelings of their children (Shipman, 2007). These features are carried forward to the neglected children, along with deficits in regulating their own emotions, or understanding the reactions that their own behaviors elicit in others (Kim, 2009). A significant subset of people with addictions show these deficits, either because they were themselves mistreated, or because the drug use itself interferes with social cognition (De Rick, 2009). Abnormal drug and alcohol users are socially segregated, shunned by their own peer group, judged and marginalized by others. Inconsistency of relationships within the peer group, often dishonest and unreliable, further erodes social trust. Cocaine and alcohol abusers show a deficient recognition of emotions that improves with sobriety. Individuals who experience their emotions with more “granularity” (a greater differentiation of experience marked by broader descriptors) are less likely to resort to maladaptive self-regulatory strategies such as binge drinking (Kashdan, 2015). Imaging of brain function correlates with this. For example, the right anterior insula receives, differentiates and relays somatic experience to the frontal lobes and is abnormal in addiction (Naqvi, 2009). These features make it hard to engage clients with addictions as they may misperceive the intentions of the therapist, react with

more impulsivity and hostility, and need extra guidance to notice and articulate emotional responses.

People with addictions favor short-term over long-term goals. The degree to which their sense of value is discounted by delays is influenced by family history of addiction, stress level, and whether the person is satiated, in withdrawal or prolonged and comfortable abstinence (Bickel, 2001). Depending on the recency of use and emotional state, people will be more likely to make disadvantageous decisions. Additionally, people with antisocial traits are less sensitive to punishment and do not learn easily from their mistakes (Noël, 2013). These deficits may make sense in a world where long-term goals are less relevant than securing the next fix but not in the therapy room where the focus is often longer-term: relationships, connection and goals valued by society, such as work and education. Because valuation is affected by emotion and external triggers, goals agreed upon in the therapy office may become less relevant in the outside world. The therapist must humbly appreciate the power of drug cues and stressors to overwhelm valued goals identified within the calm boundaries of the therapy office or else risk reacting with frustration or having the client leave in shame, hopelessness or anger.

A Relational Understanding of Defenses in Addictions: Denial and Splitting

People with addictions are often considered to be “in denial,” unable to understand the extent to which they have deteriorated. While some clients can show an astounding refutation of use despite clear evidence to the contrary, most are quite cognizant of their use or deterioration. Rather, they are clinging to a reliable defense in the face of condemnation and efforts to wrestle their refuge from them. Personal

experience of others' failure to understand the allure of drugs, a sensitivity to judgment, and self-doubt may clash with the implicit and explicit goals of the therapist to get them to stop using drugs, and encourage secrecy and caution, and an attempt to justify and defend their use. With a therapeutic stance focused on their emotional experience rather than on cessation of use, such denial may melt and give way to pain, doubt, fear and an opportunity for new connection, hope and change.

People will double down on other rigid defenses in the face of perceived hostility and threat. While it is healthy to feel doubt and ambivalence, people with addictions may present one side of the argument or another, splitting different schemas or parts and so minimizing distress and internal conflict, at the cost of projection, paranoia and isolation. A client may try to convince themselves and the therapist of the reasonableness of their use, while externalizing the blame to family members, or insisting that people are misunderstanding and controlling them. At other times, the same client may become filled with self-doubt and self-blame, clear that they must change their ways and unable to perceive the contribution of others to their use. It is tempting to argue with the first and side with the second but it is essential that the therapist maintain therapeutic neutrality, attending to all the split-off parts of the client, containing the ambiguity and enabling the client to tolerate ambivalence.

Therapy is doomed if pretense and dishonesty are maintained, but if the therapist can persistently focus on the emotional experience driving such defenses and sustain a collaborative stance that prioritizes the client's feelings rather than cessation, the alliance will strengthen. It is rarely necessary to confront these defenses head-on. Traditional confrontational interventions are notoriously ineffective (Meyers, 2002). Instead, a nonjudgmental acknowledgment of the

possibility of the denied or hidden behavior is sufficient, welcoming it into the therapy as an obvious and constant possibility. If the client expresses outrage or hurt at the therapist's consideration that they may be concealing use, then that should be discussed and tolerated. Sometimes, clients will ask me "You don't trust me?" to which I answer "Of course! I trust all parts of you, those that feel comfortable here and those that don't, those that want to change and those that want to continue using and hiding. Can we make room for all of you here?" If use occurs then consequences will present themselves and the therapist can demonstrate their compassionate curiosity into the experience of the client, and on their well-being. This is what will soften these defenses and permit the establishment of a therapeutic alliance.

The Use of Positive Emotions in Addiction Treatment

Punishment-based models were favored in addictions treatment for years, and are typical for exhausted loved ones but are usually ineffective. Instead, positive reinforcement using praise, support or money has been highly effective (Higgins, 1999). Community reinforcement approaches (CRA) maximize positive feedback via identifying valued goals and shaping behavior to attain these goals, and CRAFT (Community Reinforcement Approach Family Therapy) trains families to emphasize positive feedback, minimize critical comments and perceived hostility while setting healthy boundaries. Outcomes are vastly superior to confrontational models (Meyers, 2002).

Central tenets of therapies like AEDP are forging a strong alliance and nurturing of positive feelings towards the self, and fits naturally with this approach. This does not necessitate an avoidance of pain or the negative consequences of

use. These are likely to occur regardless and can be held and processed within this positive and collaborative alliance. In fact, deep grief about the consequences of substance abuse is often one of the first important emotional breakthroughs that support motivation to change and the turn against maladaptive behaviors.

