Gestalt Therapy for Addictive and Self-Medicating Behaviors

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Philip Brownell, MDiv, PsyD, is a licensed clinical psychologist in North Carolina and Oregon and a registered psychologist in Bermuda. He is an ordained clergyman and writes a weekly column on integrative issues for The Royal Gazette, Bermuda’s largest daily newspaper. He is currently a staff psychologist at Benedict Associates, Ltd., where he offers a broad range of assessment and counseling services to child, adolescent, and adult populations, including individual, couple, family, and group therapy. He is the editor of the Handbook for Theory, Research, and Practice in Gestalt Therapy (2008), author of Gestalt Therapy: A Guide to Contemporary Practice (2010), coeditor of Continuity and Change: Gestalt Therapy Now (2011), coeditor of Gestalt!, the official journal of the Association for the Advancement of Gestalt Therapy (AAGT), associate editor of The Korean Journal of Gestalt Therapy, journal of the Korean Gestalt Therapy Association, a consulting editor at the European Journal for Qualitative Research in Psychotherapy, and cochair of the AAGT’s Research Task Force. He is a member of the New York Institute for Gestalt Therapy, the American Psychological Association, and the AAGT.
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Philip Brownell, MDiv, PsyD
This book is dedicated to

The Brownells of Lemon Street
and Mississippi Bar:

Warren, Barbara, Philip, Cathy, Mark,
Jeff and Tim–A petri dish of creativity!
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Other people—Michael Clemmens and Helga Matzko come to mind—have written about a gestalt therapy approach to addictions. I am indebted to both. However, what I wanted to write was an application and extension of some of the things I had written in the preceding volume, *Gestalt Therapy: A Guide to Contemporary Practice*. I hope that this book will build on that in a way that provides therapists and counselors in substance abuse and addiction fields a guide to help them develop a way of doing gestalt therapy with their clients.

I became firmly convinced while working on a dual diagnosis (co-occurring disorders) intensive care unit when I was in my doctoral program that gestalt therapy is a very useful way to do treatment with substance-dependent clients. It is not at all the confrontational and alarming approach popularized in the late 1960s. Although I had seen it used effectively in a unit at the Oak Knoll Naval Hospital in Oakland, California, at that time, I have since learned its theoretical base and its relational and supportive nature. Gestalt therapy, to me, has all the best of where many current psychotherapies are currently headed in their evolving convergence.

I also chose to write about this area, recovery work, because I have some personal history here. I grew up in an alcoholic home and learned what many know as a codependent way of conducting relationships. I did my own therapy around that (and other things); such is what psychotherapists are expected to do, but I also did it because I wanted to live better. So, I believe it is a worthwhile field to spend time writing about.

Many people choose to learn and practice gestalt therapy because they have been with a gestalt therapist for their personal work. I did
not. I learned gestalt therapy because I had already been around it, and I realized that it made the most sense to me. So, I just felt the two of these streams came together at a point in time: my personal history and my convictions about the value of gestalt therapy.

Isn't that the way a lot of these kinds of things go?

I hope the reader will make a project out of reading this book. There are many contemporary gestalt therapists who are writing, and it is possible to work with most of them to augment this book and the previous one with personal, face-to-face training. Those from outside the world of gestalt therapy are referenced because in some way the work they have done converges with, is in consilience with, or complements the gestalt approach.

As a byproduct of the way I have written and the associations I have made to other practices, I hope the reader will also sense how relevant gestalt therapy is. In many cases, I do believe the research that has been carried out on some other approach can be said to apply to gestalt as well, and that is because the two, in some central way, share an essential and salient feature.

As I put the finishing touches on this book, I write from Southampton, Bermuda, where a tropical storm is brewing in the Atlantic, and we are finally getting some much-needed rain. The tree frogs are happy, and they are singing in a noisy chorus. In the next week, I intend to take my wife and rediscover the beach, the warm water, and the beauty of this place. Perhaps, we will watch the parrot fish splash near the surface as they chip away on the rocks. The beauty of this place is so intoxicating that one could become . . . well, addicted.

