ADDICTION AND MEANING[1]1

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Human beings are beings of meaning; we seek meaning in our lives and for our lives. Existential theory and practice proposes that we are beings faced with the responsibility of making free choices, choices designed to support each of us to live an authentic life in relationship with self and other. Those suffering in a life of addiction cannot experience life authentically, and suffer from a loss of meaning. Existential Analysis offers specific treatment methods designed to help individuals, through the activation of will, to be released from the bonds of addiction, so that they can live meaningful lives freely, responsibly and authentically. Two such methods include: the Meaning Searching Meth.

The case study offered here demonstrates these methods in practice.

Key WordS: addiction, case study, meaning, methods, wilod, and the Horizon of Life Problem Method.

SUCHT UND SINN[1]

Der Mensch ist ein Wesen des Sinns, wir suchen Sinn in und für unser Leben. Die Existentielle Theorie und Praxis stellt es in den Raum, dass wir Wesen sind, die mit der Verantwortung konfrontiert sind freie Entscheidungen zu treffen, Entscheidungen welche dafür konzipiert sind uns dabei zu helfen ein authentisches Leben in Beziehung mit dem Selbst und den Anderen zu führen. Jene hingegen, welche an einer Sucht leiden, können. Authentizität nicht erleben und erleiden einen Sinnverlust. Die Existenzanalyse bietet spezifische Behandlungsmethoden an um Individuen zu helfen, durch die Aktivierung des Willens, sich der Ketten der Sucht zu entledigen um ein sinnvolles Leben in Freiheit, Verantwortung und Authentizität leben zu können. Zwei solche Methoden sind: Die Sinnerfassungsmethode und die Methode des Lebenshorizontes. Das hier angeführte Fallbeispiel veranschaulicht diese Methoden in der Praxis.

SchlüSSelWörter: Sucht, fallbeispiel, Sinn, Wille

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Dieser Artikel beschäftigt sich mit dem Inhalt der Präsentation der Klinischen Anwendungen der Existentiellen Grundmotivationen auf dem Weltkongress für Existenzielle Psychotherapie in London, 14.–17. Mai 2015.

WHAT IS ADDICTION?

Certainly there are myriad hypotheses as to what addiction actually is, and there are just as many thoughts as to causes. In Existential Analysis (EA), we see addiction as the simultaneous experience of an imperative that has a powerful driving character, which forces an attraction to an object or substance, while simultaneously offering the affected individual an experience of powerlessness in the face of a subjective deficit.

Unquestionably a hallmark of any addiction is suffering. What, from an EA perspective, does the addict/person suffer? 1) A loss of freedom 2) an a-personal behaviour, which I liken to being alienated from oneself; there is no relationship in addiction because it is not possible to be in authentic relationship with something.

EA sees the cause of addiction as a dynamic process. The addict/person finds herself caught in a paradoxical nightmare of experiencing something that feels like both a desire and a compulsion. She finds herself drawn toward the addictive 'thing' and quite often convinces herself that it is a good thing, a necessary thing (I will just have one; I earned this reward; no one will know etc.) only to be filled with abject remorse (How could I have done that again? Who did this to me? What was I thinking? I promised myself that I would never do that again).

For the addict/person there is an inner existential emptiness that he needs to fill in order to gain life (relief, courage, joy, numbness etc.), but this proves to be short lived. I liken it to trying to hold water in a colander. We can make a colander appear to be full, but only with a constant, powerful flow of water, and the addict/person simply cannot keep the flow turned on forever.

Earlier, I mentioned that the addict/person also loses freedom, and this is experienced in varying degrees with every addiction. Think of life as 360 degrees of possibility. These freedom degrees, if you will, are really only a pseudo possibility because of influences like our specific biology, culture, socio-economic status, trauma and attachment experience. The further one falls into the addiction, the less freedom there is available. I have worked with men and women who, from the outside, would seem to have almost no freedom as they spend hour after hour and day after day smoking on their crack pipes. The orbit of the addiction becomes so very tight that it appears that the individual has lost all will.

