

**Advanced Recovery:  
Emotional Strength and Spiritual Discovery**

Working with people in recovery since 1964, we've seen the conflict between the spiritually-oriented 12-Step movement and the scientifically-minded health professions begin to reconcile. Health professionals are giving more importance to spirituality, and many people in 12-Step programs now augment their recovery with psychotherapy and doctor-prescribed, mood-altering medications (e.g., anti-depressants). This article describes a model of spirituality and science that strengthens the recovery process.

If not sooner, the need for such a strengthening model is apparent at the stage of recovery in which relapse is potent. One client called this stage the "Grim Gray," meaning that contemplating the rest of his life as an alcoholic in recovery held no new promise. Questions such "Is this it?" or "Is this all there is?" - asked by many people at the mid-stage of life - takes on a special significance for the person in recovery who can't resort to drugs or alcohol to buffer life's disappointments. The impulse to "go out," to relapse and return to drinking, becomes discouraging to people who thought they were fully committed to sobriety and recovery.

Beyond the potential crisis of relapse, many people in 12-Step programs find the promised "serenity" of recovery to be elusive. Inner serenity is a goal of every spiritual tradition, but the spiritual path to the goal is often obscure and meandering. In addition, the 12-Step form of spirituality reflects the 1930s Protestantism of its founders and is not effective for everyone: even the most

well-known of the founders, Bill Wilson, ranged far beyond A.A. in his spiritual search, including the use of LSD in the hope of having new spiritual experiences. Now more than ever, living as we do in an age of anxiety, the promise of serenity needs to have clear, sober paths to its realization.

In order to consider any path to spirituality and serenity, it needs to fit into the larger picture of the addictive and recovery processes.

### **The Nature of Addiction**

The classic definition of addiction is that it is a mental obsession and a physical compulsion (Alcoholics Anonymous, 1976), and the most widespread 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*, the insatiably hungry monster Cerberus in the third circle of hell is the precise picture of compulsion (Schaub & Schaub, 2003).

Cocaine, heroin, anti-anxiety agents (e.g., Valium, Xanax), painkillers (e.g., Oxycontin, Vicodin), sedatives, amphetamines and other drugs can also become addictive. In addition, there are addictions without alcohol or drugs, including eating disorders, gambling, pornography 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 (Schaub & Schaub, 1997).

**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. Alcohol sets off a predisposed craving in the brain for more alcohol. As of the time of this article, this model is the most prevalent understanding of addiction.

**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 superficial consumerism 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, 2) alcoholics are people who experience this existential anxiety more acutely.

These models are greatly simplified. Their theme, though, is clear: feelings of need and vulnerability cause or contribute to the development of addiction. Clients repeatedly describe that the onset of their addiction was their first discovery that alcohol took away their fears and made them feel more normal.

Therefore, special attention must be given to the person's vulnerability in order to help him strengthen his recovery.

### **Early Treatment Principles**

No recovery 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 attempt to help the alcoholic. The therapist becomes significant when the actual drinking has stopped and the person has detoxified.

Once detoxified, the alcoholic without alcohol is now exposed to the pain of life without his "medicine" and will feel at different times the need to return to alcohol for relief from his vulnerability. This need accounts for the failures in alcohol treatment. Relapse is an unfortunate but not uncommon part of the recovery process. Neither the client nor the therapist should be disheartened if relapse occurs. It is understandable in view of the enormous life change the alcoholic is involved in.

Early therapy should be psychoeducational. The recovering person needs to learn 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 psychoeducational process.

The power 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 – often a "sponsor" - and to tell the sponsor about the urge to drink. There are countless other examples of how A.A. provides guidance and support for the person new to sobriety.

The 12-Step insistence on spirituality makes some people wary of A.A. as a cult, but from our view that early introduction to spirituality plants the seed for the full flowering of recovery later on. All people need to awaken their natural spiritual potential to cope with the inevitable difficulties of living, and people in recovery have a compelling reason to develop new ways of coping.

### **The New Pattern - The Sober Person**

If the person accepts the 12-Step guidance, he literally begins to build a new pattern of thinking and behaving - the pattern of 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 stay sane and save his life. He thinks and feels "as if" he is a sober person.

This new sober pattern needs to become strong enough to cause conflict in the person: the new sober pattern must compete with the old pattern of alcoholic thinking and behaving. He is learning how to identify with (i.e., direct energy toward) his new sober self and to disidentify (i.e., withdraw energy) from his old alcoholic self. If successful in building the new sober pattern, the person in recovery will literally hear the two sides - the new sober person and the old alcoholic one - arguing in his mind. This argument is good: it means that the old obsession is being disrupted by the new thinking.

### **The Synthesis of Emotional and Spiritual Growth**

When this new sober pattern is minimally established through psychoeducation and/or a 12-Step program, the deeper promise of serenity in recovery can begin to be approached.

The synthesis of tools to accomplish this promise includes insight, support, imagery, meditation and a map of the less traveled road of enduring spiritual development. The first stop along the road is basic emotional knowledge.