*Philip Brownell*
Of course, I thank the people at Springer Publishing Company—Jennifer Perillo and Kathryn Corasaniti. Thank you for dealing with what I sent you.

Most of all, I thank my wife Linda. She is a people person who put “both of us doing things with people” on hold while I hung out with the computer. She hates to be stuck in the house, so she spent a lot of time doing things on her own outside and away, not wanting to bother me when I was writing. I am looking forward to us rediscovering one another. She is a wonderful person, and all my friends in the world of gestalt therapy who know her can truly get behind the phrase “his better half.” She is more like my better 75%.

I also think of the people I knew along the way in my own recovery, and that brings to mind Dennis Henderson. Hi, Dennis! Thanks for all your help.

I would like to acknowledge my parents Warren and Barbara Brownell who have both passed out of this world. Thank God, truly, that I was able to reconnect with you.
I grew up in an alcoholic home. My mother would drink beer and wine, and she would impulsively embark upon projects and adventures that required the rest of the family to accommodate her. Many times we would be off in the middle of the night after she had been drinking. Once, she was determined that we needed to drive from Sacramento to Oakland, California, through dense valley fog, to see my grandmother. We could not see much past the front fender, and we were going about 65 or 70 on the interstate. I was terrified, so I demanded to drive in order to keep us safe. I was only fifteen and a half with a learner’s permit.

Another time she and one of her drinking buddies were laughing it up at the house, and she told me to kill some chickens for the barbecue. We had raised about 120 chickens, and they were all of age to be eaten. I had a friend over to spend the night, and I was mortified that my mother would be drunk in front of him, so I asked in a disgusted tone of voice, “How many do you want done?” She must have thought that I looked funny, because she and her friend looked at one another, laughed, and then she said, “All of ‘em.” So, my friend and I wrung the necks of all 120 chickens, and then everyone in the house spent the rest of the night plucking feathers and cleaning chicken carcasses so we could put them in the freezer.

Things were clearly out of control at times in our house. Sometimes, I could not contain myself and I would let her have some of what I really thought. I will never forget becoming upset when my parents came through the door one night; my mother was drunk, and I let her know I did not like it. She cried out that she wanted me to respect her, and I said, “How can I respect you, when you act like this?” That is when I flopped down in a chair to sulk, and my father came and stood
over me, shook his head, looked disgusted, and said, “When are you ever going to learn?”

I learned. I learned to be hypervigilant. I learned to get myself out of the way. I learned to take advantage, and when I was an adolescent and wanted to fit in with my friends, I learned how to sneak my mother’s horribly tasting cheap wine out of the house so we could get drunk together.

I compensated for what I learned by trying to achieve my way out of my past, and I became a professional people helper.

Does not all this sound inspiring? I am an adult child of an alcoholic, but I do not wear that as my chief identity. I spent several years in therapy and read many recovery books, including many about codependency, and so I know that part of life. I am familiar with the scene, and I chose not to stop there.

My mother eventually quit drinking. She went to rehab. She attended AA meetings. She also worked her way beyond mere sobriety as a goal, and eventually she moved on. Her primary identity was not that she was an alcoholic. She found a life beyond recovery, and to me that is the chief aim of recovery. If one is truly recovered, one does not simply replace one compulsion for another.

In a way, then, recovery is paradoxical. If one is successful, one finds him- or herself in another universe. There is life beyond meetings, sponsors, working the steps, and rehearsing continually one’s fail-safe cards and correcting thinking errors. Relapse does not occur any longer, so one is no longer reminding oneself of the steps in the relapse cycle. One has actually recovered. One is not still in recovery. One has moved on and found life. Recovery is paradoxical because you achieve real recovery once you are no longer in need of it.