Will is of course an interesting and crucial component of any treatment plan and it is so very hard to address and activate in the addict/person What we know in EA is that the person cannot actually fall ill (see Frankl 1985), so it is a given that behind every addiction lies a neediness, an emptiness, a seemingly insatiable hunger. Addiction simulates greediness for life by gulping in pseudo external nourishment because the addict/person is unable to find that nourishment from within. The addict/person engages in the addictive behaviour and there is a false, temporary sense of fullness (absence from pain, trauma, loneliness etc.), and when the colander empties the addict/person suffers all over again with each progressive experience taking the addict further and further away from the person.

Perhaps the greatest flaw that I have witnessed in providing more than 12500 hours of therapy – a significant portion of that time working with people in addiction – is the lack of the treatment provider's complete skill set. Thousands of counselors and therapists are trained in disease model addiction treatment modalities only, and they take that training into a field that is incredibly complex. I have never, not once, worked with someone who was experiencing a stand-alone, sui generis, addiction. In every case there has been some concurrent disorder. Thankfully, training in EA can help us prepare to deal with these disorders as they appear across the four fundamental motivations (Längle A 2003a, 52 ff.). There are times in treatment when anxiety is dominant (FM1), when depression crushes the therapeutic space (FM2), and when personality disorders, and/or trauma take precedence (FM3). One must be able to recognize what presents strictly from the addictive behaviour, what might have anteceded the addiction, and what obstacles might prevent the person from strengthening and moving forward. Addiction is a temporal disorder; it offers a shameful past, a fettered present, and a seemingly hopeless future. In a true addiction treatment setting the existential therapist will be equally at ease moving through each FM in a skillful, seamless manner. Yes, we keep the addiction in our line of sight, but we cannot let it blot out the sun so that we miss phenomena that need to be bracketed and treated. Interestingly, I have helped more than one person leave an addiction by helping him or her with debilitating anxiety, depression, and/or trauma. Once people feel safe in life, once they can find a value in living, once they have a better understanding of self, they can sometimes simply walk away from the addictive behaviour.

EA TREATMENT OF ADDICTION AND MEANING

History

Early on in the sessions (usually by session two), I let the client know that I will be on a bit of a fact-finding mission. I want to discover how she is imbedded in her world, so that I can get a picture of the addiction pathology, but also so that I can get glimpses of the person beneath the addiction. I will typically follow a pattern of asking:

- When was the substance taken;
- Which substance;
- How often;
- How much;
- For how long;
- To what effect;
- Under what conditions;
- Alone or with others or both;
- Did she have his own idea as to why she used;

• Was it loneliness, shame, guilt, for fun, to ease physical pain, difficulty in a relationship, a reward, a hunger to feel life, peer pressure;

• When did she start, under what circumstances; and

• Was there a family history of addiction?

This phase of treatment is crucial for a few reasons. A thorough history is never a waste because without the history we have difficulty seeing the phenomenon as it is. A telling of the history allows the patient to hear himself describe his own life to another, and begins the possibility of insight, and it also begins to create the ground for the building of the therapeutic relationship. I then establish a formative contract with the client so that we can establish what his goals are. Keep in mind, his treatment and his goals are his and not mine. Because abstinence is the model that I use for myself (and one that many others choose) it does not mean that it is the best approach for every client. As Alfried Längle explains 'this teaches the patient to become responsible to himself and another. It begins training in keeping one's word both to self and another.' If mistakes are made in the contract phase – and they almost always are – we use them as an opportunity for learning. Typical **things in a contract might include: harm reduction plan, a removal of the substance from** the home, an agreement to stay out of the bar, planned delays so that the client does not go straight from impulse to use, informing other people about the treatment plan etcetera.