**Basic emotional knowledge.** Discussed in depth elsewhere (Schaub & Schaub, 1997), the core feeling of every human being is vulnerability. At its root, this vulnerability exists because we all live with life's unpredictability and the guarantee of change and loss, including, in time, the loss of ourselves. No one, no matter how smart, rich, religious or good-looking, is exempt from this essential fact of life. For the reasons suggested above in **The Models of Addiction**, the alcoholic is especially susceptible to this universal vulnerability.

Despite everything he may learn in recovery, it will be intolerable feelings of vulnerability that will cause him to relapse. A strong recovery requires that he develop new, healthier responses to his underlying vulnerability.

To do this, he first needs to recognize that he is feeling vulnerable. In the beginning of recovery, this is difficult to do. Drinking alcoholically, he numbed his emotions for many years and now, in recovery, he has no vocabulary for many of his emotional changes.

### **Fight/Flight/Freeze Reactions**

The recognition of vulnerability in his daily life can be made easier by educating him about fight/flight/freeze reactions.

Fight/flight/freeze are of course the three primal instincts of any living being who feels unsafe and vulnerable. The recovering alcoholic will experience many intense moments of fight/flight/freeze, and as the therapist hears descriptions of these reactions in the client's life, he will be hearing the signals of vulnerability.

The client won't 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 or that he obsessed (freeze) over making an important phone call but never made it. When such a reaction of fight, flight or freeze is recognized, the therapist can then investigate the circumstance that triggered the reaction. Predictably, the reaction will reveal vulnerable feelings.

As one example, the client who wanted to beat up his boss was asked to go back into his memory 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. What was the form of criticism? The boss looked at him in a "certain way." Recognizing the vulnerability that was stimulated in such a moment, the client can begin to go beyond the fight reaction and deal with the more central issue - how to live in the world with his vulnerability.

To assist in recognizing the client's vulnerability, the following list of fight/flight/freeze symptoms can be helpful.

### **Typical Fight Reactions to Vulnerability**

**Mental Patterns of Fight.** Criticism, rigidity, judgmentalism, intolerance, fanaticism, hyper-vigilance, arrogance, manipulateness.

**Physical Patterns of Fight.** Physical tension and constriction resulting in hypertension, headaches, gastrointestinal disturbances, chronic muscle ache. 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.

### **Typical Flight Reactions to Vulnerability**

**Mental Patterns of Flight.** Self-depreciation, victimized thinking, self-pity, denial, excessive fantasizing.

**Physical Patterns of Flight.** Low energy, compulsive TV watching, repetitive self-soothing, avoidance, isolation.

**Emotional Patterns of Flight.** Helplessness, hopelessness, emotional flooding, guilt and shame, unworthiness.

**Spiritual Patterns of Flight.** Magical thinking, narcissistic theology, grandiose religious fantasies, superficial spiritual dabbling.

### **Typical Freeze Reactions to Vulnerability**

**Mental Patterns of Freeze.** Obsessing, chronic refusal to decide, numbed mental processes, disconnection, dissociation, unthinking acceptance of others' opinions and demands, indifference, inability to focus, self-absorption.

**Physical Patterns of Freeze.** Overeating, immobilization, lack of self-care.

**Emotional Patterns of Freeze.** Numbness, refusal to take responsibility, guilt and shame, co-dependence.

**Spiritual Patterns of Freeze.** Emptiness, lack of relatedness to a larger vision of life, lack of meaning or purpose.

We can view fight/flight/freeze as extreme reactions to vulnerability. There is nothing inherently wrong with an extreme reaction 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 resort to extremes and have no capacity to choose when to use them.

### **Emotional Development in Recovery**

The therapist's focus on identifying incidents of fight/flight/freeze will in time help the client to recognize those vulnerable moments for himself. With this increased self-awareness as the groundwork, the client then needs to learn new, healthier responses to his moments of vulnerability.

The therapist should not assume that the client will know any healthy adaptive responses. The client 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 client may be chronologically forty-two but he is sixteen year old in terms of his coping skills.

### **Five Emotional Goals**

There are five important goals in this stage of recovery.

Two are cognitive concepts which should be taught and discussed until the client 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. This concept tries to modify the cause/effect trigger between vulnerability and fight/flight. It tries to calm down the client's instinctive reactions and to

increase the client's ability to choose his responses to feeling vulnerable. This is an example of the brilliant retraining of the mind that takes place in the program.

**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 perhaps he can't live without alcohol.

**The third goal of this stage of recovery is teaching stress management skills.** These are the healthier responses to feeling vulnerable. In general, the skills will be derivatives of meditation techniques, but they must be pragmatic in that the client can do them 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 clients 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 11<sup>th</sup>, many clients 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. Their general goal is the reduction of fear and the increase of relaxation and peace. In the spirit of working collaboratively, the therapist and client 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 therapeutic view of recovery from addictions. Sometimes, difficult and painful experiences attributed to being "an alcoholic" are actually the result of being a traumatized person. This second recovery is a long-term process, and skills such as stress management mentioned above can aid this process.