I know that this runs counter to the idea that addiction is a disease in which the addict has no control, and that one needs to follow the steps, keep coming back to meetings, make oneself accountable to at least one other person (like a sponsor), and constantly be vigilant to protect oneself from relapse because one is never really over this disease. I believe these things, and other kinds of things that are part of a recovery program, are needed at one point in the process. A person might never actually get beyond that point, and so, for such people, these are needed perpetually. However, I do not believe that one is truly recovered until one no longer needs “recovery.” In a sense, then, you achieve it by no longer aiming at it.

This book is a gestalt therapy approach to working with people who suffer from addictive and self-medicating behaviors. It is not a paint-by-numbers approach, a cookbook with recipes to prepare a therapeutic
dish or a workbook that people can fill in the blanks and learn ten ways to overcome addiction. It is a description of what a gestalt therapist might do working with clients who are addicted and want to begin in recovery (or continue beyond sobriety).

There are several parts to the book.

Part I covers the need to change. People need to change, but do they want to change? People need to change, but do they think they can change? What is this thing called recovery anyhow? Part one is a basic orientation to the field.

Part II covers a basic orientation the field of gestalt therapy. It is only a basic summary, but it is one that goes to the core of what contemporary gestalt therapy is all about. The reader is advised to consult the preceding volume (*Gestalt Therapy: A Guide to Contemporary Practice*) and the other references noted in the text.

Part III describes a structure; it is an outline of a possible program or way of thinking about and organizing one’s recovery. The goal as I have identified it in this book is to actually recover. That means accomplishing what corresponds to that threadbare advice: “Get a life!” One’s life is filled with interest, possibility, and the presence of whole worlds of experience and existence. This could be a starting place.

The final part is a series of brief reminders: live in the present, work your own program, trust in the process, and utilize your recovery community.

That’s about it. There are volumes on the finer points of gestalt therapy and addictions work. This is not an exhaustive treatment of either. Hopefully it is a significant contribution that will help people think and help therapists work thoughtfully with their clients.
The Need to Change
The Nature of Addiction and Self-Medicating Behaviors

When I meet people to do psychotherapy, I try to focus on that meeting. The focus is not what I want out of the meeting but what the client wants. What does any given person think he or she might accomplish by coming to a therapist? Just as therapists know that therapy is the client’s work—that the client must do personal work and work hard to face things previously not faceable—the goal or hope in doing such work must also belong to the client. That is why I try to focus and even re-focus as the work unfolds to make sure the client gets to where he or she wants to go, or for that matter, so that the client begins to realize what he or she actually wants.

Whenever I have asked people what they want in life, many people say they want to be happy. However, only a few know clearly what that means for them. Nevertheless, various psychotherapists would attempt to work with the client to reach the desired goal. A cognitive therapist would explore the way the client thinks in order to detect faulty thinking patterns that disrupt the client’s happiness. A relational psychoanalyst would explore the connection between the client and him- or herself under the assumption that the way the client relates to the therapist is the way the client will relate to others, and that relationships, going way back to an infant’s first attachment, are the bedrock of happiness. A behaviorist will utilize and multiply the activities and behaviors that bring the client pleasure and shape the client’s life through
reinforcement. A solutions-focused therapist will fantasize with the cli-
ent what might make the client happy, and then together they would
devise a plan to travel the shortest distance to that goal. A gestalt ther-
pist would establish a meaningful relationship with the client to explore
the client’s subjective experience of life, how the client makes meaning
out of experience, and how the client connects with others in relation-
ships, and to bring to the client’s awareness the patterns by which the
client does whatever he or she does, trusting the client to make creative
adjustments, with increased awareness, that would lead to happiness.
However, none of these approaches is guaranteed to produce
happiness.
The psychiatrist and the drug dealer have another answer, though,
and that is to alter the brain chemistry: “Take this Valium, and then
you’ll be less anxious, and perhaps then you will be happy.” “Take
this lithium, and then you will be less given to mood swings of mania
and depression, and then perhaps you will find happiness.” “Take this
Zoloft and over time your mood will be less depressed; you will be
happy.” “Smoke this weed.” “Sniff this cocaine.” Many people who
cannot afford prescription drugs self-medicate through the use of
street drugs, but these “solutions” are not long-term solutions; at best
they manage a given disorder that remains intact. Just as a diabetic
must take insulin to maintain metabolic equilibrium, some people
with mental disorders must take their medications to stay in balance.
But does that make them happy?