One of the most effective methods that I use with clients includes the idea of establishing a dialogue of ambivalence (Miller & Rollnick 2012). Miller and Rollnick's work was actually a springboard to a method that I have developed that opens an arena for a dual dialogue. As we know ambivalence is being of two minds, and early in treatment the patient often feels that there is only one voice, the voice of the addict. Part of the work of treatment is discovering the essence, the true voice of the individual, so that we can see the voice of the addict and the voice of the person are in fact diametrically opposed.

Freedom From and Freedom To

One of the terms that come up again and again when I am working with addicts is the idea of imprisonment. The patient talks about feeling that she is compelled to use, forced to engage in a behaviour that goes against his best interests. I hear about how the addiction occupies the patient's waking and even sleeping mind. Certainly one goal of treatment is to help the patient achieve freedom from the addiction, but we must also help her to discover the freedom to live life, to experience relationships, to rediscover the authentic person. Here we think in terms of FM2. What do you like? What have you liked in the past? What do you imagine you would like? How can you find more value in your life?

Meaning, Personal Existential Analysis, and Will

Remember that the patient is under the illusion that they have no will. They feel compelled to use/act addictively. A fundamental tenet of EA is that the person cannot act against his or her will. We therefore need to search for explicit, specific meaning as to why

someone wants to change the behaviour. What motivates this person, at this time, to leave the ersatz life of addiction? We need to help them become clear as to the reason for change.

Meaning, or its lack, comes up directly in therapy, and it often appears both ontologically and individually. The patient will say something like: What is the point of any of this? I just can't see any meaning in life. I don't see any meaning in what I am doing here? What am I doing with my life? In EA we attempt to engage the patient by employing two practical methods to help find meaning (Längle S 2003, 87).

The Meaning Searching Method (MSM)

1. **Perception**: What are the facts? What are the possibilities within those facts? How can we loosen from wishes, anxieties and pure ideas?

2. **Evaluation**: What feelings are present? What are my values? How would I rank them? Where do I feel a connection in relationship? We are trying to have the patient let go of the pure cognitive assessment of the problem;

3. **Selection**: I am sensing my essence, which puts me in a place where I can make a choice. I can begin to respect the consequences of that choice. I can start to loosen my- self from old habits, fixations and passivity; and

4. **Action**: Here I begin to bring myself into play. I realize that my life is my responsibility. I develop a means, a strategy, an experience that gives my life personal structure, and I take the risk of stepping back into life.

Horizon of Life Problem

1. **Reference to the loss**: What happened? How did you lose meaning? Do you have your own hypothesis?

2. **Taking up the lifeline**: What was meaningful in your life? What would you have liked to do earlier? Do you have an explanation for this feeling?

3. **The existential turn**: What are the questions in which you find yourself? Is there anything waiting for you? What is the challenge of your life? What is life asking of you?

There are two other therapeutic techniques that we use in existential therapy when working with addiction:

1. **Self-Distancing**: help the client to experiment with the idea of self-distancing. In this case, we try to find out where the client might already have established some distance from his addictive behaviour. When does he not use? When does something in life occupy him? A job? A hobby? Reading? Watching movies? Again, the idea is to explore times in the client's life when he is occupied by something other than engaging in the relentless cycle of addiction;

2. **Self-Acceptance**: There are times when we find that our client is trapped in the reality of FM1. He CANNOT. If, at the current moment, he cannot disengage with the

addictive behaviour, he can at least come to some kind of consent. Instead of battling, shaming, using, battling, shaming, using, the client can say, “for now, I will accept that addiction is part of my life, and I will accept the consequences that go with engaging in the behaviour. I choose to use is existentially healthier than abdicating responsibility for my actions. I am no longer driven by some demon.”