Emotionally Focused Engagement Strategies: Early Phase

The objectives of this early phase are to establish a therapeutic alliance and discuss the client's goals as well as obstacles to achieving those goals. Some obstacles may be practical such as medical concerns, housing, criminal charges or finances; these must be addressed, although are not the focus of this article. It is important to help the client explore the purpose and benefits of the drug use as part of establishing a therapeutic alliance and to really understand their reasons for doing what they do, asking for example: "What do you like about the drug/behavior? How does it help you?" This exploration and validation often surprises the client and is a very welcome contrast to prior treatment experiences. Understanding can be deepened by exploring the "cons of changing:" "What would you miss if you stopped or cut down? What would be unpleasant or difficult without the use/behavior?" which may reveal dread, self-loathing, doubt, and powerlessness.

The "cons of continuing use" and the "pros of changing" should be considered last because a positive alliance and positive affects will have already been established. The client will be better able to explore feelings surrounding their use and less inclined to defend their use. We hear the obvious (e.g., relaxation, fun) but also more nuanced aspects such as "I feel confident or strong," "I feel less alone," "I can turn my mind off and stop worrying," "I can love my partner," or "I am nicer to my kids." Taking time with this process, focusing on the emotions experienced as people

deepen into what they are saying, will bring up anxiety or defenses against impermissible or intolerable feelings or may deepen into feeling core states of primary emotion unfettered by defense or anxiety. These might be negative (anger, hate, self-loathing) or positive (joy, love, desire). It also begins to "de-fuse" the feelings from the behavior (to borrow a phrase from the ACT literature (Hayes, 2012), as the therapist validates the healthy feelings, allowing them to imagine effective actions quite different from, and far more effective than, the addictive behavior. This process, often undertaken in the first session, can be powerful and transformative. This discovery and connected exploration is powerfully motivating for further change and injects enormous hope for the client that things can be different in the future. The client may express more "change talk" (e.g., "I'm going to stop," "I can and will change because I can feel differently.") that correlates with actual shifts in behavior (Miller, 2009).

As an example, Carl, a professional in his 60s, was referred for intractable and devastating inhalant use that he had started as he was being monitored for alcohol use by his licensing board. Jovial and charming, he said that his life was full and rich and that his use was crazy. A long-standing AA attendee, he offered comprehensive lists of negative consequences, his character defects, peppered with AA slogans, though without affect. Exploration of the positives of use started with evasive self-deprecation but, with persistence, developed to a description of the powerfully compulsive blissful forgetting he experienced on huffing, even though it lasted only moments before he lost consciousness. Deflecting the shame and instead validating the relief he felt surprised him. We were able to stay with the positive emotion aroused by this validation and relief of aloneness, which he found immensely touching and brought tears. Processing the experience afterwards (called

metaprocessing in AEDP), he understood that he often felt inadequate, overwhelmed and alone, and had complicated grief feelings towards his violent alcoholic father. He felt enormously grateful and hopeful that the work could help him feel more connected to himself and his wife. This first session set the tone for future work where his use was not criticized, and the underlying feelings could be held and tolerated, with gradual diminution of use and replacement by an enthusiastic search for emotional depth and connection in our therapy. Exploration of the positives of use, and of the negatives of quitting, revealed defenses of shame, intellectualization and jokiness, hidden rage at his father and within, deep feelings of pain and aloneness, yearning for love and connection.

Emotions: Going Beyond Standard Relapse Prevention

In a typical Relapse Prevention approach, a relapse is examined using a behavioral chain analysis. This breaks down the triggers, thoughts, feelings and behavioral steps that preceded use, as well as the context that made the use more likely. This helps to identify interventions that might change the outcome next time (Witkiewitz, 2004). However, for change that is resilient, the client must manage emotions differently, develop reflective capacity, and seek security that is more real than drug use. Gentle, titrated but persistent exposure to those painful emotions that set off cravings and relapse, in a secure therapeutic relationship, allows for an opportunity to transform a private or feared emotional experience to one that is shared and bearable. This is the essence of good therapy such as AEDP.

To get to this emotional experience, a moment that barely exists for the addicted client swept up in automatic behavior, must be found and deepened. This moment happens just as the urge sets in, or just as a decision to use is crystalizing.

We must “widen the triangle of experience” or thin-slice the moment. However, finding the trigger can be challenging. Clients may attribute use to opportunity, or a person, thing or place (e.g., they passed a liquor store and simply went in). Or, they might jump to self-blame and attribute use to weakness or because “they weren’t following the program” (referring to 12-step meetings). While these proximate triggers are worth considering and amending, the question remains: Why on this occasion did they go into the liquor store and not yesterday? Perhaps the decision was made some time before they passed the liquor store. How did they feel earlier in the day? What else was going in inside them? AA has a useful mnemonic HALT (Hunger, Anger, Lonely, Tired) to help people pause, consider and attend to their internal state. We can go deeper. These moments need to be widened by the therapist, honing in on the emotional state that determines whether a trigger is a trigger, or merely rolls off their back.

A foundation of psychoanalysis is that the ways clients feel and respond to feelings within the therapeutic relationship are ways that were learned in childhood. AEDP is constantly gathering data on how people shift into defense or anxiety in the face of affect. It is helpful to monitor the sequence of behaviors in the session itself. In this way the therapist can begin to get a sense of triggers and manner of coping that might be outside the client’s awareness. For instance, if the patient withdraws or dismisses in the face of positive comments from the therapist, most likely there is a parallel version occurring in the world that involves substance abuse. It is productive to coach the client to reveal more deeply whenever there is an urge to use. This microanalysis and monitoring of the events immediately preceding use can identify important emotional cues that triggered the desire to use and highlight what is being avoided internally. The AEDP techniques of deepening are useful here: using the

different channels of experience, moving slowly and softly, repeating the client's words, using imagery, bringing the client back to the place and moment, noting and staying with somatic experience, and lending one's own experience to the client.