It’s about 7:30 pm on the locked unit. People have had their evening
meal. Some have settled down to watch television in the group room.
Others are sleeping already in their beds.
We used to take people out for cigarette break, but that doesn’t hap-
pen anymore. Smoking is dangerous to the health, and nicotine is an
addictive substance. It makes no sense to advocate a recovery motif,
including the non-support for addictive substances–but then to support
smoking. Although it is annoying to have to fend off the complaining
and whining about not being able to smoke, no staff members want to
escort the patients onto the landing and stand in their midst while they
smoke, nor for that matter to deal with them when they beg for a second
cigarette. Inside, nobody looks at the methadone being handed out. As
with the nicotine, we don’t want to think too deeply about supporting
one habit while complaining about another.

Occasionally, people are admitted for treatment precisely because
they have become addicted to medication that has been prescribed in
an entirely legal fashion.
Some are addicted to analgesics (pain medication); what started out as a natural response to back injury or surgery obtained a power of its own. The morphine (also known as MS Contin), meperidine (Demerol), oxycodone or oxycontin, or hydrocodone (Vicodin) assumed control. The pain sufferer developed tolerance, became dependent, and then realized he or she had become addicted.

Others are addicted to anxiolytics (antianxiety medications). The alprazolam (also known as Xanax), chlordiazepoxide (Librium), clorazepam (Klonopin), clorazepate (Tranxene), diazepam (Valium), or lorazepam (Ativan), and the sedatives such as amobarbital (Amytal), pentobarbital (Nembutal), secobarbital (Seconal), or tuinal (which is a combination of amobarbital and secobarbital) that they are prescribed obtained powers of their own. An anxiety-prone person, often unable to sleep at night, first found relief and ability to rest at night and then developed dependence and tolerance, and became addicted.

What is happening in a person who uses some kind of substance or repetitive and compulsive behavior to make him- or herself happy, to overcome bad feelings, or to attempt to manage something that has become unmanageable? At what point in the process does that person become addicted? What is addiction? What does it mean to self-medicate?

DEFINITIONS

The constructs of “addiction” and “self-medicating behaviors” overlap. For some people and in contexts of discussion they refer to the same thing. On the one hand, a very strict understanding of addiction requires physiological dependence upon one or more illegal drugs (DiClemente, 2003), tolerance, and withdrawal. On the other hand, a wider understanding identifies addiction as being anything in which people are consumed with behavior that becomes centrifugal in nature, that is, forcing other parts of life to the periphery of living (Alexander & Schweighofer, 1988).

Some people believe that an addiction is apparent when there is a loss of control over the use of a substance or the repetition of behavior, and continued use of this substance or behavior persists in spite of negative consequences and attempts to quit (Henderson, 2000). In such cases, one’s life becomes unmanageable, and the addicted person faces unwanted consequences that result from the overuse in question (Matzko, 2007). It is as if the substance or the behavior has control of the person rather than the person making choices and choosing to use or behave in a certain way. Indeed, this is the assertion of step one in
the now classic list of twelve steps used in many treatment approaches (Alcoholics Anonymous, 2002).

Self-medicating behaviors are soothing in nature; they include features of addiction, but they are primarily relieving and psychologically reinforcing. They can include eating, sex, drugs, spending or shopping, and gambling. When self-medicating overlaps addiction, behaviors can include substance abuse, internet addiction, and co-occurring issues such as eating disorders and compulsive gambling. (Wilson, 2010; Young & de Abreu, 2011; Slutske, Piasecki, Blaszczyński, & Martin, 2010).