Will

We think of will, in EA as a continuous process, which is carried by the emotion, conducted by the inner sensing and confirmed by the reason (see Längle A 2003b). The process of the will includes: getting moved by an appeal (being touched by a value); selection and coming to a decision (the will grows by separation and choice); resolution to unlock its power and an inner consent to a chosen value; and the action or execution of a resolution (as opposed to a reaction). We experience our will as liberating, relieving, enforcing, giving clarity, asserting and making a path. Will is identical with ego. My will is me (hence the person cannot do anything that is counter to his or her will). Will is the resolution to get involved in a chosen value. It always implies a value; it is represented in a feeling; it is judged as good; always has a why; has more value than that which I have left behind; and implies a readiness for effort and activity.

People often misunderstand the will by thinking it is rational or logical or about moral conscience, but will is riding on the back of feelings. It is directed by the moral conscience and it is controlled by the reason.

Look at all now that is moving in you and what should be done in response:

What is the inner movement?

What would be mine if I did this?

What would correspond to me?

There may be emotions leftover from last step of PEA2:

What feelings come up, what is the most important? What connects to the felt sense?

This is checking what responses are important and which most correspond with the values.

Do I live for that hour? Do I really want to do it?

It doesn’t have to be realistic at this stage, just what is the movement, what the natural desire or response is. There are no expressions yet of possible limits or concerns.

You leave the client alone when you as a therapist don’t know what you would do. You must, as a therapist, know what you would do f you were them, what matches your will; this is true accompaniment.

After realization of the will, I go to the details and this is to make things real, to make it happen:

• What specifically do I want to do?

- With whom to be involved?
- How? What are the tools and means?
- When? What time do I need to prepare?

A Case Study – Dave

Dave showed up at my office with a puzzled look on his face. He explained to me that a medical professional had referred him after overdosing on ketamine on the weekend. He said that it was the first time he had ever done the drug, but admitted readily that he had a longstanding relationship with both cocaine and alcohol. He told me he was 35 years old, and he mentioned that his wife was in the waiting room with their young child, and he said that he was terrified that she was finally going to follow through with her threats to leave him. He admitted that she had almost gone a number of times, usually as a result of him going on a three day 'run', and once because she discovered that he was sleeping with someone else. Dave put his elbows on his knees, covered his face with his hands, and sobbed, "I gotta get this straightened out. I am afraid that if I lose my family that I will kill myself, maybe not intentionally, but by overdosing again, or maybe getting stabbed at a party. Man I have told myself a hundred times that I have to stop, that I can't afford to keep doing this, but after a few days I just end up right back at it again. I don't know who I am anymore."

In this case study, I will focus on applying the meaning searching method and horizon of life problem method with Dave. I tend to fold in the horizon of life questions within the meaning searching method.

Perception: The facts in this case are reasonably clear. The client overdosed on ketamine, and he admits to having a long-standing (over fifteen years) addiction to cocaine. Dave admits that he spends thousands and thousands of dollars yearly on his habit, and is concerned that his wife will leave him, and that his use will eventually cost him his job. During the fact gathering part of our work, Dave also admitted to me that he had lost both his mom and his dad to heroin overdoses. In telling this part of his story, Dave seemed to get an awakening of sorts as to the temporal nature of the things that addiction was bringing to his life. He could see the past losses, the current loss, and the possibility of greater loss ahead.

Evaluation: Dave told me that he felt deeply ashamed of himself and of his behaviour. When asked what his values were, he told me that he used to know, but he wasn't really sure anymore. He explained that he had always felt that his family was the most important thing to him, and that it was also extremely important that he be seen as a good boss and employee (he had a few dozen people working under him). He said that he felt scared that he might never stop his pattern of using, and feared that would lead to him losing everything that ever truly mattered to him. He cried while telling me that he really did love his wife and child, but he wondered if he could ever love himself again, and he wondered if maybe it was too late.