Unwrapping the Urge: Using Mindfulness to Investigate and Tolerate Emotions

A useful exercise is "unwrapping the urge", where a craving is evoked and attended to with curiosity (Talley, 2017). People are invited to imagine themselves in the moment where the urge arose, noting the effects on the breath, what feelings arise, location in the body, and memories associated. The client is invited to stay in this moment, observing without reacting, being gentle and accepting without judgment. Rather than repressing the emotions, or rushing automatically to escape them, we help the client experience them and their reactions to them. One can ask the urge to speak and express its feelings and intent, ask what it needs in that moment, what it longs for. The therapist may also help the client note how the craving waxes and wanes. At the end of the practice, the therapist and client can explore reactions, which often include a surprise that it is possible to feel such urges without reacting. Further, during this 'meta-processing' phase, the experience of craving can fundamentally change from one of aloneness and escape to one of positive emotion including pride, mastery and connection.

Case Example Two: Exploring a Craving

Miles is a 28-year-old man with opiate and benzodiazepine addictions, gambling and excessive porn use. He has not worked consistently for years, has been in and out of rehabs and feels demoralized. He is married to Mary, who is

highly anxious and frustrated by him. He is started on buprenorphine (suboxone) for opiate addiction. In his second week of treatment he describes feeling intense cravings in the afternoon and reports he took extra buprenorphine, assuming the dose was wearing off, and isolated in his room.

Th: Can you tell me what was going on yesterday when the urge came up?
Cl: Nothing. I came home from a meeting. I've been to a couple, checking them out, and I was feeling pretty good. **[People often say "nothing," not noticing emotion. To help them, I try to be more specific.]**
Th: Can you recall where you were when the feeling arose?
Cl: Hmm. Not really. Just around…. watching TV 'til we went out. Mary and I were going to meet her parents for dinner.
Th: And before you left for dinner you took an extra buprenorphine? You felt some craving, some urge?
Cl: Yeah. I got sweaty and antsy and thought the "bupe" was wearing off.
[While it is important to make sure the dose is adequate to manage cravings, people in early recovery interpret many unwanted feelings as opiate withdrawal.]
Th: Can we let that feeling come over you now for a moment? You know it well. If we explore it here we can understand it better and get used to it a bit so you have some options. **[I encourage him to experience the feeling, emphasizing "we-ness" and provide some psychoeducation.]**
Cl: I get that feeling in my stomach, a bit nauseated… *(puts his hand to his chest, breathes and leans back)*. **[There is a mix of visceral anxiety here in the stomach, which I would not deepen, but also some somatic activation as his puts his hand on his chest.]**

Th: And see how you're touching your chest….. what do you notice there?

Cl: It's a bit tight. I got a bit nervous thinking about the dinner, talking to her parents. Mary can give me a hard time in front of them.

Th: What are you feeling right now? [**I bring the experience into the here and now which will help deepen and later transform.]**

Cl: Well, I just went up to my room and chilled *[waves his hand in a dismissive gesture]*. [**It could be useful to ask about what constituted chilling here: gambling, porn, drug use, ruminating. But I want to emphasize that there are feelings behind the dismissiveness and avoidance and I would prefer him to have a new experience of managing and sharing affect. I can come back to the coping strategies later.]**

Th: Well, that makes sense. And before you went up you had this feeling, this tightness here *(touching my chest).* Can we stay with that?

Cl: They think I'm a bit of a fuck up, her parents. **[He shifts to thinking about their minds, not his feelings, so I bring him back.]**

Th: Hmm. And this feeling? Can you stay with that for now? It's there, when you're thinking about using. In the TV room? **[bringing him back to his experience]**.

(He sighs and rubs his thighs.)

Cl: Oh yeah. I feel a bit, not angry just, you know, frustrated.

Th: I'm glad you are noticing that. See if you can stay with this a bit longer. You're doing great. See how you're experiencing this frustrated and angry feeling. Feel where it moves..... perhaps there's something it wants to say.

Cl: Oh, well, I hate this feeling. It wants me to turn off, turn it all off.

Th: Maybe you want that. But this feeling might want something else. Can we see?

Cl: Who are they to judge me? *(He moves forward, with clear anger but still projected onto them, what they think of him.)*

Th: Yes. You feel that anger, right? That anger wants to do something... when you think they judge you ...

Cl: Shout at them. Kick them out *(animated and angry*).

We continued with an anger portrayal, which transitioned to being about his own father's harsh judgment of him. In metaprocessing he was able to see that his turning off was a way to manage the anxiety of feeling judged, and that he was angry and feared expressing that. While there were likely deeper, more primary feelings of pain, aloneness, and rejection that he experienced in his father's gaze, at this point I praised him for being able to explore any feelings, rather than shut down or use. It was a highly arousing session, and left Miles quite surprised and shaken, so we spent considerable time ensuring he felt good about his accomplishment and had a clear plan for the evening that would keep him safe from using.

Therapists may avoid evoking urges and deep emotions for fear this will trigger an irresistible tumble into use. This is wrong. Problematic addictive behavior occurs as a private experience where a need to avoid an emotion drives a maladaptive defense. Similarly, worrying they are condoning a "bad" behavior, therapists might preface or bookend their exploration with cautions, admonishments or other comments that can curtail the deepening of the emotional experience. Instead, it is better to stick to exploration, the bearing of emotions together and transforming a prior sense of aloneness or powerlessness into an experience of being seen with compassion and ability to respond meaningfully. When a powerful

feeling is shared with someone who is experienced as caring and responsive, healing occurs.