Gorski (1989) claimed that addiction includes the effects of the substance and the way in which the addicted person thinks about using or behaving. The thinking problem includes irrational thoughts, unmanageable feelings, and self-defeating behaviors; consequently, the cognitive category alone (the way a person thinks about the substance) is inadequate to address what is actually a whole-person process, but Gorski’s observation that addiction is a matter of the effects of the substance and the way in which the person orients to the substance is useful.

Carlo DiClemente (2003) claimed that there are three critical dimensions to addiction: (1) the development of a well-established and problematic pattern of using a substance or self-medicating that is pleasurable and reinforcing, (2) physiological and psychological features that constitute dependence, and (3) the interaction of these things that makes the behavior in question resistant to change. The term dependence shows that

the pattern of behavior involves poor self-regulatory control, continues despite negative feedback, and often appears to be out of control…

…failure to change, despite the outward appearance that change would be both possible and in the best interest of the individual, is considered a cardinal characteristic in defining addictions.

(DiClemente, 2003, p. 4)

The journey from use to abuse and then to dependency is “related to the person’s capacity to interact with others and his or her ability to tolerate sensations such as frustration, anger, and fear” (Clemmens & Matzko, 2005). The addictive and the self-medicating character of these behaviors become so recurrent and habitual that they constitute a procedure in living. Addiction and self-medicating behaviors are the first options an addict turns to under virtually any kind of stimulation (Clemmens, 1997, 2005); it is what he or she does as a way of life. Addiction absorbs elements of a person’s horizon, reducing potentialities and possibilities to a small repertoire of options.
Another way of understanding addiction and self-medication is to comprehend the larger contexts, what gestalt therapists call the field (or fields), in which they occur. More will be said about field dynamics in a subsequent chapter, but at this point it is enough to say that addictive behaviors are complex disorders that develop through multiple processes that are biological, cognitive, psychological, and sociocultural in nature (Donovan, 2005). Thus, addiction and self-medicating are never one-person processes, as if the problem belongs to the addict alone. They always involve other people even though the addict or self-medicating person remains responsible as the agent of behavior for whom the use of a substance or the use of some kind of action serves some purpose. Addiction and self-medicating behaviors are functional and relational.

This brings to mind the differences among various constructs when thinking about addiction and self-medicating. Some view addiction as a disease, and in that case one either has the disease or one does not, regardless of how much or how little one uses medication. The first journal dedicated to the addiction issue was the *Quarterly Journal of Inebriety* (JI), which began publishing in 1876. The JI’s central proposition was that inebriety (consisting largely of alcohol and opiate consumption) was a disease, and that position was greeted by opposition, criticism, condemnation, and denunciation. Most of these reactions were from religious leaders, who viewed the journal as one excusing crime and vice (Weiner & White, 2007).

Others view addiction and self-medicating on a continuum of behaviors. On such a continuum, one might find lesser or greater examples of a given dynamic. Figure 1.1 provides an example of such a continuum. One could be said to have the “disease” at the addiction end of the continuum but not necessarily to have it at the intoxication end. One could say that the social user who is not dependent does not have the disease, but that the addicted user, who may or may not be intoxicated at any given time, has it. Further, the issue of self-medicating can be seen to inhabit a “no-man’s-land” between these two extremes. In some cases, self-medicating is just one feature of an addiction, while in others it is not part of an addiction at all. In some cases a person either chooses not to stop drinking or cannot stop drinking, but the drinking in question does not cause problems in the person’s life and he or

![FIGURE 1.1 Continuum of Use and Addiction](image-url)
she does not exhibit tolerance. Discerning the way in which any given person manifests abuse, self-medicating, dependence, tolerance, and addiction requires an appreciation of complexity and the capacity to engage in critical thinking (Taleff, 2006).