Selection: Dave was an interesting client in many regards, but it was in his ability to sense his essence even after two decades of acting addictively that made him accessible. Within a couple of sessions, we were able to explore a time when Dave had promised himself that he would never follow in the footsteps of his parents. He was able to clearly recall what he was like at the age of twelve, and he immediately saw that he was never 'destined' to be an addict. Over the next two sessions, we traced his beginning use, and we charted (actually graphed) his use in a way that demonstrated the negative correlation of use to value, and he felt immediately empowered when he witnessed the addict slowly taking over his life. He pounded on his knee at one point, and said 'son of a bitch! I am not going to let that bastard run my life anymore.' This was a crucial statement. Dave saw the damage, he understood the connections, and he got in touch with a part of himself that only a few weeks ago, he feared might be gone forever.

Action: I remember as if it were yesterday when Dave said, "Ok, I got it. Now what do I do? Where do I start? What kinds of things do people do when they get to where I am? Should I go get treatment? Should I go to NA? I need to be coming to see you at least once a week.' Notice the 'I' statements.

As you can see, Dave was ready to do battle; he was ready to re-engage in life. He believed that his will belonged to him and not to the addict. He understood, and repeated to me in his own words the fact that he had to orient himself to a life that had value. For Dave, value was his family, his work, his friends and his reputation. He was able to see that his life in addiction was no life at all, and we used these things to strengthen his will. He, to quote an old saying in addiction, was sick and tired of being sick and tired. When I asked him what he thought life was asking of him (we had looked at the existential turn, and he saw quickly how he needed to approach his life differently), he told me that his life had been empty too long, and that he was itching to live a life 'that mattered. I want my wife and daughter to be proud of me, and maybe just as important, I want to be proud of myself. I think that life is actually telling me that I need to wake the hell up. Maybe it's asking me, what took me so long to see what mattered because it was right in front of me all along.'

Our next step was a straightforward one, and it is a step that I do not skip in addiction treatment. Dave was ready to do something, but he wasn't sure what that something might entail. We spent a session going over the different ways in which he could get help for his addiction – some- thing referred to in the motivational interviewing literature as designing a menu (Miller & Rollnick 2012) – including: building a harm reduction model, in patient treatment, out patient treatment, day treatment, and a traditional 12 Step/Self Help disease model focus. Dave felt that he really needed the support of a group of people that suffered from something similar to him (the local chapter of Narcotics Anonymous), and he also felt that he would benefit from coming to see me every two weeks for a year (the year was his contract with me and with himself). He also thought that it was a good idea for his wife to get counselling from someone who understood addiction, and she agreed with him wholeheartedly and I made a referral to someone I trusted. Every two months, the four of us would meet together to assess progress and potential problems.

I met Dave almost seven years ago now. He was actually he very first client that I worked with using Alfried Längle's specific addiction treatment protocol. I think that the first workshop of Alfried's that I ever attended was on Addiction and Meaning – and the notes I took during that lecture have informed so much of this article – and I can remember to this day how it resonated within me. Dave has been clean for the full seven years. He did smoke marijuana for a few months in the third year of treatment, but decided on his own that it really did not add anything to his life, so he stopped. His daughter is doing well, and his wife is thrilled to be with 'the guy that I knew was in there all along.' The family is long since come out of debt, and they are saving for a cottage. Dave comes to see me three or four times a year 'just to make sure I'm being brutally honest with myself' he says. Existential Analysis is a thorough, effective, and comprehensive theory and practice that offers the practitioner concrete methods to help patients suffering from a life in meaningless addiction.

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WEITERBILDUNGSTERMINE

Weiterbildungscurricula:

Neue Gruppen

Traumatherapie

Leitung: Dr.in Liselotte Tutsch, Dr.in Luise Reddemann, Mag.a Renate Bukovski, MSc

Salzburg, S: 15.–17.4.2016, 1.–3.7.2016, 2.–4.9.2016,

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Vöcklabruck, oö: Start einer neuen Gruppe 2017

1. Wochenende: 24.–26.2.2017,

Fr 16:00 – So 13:00 Uhr

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