Carl's first session (above, case example one) was overwhelming, so we rehearsed how he would manage that evening, and I had him text his sponsor from my office. Nevertheless, en route to the second appointment he detoured to a hardware store, purchased and used inhalants. He did not show for his appointment but came in several days afterwards and said that he'd had no thought process about using. In his mind, he was simply acting automatically and presented ashamed. We explored the triggers and discovered that he had anticipated pain and anger and was not yet able to manage these effectively. Reviewing these feelings together validated his defenses against experiencing powerful emotions, and facilitated a different outcome. In future sessions, we were very careful to regulate his anxiety, looking for, noting, and managing subtle signs of dissociation, avoidance or defense that I may have previously missed, and explicitly emphasizing our partnership in being with his feelings. We ended each session with a recap of how he was feeling, what his intentions were and what his plan was. I did not "cause" Carl to relapse; he was using before he was referred and we needed to discover these triggers together. If the work was not emotionally moving it would not have been useful. Only by surfing the affect could we build capacity to feel emotions kept at bay for decades and develop alternate coping strategies.

High Anxiety Clients and High Defense Clients

Some clients may be dumbfounded when asked about feelings, having paid little to no attention to them in the past. Feelings may not been modeled appropriately and/or allowed in their family of origin, resulting in warded-off affective

experiences. They will find it very difficult to describe a feeling and may become either anxious or defend in various ways. The therapist needs to be compassionately persistent, remaining committed to staying with their client's internal felt sense, helping them ride the waves of affective experience. Initially, this may be focused on the experience of anxiety which is an important therapeutic end in and of itself. Over time the client will learn to discern affect and express emotion with more granularity. Each time the client is led back to their feelings, more is learned about the way to manage overwhelming anxiety, the ways emotions trigger anxiety, the ways the defenses ward off the emotion, and the ways such avoidance has harmed them. Initially, much psycho-education may be needed. I often share the following with my clients:

> *Sometimes as a child, it can feel or be unsafe to feel certain emotions, especially if we are too young to understand all that is going on in our World. We have to cope the best way we can at the time to survive. As adults, those patterns remain long past their usefulness.*
>
> *You have to feel secure to explore and bear these warded-off affective experiences. Therapy can provide this opportunity. Emotions evolved at the very heart of how we make decisions in a complex social world. If we ignore them, we cannot make healthy decisions.*
>
> *Increasing emotional granularity helps us understand ourselves and others and provides essential information to guide effective behavior.*
>
> *Emotional literacy reduces anxiety and suffering and allows for the possibility that someone could be there for us.*
>
> *As we focus on how we truly feel, we learn how we can manage our feelings in effective ways like connection, planning, assertiveness, humor and creativity instead of avoiding by engaging in addictive behaviors that which have been so costly in the past.*

> *Drug/alcohol/sex use can be either fun or avoidant. Each time you choose to experience feelings instead of avoiding, you get a chance to manage your challenges effectively and feel empowered.*

Even while this process is painstaking, it is rewarding. People feel excited to learn about themselves and grateful to have such deep attention to how they feel. As experiential therapists, we know that being seen and validated through the eyes and heart of a caring other evokes change. This adage applies to every population we work with, including people with addictions. They feel hopeful to discover there are reasons why they use and opportunities to take a different course. They feel respected and cared for when they hear the therapist validate the good reasons they flee emotions—such a contrast to the usual addictions therapy where use is a failing from which no good can come.

Special Challenges in the Early Phases of Addictions Treatment

There are numerous challenges to the early work, resulting from the effects of the particular drug, the effects of the addictive process itself, and the social fallout of the addictive behavior.

Firstly, if the person is intoxicated or in withdrawal, safety may be compromised. The clients themselves may injure themselves or others because of impairment or withdrawal, and assessment by a physician or social services might be needed. If the therapist is concerned, then intervention is an act of caring, while turning a blind eye may be a threat, including to therapist licensure. It is useful and prudent for therapists to know the basic signs of intoxication and withdrawal from

each of the drugs and alcohol (for signs of withdrawal and intoxication see *www.nida.org*).

Beyond acute withdrawal, clients may experience “post-acute withdrawal syndromes” that will affect their participation in therapy and their attachment capacity. After a marked reduction of alcohol or sedative use, people may have anxiety, increased irritability, and difficulty falling and staying asleep. Opiate cessation may also bring a feeling of aching, perhaps resembling a low-grade flu, as well as depressed mood, irritability and anxiety. Stimulant cessation may make people apathetic for several weeks. Anyone who has ceased a significant addictive behavior will feel distracted, anxious or irritable when resisting cravings. People can present quite emotionally labile and be labeled bipolar, borderline or hysterical. All of this affects a client’s emotional capacity in and out of session for several weeks and the therapist should educate, provide hope and expect a reduced threshold for overwhelming someone’s capacity to be in core affective experiences.

As people have grown accustomed to getting excited by addiction-related behaviors, having paired anything fun with use, they can experience a reward deficiency syndrome of apathy and a heightened preoccupation with, and anticipation for, cues associated with the drug (Goldstein, 2002). This increases the likelihood of relapse, and also makes the pursuit and intensity of alternate reinforcers hollow and correlates with altered tone in both the dopamine systems and the stress-hormone axis, changes inherent to the addictive progress that persist for many months after cessation (Koob, 2013). Clients should be reassured that things and people will feel more interesting and attractive in time.

Attachment is compromised at this point. Attachments are reinforcing: They are essential for survival and so shape behavior. Their relational nature drives the

capacity to mentalize another's mind and to care about, and respond appropriately to, their feelings (Feldman, 2017). Addictions utilize the same pathways and become entwined in the pursuit of attachments and the management of painful loss of attachments. But people wrapped up in addiction are seeking a self-soothing and reward that is not relational. It is solipsistic, and a doing-for-oneself, a turning away from another because that may seem safer, reliable and gratifying, at least in the short term. Thus, people in this state are more self-centered. Rather than guilt, they tend towards shame and may appear narcissistic or antisocial. Partners—and therapists—need to tolerate such limits on the client's capacity to attach, feel and express guilt, or care deeply and authentically about others. This tends to last for several months, depending on whether they ever had such positive experiences and capacities. Intimacy and connection with the therapist will evoke strong emotions that are often defended against, including anger or desire, or arouse overwhelming anxiety and fear.