A CLOSER LOOK AT SELF-MEDICATING

Self-medicating can refer, literally, to using a substance as if it were medication—taking a substance so that it will somehow ameliorate unwanted or uncomfortable experience. For instance, a person can drink alcohol to enhance the sedative effect of a prescribed medication. A person can smoke marijuana to blunt anxiety or use cocaine to overcome social awkwardness. It is a covering up of one kind of experience with another. It is a dissipation of one kind of experience with another. Thus, it can also refer to action that distracts or covers up actions such as yelling angrily at one’s partner after learning that one’s performance review at work left one’s job security in doubt. The purpose of self-medicating is to make bad feelings go away, and people can do that by using a substance but also by engaging in various behaviors, both of which have a biochemical effect in one’s brain and a relational impact on one’s social life.

Often, the dynamics of self-medicating are learned in the intergenerational structures of one’s family relationships. In alcoholic, dysfunctional families, children learn a codependent coping strategy (Scaturo, 2005; Beesley & Stoltenberg, 2002), grow up having to deal with an alcoholic parent, and tell themselves that when they get free—when they grow up themselves—they will never drink. Then, they realize several years down the road that they get by in life by overworking, spending, eating, sexual activities, relationships, gambling, or excessive anger in rage—all behaviors utilized when life circumstances deal out discouragement, stress, loss, or other reminders of the pain they had to go through when they set their childhoods aside to serve the needs of their parents. Even if one did not grow up in a dysfunctional family, he or she can enter into a codependent relationship—“a relationship based on a bond of suffering and conflict with a person who is physically or emotionally incapacitated and does nothing to solve his or her problem” (Noriega, Ramos, Nedina-Mora, & Villa, 2008, p. 208). In such an instance, the “person maintains a low self-esteem, remains unhappy, yet wishes and seeks fulfillment. Compulsions and addictions (‘repetition compulsions’) can provide temporary fulfillment, but lead to more suffering...What results from the above
described wounding process is co-dependence in its primary form.” (Whitfield, 1993, pp. 58–59)

Thus, self-medicating is a common feature of addiction, whether it is in the behavior of the primarily incapacitated individual or the person codependently related. Beattie (2009) reflected on the phenomenon, saying, “Codependency is subtle, insidious. To recover from chemical dependency, we admit that we’re powerless over alcohol. We realize we aren’t controlling alcohol; it’s controlling us. Now alcohol was controlling me again, but it was the alcohol someone else was drinking.” (p. 66)

DIFFERENTIATING BETWEEN ABUSE AND ADDICTION

The *Diagnostic and Statistical Manual of Mental Disorders, 4th edition*, with text revision (APA, 2000), differentiates between substance abuse and substance dependence. While substance abuse is characterized by the use that is risky and that causes disruptions and problems in a person’s life, dependence is characterized by the use that is abusive in nature and includes tolerance, withdrawal, and compulsive use in spite of attempts to quit or reduce frequency or amount of use.

More specifically, substance abuse is defined as maladaptive behavior in patterns of substance use that manifest “recurrent and significant adverse consequences related to the repeated use...” (APA, 2000, p. 198) in which any one or more of the following can be seen within any given twelve-month period of time and the conditions for substance dependence have not been met: (1) recurring use that results in failure to fulfill obligations in the various contexts of life (such as work or school); (2) recurring use in which physical risk (such as driving while impaired) is present; (3) recurring substance-related legal problems; (4) continued use in spite of repetitive social or interpersonal problems that are direct consequences of repeated use.

More specifically, also, substance dependence is defined as cognitive, behavioral, and physical characteristics, showing that a person continues to use a substance in spite of the fact that it causes a great deal of difficulty and that three or more of the following can be seen during any given 12-month period: (1) tolerance (the need for increasing quantities of the substance to achieve intoxication or the desired experience); (2) withdrawal (cognitive and physiological behavior change resulting from declining levels of a given substance in the blood or body tissues in people who had maintained heavy dosage over time); (3) compulsive use, either by taking more doses
over a longer period of time than originally intended and/or continuing to use in spite of a desire to reduce or discontinue using; (4) so much time is spent in the rituals of obtaining or using the substance that using pushes to the side the other aspects of life, even important social, occupational, and personally significant people and activities; (5) in spite of the mounting damage and loss accruing through the use of the substance, the person in question continues to use. The key element is that even in the face of this accruing loss, and even when the person admits that he or she ought to quit and wants to quit, the use continues.