**The fifth goal is the recovery of intuition.** True intuition includes and transcends rational thinking. By helping the client to re-discover his intuition, another tool is added to the client's ability to deal with vulnerable moments. Because of all the poor choices the client made during his addiction, this transition to cultivating a trust in a deeper, wiser self is a vital step in the healing process.

### **A Sixth Goal**

A sixth emotional goal, which comes much later in the recovery process, is the expansion of the client's identity beyond the label of "an alcoholic." At first, this might sound controversial. Doesn't the person in recovery need to stay aware his entire life that he could relapse if he's feeling too hungry, angry, lonely, or tired? Absolutely yes, but he also needs to understand that his vulnerable thoughts and emotions are not because he is "an alcoholic," but because he has an extra-sensitivity to feeling vulnerable. His alcoholism was

his response to this vulnerability, and it is the solving of this vulnerability that brings us to the next step on the path of recovery - spiritual development.

### **Spiritual Development**

Derived from the 12-Step emphasis on spirituality, many alcohol treatment approaches encourage spiritual development as part of the recovery process. The word "spirituality" is carefully chosen to distinguish it from religion.

In our own approach to spirituality, we ask the quintessential American philosophical question: Does it work? If something works, we use it. If it does not work, we let it go. Spiritual development has proven itself. We have seen over and over again the vast difference between a person who is developing spiritually and one who is not.

The importance of spirituality is a conclusion clearly supported by the world cultures of every time and place. Who is the most honored in any culture? The spiritual teacher. Thousands of years later, the teacher's life and wisdom are still actively revered, while the kings, queens and powerful are at best a line in a history book no one reads.

Spirituality is a dormant possibility in each person. It is a process of expansions of identity until he realizes he is participating in a larger life than his separate, anxious, self-absorbed personality. This state of affairs always existed, but now the person realizes it. This "larger life" may be described as God, but the 12-Step programs are careful to say "God as you understand God" (Alcoholics Anonymous, 1976).

In our experience, enduring spiritual development only takes place through direct experience. Clients 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 that lasts comes from lived experience.

Every person in recovery has already had at least one spiritual experience. It is recovery itself. Recovery is a miracle, a religious experience, a life saved from self-hatred and self-destruction. The question is how to aid the continuation of the spiritual discovery process.

### **Choosing A Spiritual Path**

With the availability of worldwide spiritual information, the contemporary person can fashion their spiritual path from many diverse influences. For example, we have a client who starts with ten minutes of yoga stretching and then visualizes her “higher power” (a 12-Step concept) as Jesus and dialogues with the visualization. Even the traditional clergy, for example, some Roman Catholic priests, are now integrating Zen breath meditation and “Christian” mantra into their retreat work.

Professionally and personally, we have examined countless numbers of spiritual paths. After the examination of many Eastern and Western spiritual maps, the authors found in Dante's spiritual classic, *The Divine Comedy*, a comprehensive view of the stages of the spiritual journey. Dante's hero, the Pilgrim, goes down to hell to identify patterns of suffering (e.g., indifference, rage, addiction, etc.), then climbs the mountain of purgatory to learn how to liberate himself from these life-defeating patterns, and then begins his discoveries of higher states of awareness in paradise. Dante emphasizes two higher states: the discovery of guiding inner wisdom; illuminations into the underlying essence of reality. Wisdom and illumination in turn lead the Pilgrim to deeper

and deeper feelings of harmony and, finally, to his enlightenment when he merges into "l'amor che move il sole e l'altre stelle" (the Love that moves the sun and the other stars).

The authors found it intriguing that all of the Pilgrim's illuminations are experiential insights into the energy that underlies all life. Dante utilizes many descriptions of radiance and light to describe this all-pervading energy. Although considered a Medieval 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, a view also consistent with both Hindu cosmology and the current scientific discoveries of quantum physics.

Therapeutically, the authors have utilized the Dantean concepts of inner wisdom and illumination as ways to help clients along the spiritual journey. These two spiritual discoveries are detailed elsewhere (Schaub & Schaub, 2003), and safe, effective, time-tested methods within the therapy setting can be employed to introduce clients to these subtle realities. The methods are always introduced in an open, scientifically-minded exploration, and can only be applied by therapists who themselves have explored and are familiar with these discoveries. Our own inspiration, Dr. Roberto Assagioli, clearly sets the standard for this attitude: "...we hope to see developed...a science of the spiritual 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." (Assagioli, 1965, p. 194).

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

### **Summary**

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

1. All people are vulnerable, but people who feel a greater degree of vulnerability are drawn to drugs and alcohol as a remedy.
2. Addiction is an obsessive-compulsive cycle of drug/alcohol use driven by the need to gain relief from vulnerability.
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 new sober pattern of thinking and behaving.
5. Since the addiction was suppressing vulnerability, the end of addiction will cause vulnerability to be a primary problem again.
6. People in recovery begin to heal by recognizing and respecting their vulnerability, and advanced 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 emotional knowledge alone. Advanced recovery requires the development of an expanded, spiritual sense of identity. Such spiritual development is most effective when it is based on direct experience.

8. Safe, effective, time-tested insights and practices can introduce the client 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 client in the transformation of suffering into a purposeful and spiritual life.

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