Another way that capacity for trust and mentalization can be eroded is through the transactional nature of interactions, e.g., buying drugs and sex. These experiences can be very warm and intense, and involve some measure of generosity, even more so when infused with a "high." Yet the relationship is not sustained, reliable or truly reciprocated. As adults, the people to whom they turned may have been dishonest, violent and abandoning. These significant others may have been partners or parents who condemned their behavior or rejected them. Such rejection may have been goaded on by slogans such as "they have to reach a rock-bottom" and "you are only enabling them." They may have had friends or dealers who let them down deliberately or inadvertently while influenced by drugs themselves. More concretely, people with addictions experience high rates of trauma

through assault and rape. The contrast in the newness of the therapeutic alliance must be highlighted and the experience of connection worked with explicitly so that the client does not defend against the connection.

Case Example Three: Learning from the Intimacy of the Therapeutic Relationship

The client is a 60-year-old man with a sex addiction. He has paid for sex and watched pornography and was accustomed to a negotiated pantomime of connection, erotic pleasure and admiration. He described a sad moment, but in an offhand way. Attempting to help him connect to the emotions, I had shared my own genuine experience of sadness with him. He looks away and reaches for his coffee cup.

Th: You look away. What happened for you when I tell you of the sadness I feel?

Cl: Well, it sounded canned, like something you should say. I pay you after all. **[This is a defense against connection or the anxiety my self-disclosure aroused. However, I did feel upset and cast aside.]**

Th: Oh, that sounds like you are paying a prostitute.

Cl: Well, you're supposed to react that way.

Th: I can understand why that might be a place you go. It's an experience you've paid for many times. But here and now, as you look at me, into my eyes, consider our relationship here, is there any part of you that can take in my genuine caring? **[I push forward with his emotional reaction to my self-disclosure.]**

Cl: *(tearing up and looking away)* I don't look into the girl's eyes during sex. I imagine they're turned on, but I don't look.

Th: So, what do you see as you look into my eyes now? **[I am feeling sad and my eyes are tearing too.]**

Cl: You look sad. You look like you care. (*He sighs.)* But you know, you're a therapist. Your training teaches you this.

Th: Yes. I am a therapist. But let's try not to push this away quite yet. Stay with what you see, what you feel here with me. [**I am discouraging the defense.]** I do care… *(waiting, as he sighs and tears up) …* Mmm. Let that in. Stay with it. There is real deep sadness for you.

Cl: Well, it's a bit gay isn't it? *(looking away again and sitting up).* **[He is continuing to push away from the feeling defense, so the session continues to work on his receptive capacity.]**

While some clients use defenses to manage unwanted, feared or overwhelming emotions, others become anxious. This can become intense and disrupt thinking and reflective capacity, and at these points the therapy needs to shift to helping the client regulate their anxiety. This is an important skill set that provides practical methods the client can use outside and also builds the therapeutic alliance as the client feels noticed, cared for and more secure. Strategies include grounding (where the client may be asked to notice their surroundings, body awareness or senses), breathing techniques (that slow heart and respiratory rate and sympathetic activation), and cognitive reappraisal and recapping (which engage the client in thinking about the situation and triggers). Once the person is calm enough the therapist can return to the prior affectively arousing stimulus and help the client experience their feelings without going over threshold.

It is very common for clients to slip into very painful affect states in early recovery. Many moments arouse profound sadness, such as when they consider all they have lost over the course of their addiction; or arouse guilt and shame as they contemplate all they have done to others. These states can motivate further change and reparation. At other times they may be overwhelming, so that the client dissociates or slips into pathological affect states. For example, if the client finds the vulnerability of these affects too risky, or anticipates the attachment figure will condemn, attack or abandon them, then these emotions cannot be expressed as adaptive-action tendencies (such as self-compassion or making amends) but may instead be turned in on the self as shame and self-attack. Engagement in the defense of addictive behavior manages the anxiety of this moment quite effectively, and avoids the painful feelings, at least for a short while but at such cost.

Case Example Four: Managing Shame in Addiction

Carol is a mother of three and grew up with an abusive and alcoholic father, and a scared mother who failed to protect her. While her siblings flailed, Carol excelled in school and career but developed an eating disorder, and her alcohol use became compulsive and life-threatening. She drove drunk with her children, passed out in front of them and was highly labile and angry. She had multiple inpatient detoxes and rehabs and attended AA but still drank regularly. She had drunk on the weekend before this session, having found some vodka stashed in the freezer. She said that she drank simply because she was an alcoholic. We did a quick review of events, scanning for a trigger, context, thoughts, emotions and behavior. She'd planned a night in with the family and cooked a meal, but the neighbor came over and announced pizza next door. Her husband declined, but the son complained

about never having fun and she relented. They left her alone while she finished cooking and she drank. She had known the alcohol was there for a few days but had not thought about it until that moment, despite opportunity. The trigger seemed to be around the interaction and the family's leaving.

Th: So, there you were, planning what sounds like a lovely evening, and your son whines to get his way. That sounds upsetting.

Cl: He wanted to play x-box. That's fine with me.

Th: Sure, I get it, too. But what about your feelings here? You had set out a plan, a nice one, and he whined his way to ruining it. What was that like for you? **[I use strong words here to pull for affect.]**

Cl: I feel bad for him. He's been through a lot. **[She answers about her son's feelings, not her own.]**

Th: What about *your* feelings? You'd wanted to hang out. It sounds nice.

Cl: Well, I did ask him to stay but he can have a terrible temper.

Th: So…. he's going to throw a tantrum? How do you feel towards him for upping the ante so he can get his way?