CONTRASTING SCENARIOS

Consider the following examples. People like these can be found in most places. These people are fictional characters, but they exhibit characteristics present in real persons.

Lisa

Lisa was a young woman of 27. She had dark, straight hair, was slender, and she liked to dress sharply in dark colors. That was difficult for her in Bermuda where the heat, humidity, and sunshine of summer keep people in light colored, casual shorts. She came from a working-class family in Canada, and she was privileged to have completed her university education. In that regard, she was the pride of her parents, and she felt a bit of a burden to make good in life and to achieve both financial and personal stability. She could work hard, and she was beginning to realize that there were some benefits to playing hard as well.

She was not afraid to show her skin a little in order to attract attention. She had had two boyfriends when she was in Bermuda. Both relationships had faded away in an unsatisfying fashion.

Lisa worked for an exempt company in Bermuda, crunching numbers as an accountant. She had done well in math while in school, and she realized that certified accountants could make their way nicely in the world, often working in diverse locations. She wanted to travel; so, she had accepted a job, moved to the island with little baggage, and she considered it all an adventure.

Not long after coming to Bermuda, Lisa realized that if she wanted to meet people, it would have to be in one of the clubs because leisure activities centered around club social life and water sports, but she
neither owned a boat nor knew anyone who owned a boat. She opted for the clubs, and she began going to happy hour at the Pickled Onion, Latin, and the Hamilton Princess. The drinks were exotic. The atmosphere was hilarious and exciting. She found herself attracted to it. She liked it, and she also found herself liking the way alcohol made her feel.

It was not long before Lisa was going for longer lunches and having a couple of drinks during the day while gone. One day she came back to the office and people could smell the alcohol on her body. She was intoxicated, which on the one hand was just fine with her because she didn’t want to feel any pain, but on the other, it was dangerous, if not reckless. She’d been lonely because she had dated several men but not found one that resulted in a satisfying, long-term relationship. She did not like to think about getting older and not having someone; so, forgetting about all that and feeling “good” with a drink or two seemed to make sense. However, that day she had had a little too much. Her speech was slightly slurred and when she came back to the office she was unsteady on her feet.

Her coworkers were aghast. They picked her up and ushered her out of the building, explaining to the supervisor that Lisa must have eaten something bad at lunch. They took her to her home and told her to sleep it off.

This kind of behavior continued. Lisa’s performance began to slip. Eventually, her supervisor talked to her about the lack of quality in her work, the numerous mistakes she was making, and her frequent sick days off work. He questioned if she had a “drinking problem” and suggested she go for counseling at the EAP.

This performance review, however, did not affect her drinking habits. Lisa did not think she had a problem with alcohol. She knew exactly why she was drinking, and she believed she could keep doing it or even stop whenever she wanted. She chose simply not to drink at lunch anymore, which lasted for about two weeks before she gave herself a gift and had a glass of wine. She told herself that just one glass of wine at lunch could not hurt, and that is where she kept it, but her consumption after work remained what it had become at her peak. She was becoming intoxicated to the point of not remembering the evening at least two times each week. Her consumption was eating up her funds so that the money that she told herself she could make and save as a result of working in Bermuda was being poured down her throat each night during happy hour. The more she drank, the less attractive she became, and the less attractive she became, the more lonely life seemed to be. The situation was going downhill.
Gilbert and Melissa

Gilbert preferred to be called “Gil.” He was 28 years old and had grown up in Bermuda. His parents had sent him to private school, which is what any family of means does in Bermuda, because the public schools do not compete. At sixteen years of age, he was on the “bike,” which is what motorized scooters are called on the island. At sixteen, Bermudian adolescents obtain a rite of passage by getting a driver’s license and a bike of their own, and with the increased freedom and apparent independence usually also comes drinking, drugging, and sexual activity. “Apparent” is the correct word in this context because actually it is so expensive to live in Bermuda that adolescents rarely move out on their own before becoming thoroughly ensconced in a successful career, and that follows some time away at the university. Gil attended Dalhousie University in Halifax, Nova Scotia, and got a Bachelor of Commerce degree with a major in business management. At one point, he thought he might stay and complete a MBA, but his parents wanted him to return to the island and start working.

When Gil was in school, he met a Canadian girl, Melissa, who had grown up in Cape Breton. She was a country girl whose parents had been devoted to natural foods and the traditional Gaelic music popular there. Melissa was the oldest of four children, and she was used to taking care of her siblings while both of her parents worked and devoted themselves to music, step dancing, and attending one ceilidh or another, time after time. Gil, and the lure of living on a subtropical island, captured her imagination, and the two set up house with one another, marrying just before Gil returned to the island.

Gil had been drinking and drugging since high school. He did not stop while at Dalhousie, and Melissa knew about it, but she considered his use to be small scale and expected it to vanish after college when it was time to settle down. However, when he returned to Bermuda and got work as an insurance underwriter, Gil was pleased to learn that quite a lot of business was written through lunches and dinners that included lubricating the deals with alcohol. Although he also smoked marijuana, he preferred feeling a few drinks under his belt.

Over time his consumption of alcohol increased dramatically. He began to pride himself in being able to “hold” his liquor, and he could down increasing amounts of beer, rum, and vodka without feeling intoxicated. There were times people had to bring him home and Melissa had to put him to bed drunk, but it was not much of a concern because he did not remember how he had gotten home. There were times when he had to call in “sick” because he had been too drunk the night before, and the night before had simply blended into the day.
after. There were also days when his hangover was too debilitating, and Melissa had to call in and tell his job that he was too ill to come in that day.

Melissa grew lonely in Bermuda. It was nothing like home for her. She wilted in the summer heat even though at first she relished the sun, the pink sand, the warm water, and the beaches. Gil was gone most of the time, and with the downturn in the economy, Melissa had not been able to find a job. She was bored. She felt neglected, and when Gil stayed out late drinking with his friends and business associates, she felt hurt. To compensate, she told herself she deserved to play as well, and so she began buying clothes online and had them shipped to herself in Bermuda. It was taking money out of their accounts that they had been saving to eventually purchase a place of their own, but she could not stop. It was the only thing she had.

After three years of rough living, Gil decided to quit drinking. The trouble was that a day later he became depressed, distracted, could not sleep well at night because of nightmares, and his hands began trembling. That tremble invaded his voice, and he felt fragile. His condition preyed on Melissa’s mind, and she told him to get some help. He could not think straight. He complained to her, “Oh great. Just when I try to quit drinking, I have to come down with the flu,” and he started to feel anxious and worried whether he would be able to go to work again.

She told him, “I don’t think this is the flu.”

It was not the flu, and the symptoms vanished as soon as he started drinking again. He told himself he would gradually decrease the amount he was drinking, but that also did not work. He realized he was caught on a treadmill of alcohol consumption and the speed was too fast to do anything but keep running. Everything he did seemed to include drinking or actually centered on drinking. The thought of doing something that did not include alcohol was simply not on his horizon.

CONCLUSION

Lisa is an example of substance abuse. Gil is an example of substance dependence, and Melissa is an example of codependent self-medication. Actually, self-medicating as a dynamic can be found in all three of them.

Addiction is a common term, and most people believe they know what it means. However, for an addiction to exist, someone must engage in substance use or compulsive behavior that is pleasurable
and physiologically and/or psychologically rewarding and that fosters
dependence and withdrawal and resists limiting or discontinuation. It
is to be distinguished from substance abuse, which is the repeated use
of a substance that is risky and/or results in some kind of loss of func-
tion, status, or benefit.

According to a popular idiom, people are not “cured” of addiction—
once an addict, always an addict; but people can “recover” from an
addictive lifestyle. Just what recovery is and the role therapists can
play in a person’s recovery is the subject of the next chapter.

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