Cl: I feel sorry for him. I understand. All those years I was drinking. I was awful. I missed every soccer game his whole season. **[She begins to cry and her breathing increases. As she is verging on shame, which can rapidly sweep her up and can justify her next drink. I quickly acknowledge her regret, then bring her back to her experience of being robbed of this nice experience she had planned for her family.]**

Th: Yes, you both missed those and so much. But here you engineered an opportunity for something different, something sweet and thoughtful… You know, I

feel a bit annoyed at him. Do you sense that? [**I affectively self-disclose as a way of modeling the experience and increasing her attention to her feelings.]**

Cl: Yes. But how can I be angry after all I've done?

Th: Of course there are thoughts about what you did. We can come back to that. We often come back to that. But for right now, if we try to hold off on the self-blame…

Cl: Yeah, he's being a spoiled brat.

Th: He is. And he is wrecking a really sweet night. Notice what you're feeling… Let's pay attention for a moment to what that's like to sit with … that he's being a spoiled brat.

Cl: Well I'm pissed with him. He's being a little shit. *(She leans forward, fingers jittering, and breathing heavily.)*

Th: Yes. And you're pissed. What do those hands feel like doing? Let the anger in fully. *(Her breathing increases.)*

Cl: To throw his x-box out the window. To make him stay. (*She looks away, starts crying and talks again about being selfish and stupid.)*

Th: Of course you were mad at him for that. Can we stay with it, with this anger? Maybe the shame can wait? He was really overriding you, ignoring how you felt, what you wanted.

Cl: Colin [her husband] says I cave, that it's not good for him, that I need to set limits.

Th: It's hard for you to be with your anger. It comes back on you, right? But now, is it OK, to be angry? **[I am trying to deepen her anger but it is slipping.]**

Cl: It's fading… *(softening and tearing up)*.. I just wanted to sit with him on the couch, watch his TV show. Just be with him.

Th: That sounds so nice… hmmm…. are these tears of shame, or of sadness?

Cl: Sad. I was upset…

Th: Yes. So sad. what's that like… let it in. Notice it. **[It is new and challenging for this client to be angry or sad. I go with her emerging emotion of sadness, though she may be avoiding her anger too.]**

Cl: (*sobbing fully)* He missed so much. I don't know if he'll ever be the same

Th: Ugh. I feel really sad with you. You both missed so much. **[I bring her back into the loss. She lost too.]**

Cl: Yes… I wanted to tell him to stay, to be my little boy with me again. **[We are very much in sadness together here. For a minute or so she is crying, before she sighs.]**

Th: Wow. It's so important that you allow yourself this sadness. Underneath all the shame, there you are, wanting something so straightforward, so positive, so warm. What's that like? To find such a simple yearning for togetherness…. just to curl up on the couch. **[We do some metaproessing here, where she feels into this simple truth. But it is necessary to loop back because her avoidance behavior was to drink. I wait until her wave of emotion has passed.]**

Th: So, where does the drinking come in here? When did you decide to drink?

Cl: Oh, right when [the son] was going to go, I knew. I was like "fine…..you should go next door."

Th: Instead of feeling sad, instead of the anger?

Cl: Instead of anything. I just didn't even think about it.

Th: And now… What does this sad part of you, who feels so sad at being left … when all she wants is that loving connection. What does she need?

Cl: Just to be with him, to be wanted… [**This is bridging a current-day experience with an older aloneness.]**

Th: Yes. so simple and welcome, right? Can you imagine getting that… asking for that…

Cl: [My husband] was ready to back me up. He wanted that too. I chickened out, and knew the vodka was there.

Th: And now? How do you imagine giving that sad and alone part of you what she needs?

Cl: Oh, tell him I want him to stay, be clear. The vodka doesn't even come into it. It seems easy here.

Th: Indeed it does. What changes could you make so it's easier next time?

Cl: Well, I'll talk with [my husband]. We can take a moment alone on this one. He could step up and insist a bit more, not leave it to me. And I'm going to leave a bottle of antabuse *[a drug that causes nausea in combination with alcohol]* up there, and [my husband] can watch me take it in the morning.

Other writers have written on ways to manage shame and pathological states. My point here is to illustrate how to identify the moment that the thought to use arises, and that by expanding that moment, and tolerating the emotions that lurk there, knowledge and mastery emerge. Expanding the moment permits important transformance strivings to emerge (Fosha, 2000), in this case love, connection and the associated anger at being dismissed and grief at all she lost, all this where drinking and shame had been. With each exploration, we can get more differentiated. We did do some explicit planning at the end, taking the clarity of her emotion to determine a plan.

In the next sessions, she was able to link these feelings to experiences of childhood when she was alone, ignored and needed to perform and please in order to survive and had the opportunity to re-do the experience in portrayals. The unwrapping of these moments increases curiosity and tolerance for disavowed and

buried emotions, tolerance of the anxiety, lessening of the shame. She was able to identify what she needed from her husband in these moments, and ask him for support. She was able to feel instead of drink. There was no need to review the negative consequences of her drinking.

Case Example Five: Use of Therapist's Self

In this example, the client is able to see his defenses to avoid painful affect and have a corrective emotional experience. Chris has 20 years of heroin and cocaine addiction, interrupted by a five-year period when he married and had a child. Following a call from the Department of Children and Families, he went to a 21-day rehab and returned home this week. His wife (seeing another therapist) is angry and critical. When he was 10 his parents had a bitter divorce, and he spent years floating between their houses, feeling utterly unseen and manipulated. He had often been late, distracted and intellectualizing.

Cl: I hate it at home. She's always on me. I'm walking on eggshells. (*He is sweaty and anxious, but animated.)*

Th: Tell me what that feels like, walking on eggshells, her on you. What do you notice right now inside?

Cl: I'm annoyed. But how can I be? I've fucked up hugely. I wonder….. should I even be a Dad? Do I want to be married? **[He is always highly intellectualizing and quickly leaving his affect for self-blame and vague questions.**]

Th: Hold it, hold it. Can you stay with the feelings? Your anger?

Cl: I feel like that mouse, the one chased by the cat…. he just pulls the plug and goes dead.

Th: Jerry. Tom and Jerry. You just pull the plug and go dead. Ugh. That's a frightening image. Terrified. You don't know any other way. Just pulling the plug and going dead. **[I am focusing on the terror. We are close to the same age, and I know the cartoon and the sense of being chased and helpless.]**

Cl: That's what I do. That's exactly what I do *(referring to heroin use with an expression of horror and dismay).*

Th: It's awful. I feel huge compassion for you right now, for your helplessness. To feel so powerless that you must pull the plug and play dead. **[I am holding my heart, speaking very softly.]** What can we do for him? I want to help him. What can we do?

Cl: Pluck him out. I'm plucking him out….. like the box is open at the top and I can take him out of there *(sobbing).*

Th: And what do you do with him when you pluck him out?

Cl: *(tearing up)* Hold him.

Th: Wow. So loving. So needed. So loving… (*He is sobbing) …* Mmm… What's that like, to be so loving to him, to you… holding him?

Cl: I wish my parents would have done that for me (*sobbing still).*

Th: Yes. You are giving yourself what you always needed. Seeing yourself, caring so deeply. No need to pull the plug. Taking so much care, so much love. Staying right where you are needed. **[I am emphasizing the difference, emphasizing positive care, accomplishment, engagement.]**

Cl: Yes. But I haven't done that for [my daughter]. I'm letting her down.

Th: We can go there in a minute. **[And we should, as he has indeed neglected his daughter in a painful repetition of his own neglect.]** But right now, stay with what

you are doing. It's so wise, so resourceful. The conflict is there but you are doing something so important.

This session proceeded with a long metaprocessing period where Chris was able to take in the newness of this self-care and feel clear that staying with his feelings of powerlessness and invisibility allowed him to bring compassion to himself and to his family, and that "pulling the plug," a defense he had learned in his teens (with porn, heroin, alcohol and intellectualization) was no longer needed.

The Pink Cloud: Managing Splitting and Healthy Ambivalence

In early recovery, some people can be very excited and positive. On the one hand, this holds hope, enthusiasm and curiosity about a new way of doing things, and deepening the experience can be fun and positive in the alliance. On the other hand, there can be a grandiose assuredness borne from minimization of fear and vulnerability. AA members often speak of this period as a "pink cloud" and it can herald a slip followed by surprise and shame or a prolonged relapse.

Therapists need to keep this in mind, because at this phase of early abstinence, the client lacks the capacity to tolerate anxiety and contrary emotions, to sit with the ambivalence. Defenses including disavowal and denial, projecting or splitting emerge. Sometimes therapists can be carried away with their clients' emotion, while at other times they may hold very conflicting thoughts and emotions. The concept of therapeutic neutrality is helpful here—not as a blank screen, but rather equidistant from id, ego and superego, considering all these different drives and intentions and ambitions without aligning with one while sacrificing another

(Greenberg, 1986). Instead, it is helpful for the client to see all sides of their *internal* experience, ambivalence and conflict, rather than battle *externally/interpersonally* with the therapist or others. It is not useful to confront the client with your thoughts or feelings because you will clash with the defenses and raise resistance. Similarly, sarcasm or inauthenticity is poorly tolerated. Instead, exploring and deepening the emotions will do one of three things: (1) permit a wave of emotion to crest and subside, freeing the stage for contrasting emotions, (2) reveal defenses that can be validated and generate curious investigation of underlying affect, or (3) create anxiety that can be tolerated so that the ambivalence can be held. Again, the goal here is not to push the client to see some truth that follows the therapist's agenda, but rather develop capacity to feel all the emotions and bear the sense of loss that comes with making a choice.

Sometimes the client will hold on to the addiction behavior despite enduring startling misery. One client said to me: "It's like I have to trudge through thick cloying mud. There's so much agony and frustration in moving forward. Heroin makes it feel just fine to lie there face down," which is profound, awesome and tragic. It is tempting to try to drag the person out of this situation, to shake them out of their stupor, but such actions are often fruitless as the person feels misunderstood and forced. *Instead, the therapist has to get down in the mud with the client, to understand and empathize both how dismal their experience feels, and how compelling the heroin feels.* Only by sharing the intensity of this can the person feel understood and no longer alone and begin to trust the therapist.

Case Example Six: Joining the Client in Misery to Undo Aloneness.

Th: Wow. What a terrible feeling. I have tightness and heaviness in my chest when you say that: “Trudging through thick cloying mud”. That is so powerful and… ugh, exhausting…*(Client is silent. looking at me.)*

Th: I don’t know how you do it, how you carry on… I feel so much for you lying there. I imagine myself lying there beside you… *(Client looks crushed but is tearing up and still looking at me.)*

Th: Do you have a sense of me there, beside you?

Cl: (*She nods, tearing.)* A little part of me feels you there.

Th: What is that like, sensing me there, in the mud, with you?

Cl: It feels a bit better. Lighter.

Th: Lighter, hmm. Can you let that in… **[I am sharing myself in a very loving way with this client and building positive affect in the new experience. In this way the client’s transformance drive can be evoked, a sense of hope that comes from connection that can be the alternative to using heroin to bear it.]**

Th: (*Client tears up, then shakes her head and turns away.)* Hmm. It’s lighter to feel me there, but you looked away, like it wasn’t easy. **[Next we attend to the defenses, for this is a very new experience, to be taken in gently.]**

A similar stance needs to be taken when there is lying. It can be bewildering to witness how some people, obviously drinking or using, continue to maintain that they are not. Sometimes the reasons are obvious: They want certain medications or to get us to advocate for them with their parents. At other times, the only motivation is to maintain one place in the world they can feel strong or loved, even when this feeling is so compromised and fragile. I have had clients maintain this stance and

denial literally to the death. The therapist should acknowledge and validate the defense, attempting to get to the pain, shame and horror beneath by whatever means: curiosity, speaking to the part of them that is hurt and scared, bringing in relatives. Sharing your own self of powerlessness can help, if it is done from a place of pain and does not evoke shame.

Working with Emotions in Middle and Later Phases of Addictions Recovery

From one month to six or so months after curtailing heavy use, people are actively managing cravings, limiting triggers, and developing some healthier routines and supports, but can feel like they are going through the motions and are vulnerable to slips. At around six months, these routines are more established as people are regaining a capacity to be interested in things and people, sorting out some of the negative consequences of their use, and managing triggers—emotional and non-emotional—that had previously encouraged use and avoidance. Those who are successfully moderating are no longer using to alleviate intolerable emotions but rather simply to have some mild fun and, if they are lucky, are not swept away in a compulsion. While research on these groups is limited, those able to moderate generally have less severe addictions, less co-morbidity, fewer addicted peers and less family history of addiction. They are more able to self-govern and take care of themselves and have healthier relationships.

Nostalgia should be a cause for caution. Memory for the addiction is suffused with positive affect of the “good old days” when it was all fun and relief, and of the eager anticipation of use. Negative consequences often happen after the good times, when people are coming down or completely sober. Once people are dreaming about using, they are far closer to using, because the anticipation biases

perceptions and behaviors that make use more likely. Walking down the candy aisle, reminiscing and salivating at the memory of how good chocolate tastes, is definitely not advised for those wanting to diet. If the goal is to control or stop use then it is important to de-fuse the nostalgia so that decision-making is guided by values rather than whim. Standard therapies try to accomplish that by reviewing the negative consequences and avoiding people places and things, but adding emotional depth can help. AA provides incentives of pride, connection and spiritual meaning; gratitude can be journaled. AEDP deepens the intensity and specificity of emotional experience and is nonpartisan—neither for or against the use—if the therapist and client are not excluding aspects of the whole experience and instead adopting a harm reduction perspective.

Case Example Seven: Nostalgia and Grief

John is 40 and has lost a great deal of money and several relationships to gambling addiction. He's about nine months into recovery. While telling me about how it felt to win, he grows excited and sits up, totally engrossed in the thrill of the moment. I focus on his positive feeling and acknowledge how infectious it is, validating its power. As he continues, I grow aware of some sense of dread within me—for here he is in treatment—but stay with his affect.

Cl: Wow! It was great - winning, the attention, the rush. Such an amazing feeling…

(He sighs, is quiet and stares. There is more than thrill in the air.)

Th: Hmm, is there something coming up, alongside this excitement?

Cl: Well, that's over, isn't it?

Th: You're sad about that… to say goodbye to such intense thrill… let that in.

Cl: It's like saying goodbye to the best time of my life.

Th: Maybe, but who knows the future. What's this like to do, to say goodbye?

Cl: I need to. It's ruined so much.

Th: And that's sad. You've lost so much (*tears and sadness in the client's eyes)…* Let that in. The thrill of winning, being seen winning… and the sadness of letting go… can you feel both?

Cl: Yes, I think so. I couldn't go back.

Th: Well, you could…

Cl: I don't want it back. I lost everything… *(pushing with his hands)*

Th: What do you notice when you say "I don't want it back"? Notice what your hands are doing.

Cl: Ugh. I really don't want it back.

In this example, I resist the urge to point out the negative consequences. I stay with the positive emotions knowing that they cannot last, for we are in the therapy office, not drinking and gambling. His sense of grief emerges, then relief. By bringing both negative and positive affects together the split is healed, the sadness paired with the memory, the nostalgia soiled. Sometimes feelings of disgust arise, and it is useful to deepen this and allow the client to associate the drug with it. People with such powerful affective responses as disgust rarely relapse.

Clients are much safer once they have deepened their emotional literacy and tolerance, discovered a capacity for sharing vulnerability and improved their tolerance of anxiety and ambivalence. At any stage, for any of the addictions, relapse is possible and needs to be anticipated. A client should know their triggers, both external things and internal feelings, and have a plan how to handle these

effectively, using relationships, therapists and good self-care, AA meetings or whatever else they have found effective. Therapy should assist restoration of these external structures, supports and lifestyle changes because people may be trying to find alternative ways of enjoying things, meeting people, having sex or socializing without drugs or alcohol for the first time. There can be considerable trepidation and old fears about inadequacy could dissuade people from taking new risks, so therapists should encourage a sense of adventure and pride in exploring. EDP is especially helpful at these phases but does not require great modification.

Conclusion

I hope this article has accomplished two things. First, I want to consider addiction as a disorder of emotional development, regulation and processing instead of as a disorder of morals, cognition or behavior. Not only does this fit with the neuroscience but it encourages the therapist to take a compassionate and collaborative stance, to listen to, and appreciate, the experience of using and wanting to use, rather than judging or trying to stop it. Only then can the client feel partnered and have the courage to find new ways to manage emotions and discover connection is an alternative to repetitive self-soothing. The treatment stops being about abstinence and instead becomes about discovery. This is the essence of harm reduction and has been so much more effective, and pleasurable to practice, than traditional ways of working.

Second, I hope experiential dynamic therapists accept more clients with addictions into their practice. AEDP's attention to core emotional experience casts addiction as a distraction and keeps transformance and connection as the focus.

This focus takes therapist most of the way toward being great addictions therapists. Just a little understanding of the tug of compulsion and triggers gets them there. Addictions are everywhere. Good treatment is needed, and it is enormously gratifying to accompany someone from a desolate, compulsive habit where they feel alone and judged to a life of connection and hope. I hope you take that journey with your clients.

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