Treating Substance Abuse as Ritual with C-CTherapy®

ABSTRACT.

A one-year progress report of a substance abuse outpatient treated with Counter- Conditioning Therapy® is presented. C-CTherapy® is a unified, non-cognitive psychotherapy. Unlike cognitive therapies, this unprecedented methodology teaches the patient a personal mental health skill. C-CTherapy® views substance abuse not as a disease, but as a human behavior condition.

Three clinical issues comprising ritualistic behavior are addressed: chronic depression, self-medication, and the use of a substance as a reward for "getting through the day." The patient discovers how her non-volitional mental pattern[1] produces her chronic depression, how she self-medicates to anesthetize her mental pain, and why she uses alcohol as her reward for "putting up with life's trials."

PROBLEM

When Shirley first called the Center for treatment, she did not identify herself as having a "substance abuse problem." Instead, this 43-year old bank manager pointed to her "poor job performance." Her dissatisfaction quotient ran high, as she expected immediate, quantifiable "results" from cognitive programs such as time management, positive thinking, and personal goal setting. Displeased with herself, others, and life in general, her functioning mentality[2] displayed a "depressive- complaining" style.

Shirley was conditioned, as are most people, believe logic and reason would deliver "results" in the workplace. Thus, she expected classes in time management and personal goals that she attended to change her behavior and her attitude, and, most importantly, to eliminate her depression. But, they did not. Clinical research at the Center pinpoints why cognitive and informational programs fail to give sustained relief.

The Center distinguishes between two discrete types of mentation. The commonly acknowledged kind is deliberate, volitional thinking[3] which includes logic and reason. The other less recognized thinking is non-volitional which includes those thoughts repetitiously "popping" into one's mind; they are illogical and non-deliberate, their foundation laid during childhood. When Shirley's volitional thinking --her logic and reason reinforced in her classes -- did not mentally set her to improve her job performance, her frustration grew. What she did not know about mental functioning sabotaged her good intentions: Logic and reason make no sustaining impact upon the more forceful illogical, non-volitional mental pattern, the source of aberrant emotional behavior.

Shirley identified from whom, in childhood, she copied her depressive mental style. Osmotically, she absorbed depressive tendencies from those adults surrounding her, from her father for whom "nothing was right" and from her mother whose style reflected "woe is me."

Shirley recalled those times her parents' depression lifted and identified their self- medicating tactics for relieving their emotional turmoil. "My happy times," she said, were family card games when mother and father got tipsy and laughed a lot." When Shirley was a teenager, her happy times centered around visiting and drinking beer with her high school friends. She continued social, non-ritualized drinking, without problems, until middle age, when a career change and marital disappointments exacerbated her aggravation. Then, like her father, she began lunchtime drinking which extended into the evening. For seven years her daily consumption increased until she sought treatment at the Center.

TREATMENT

When Shirley first entered treatment she was driven by nergative thought-voices[4] such as, "I can't do it right" and "nothing to look forward to, in life." Mentally validating[5] these thought-voices (negative directives), she operated as if they were "truths." In fact, they were her gloomy outlook -- these automatic, repetitive thoughts fostered her chronic reservoir of depression.

The clinician must not underestimate the strength and power of the non-volitional pattern, for it fosters the patient's depressive habit and, in Shirley's case, propelled her to abuse. As Shirley discovered, the pattern runs her!

Throughout the past year, however, in the process of building her C-CTherapy® mental health skill, Shirley patient has been learning to work with the thought-voices comprising her emotional, non-volitional pattern. She has practiced "identification exercises," such as detecting the repetitive thoughts "popping" or "drifting" into her head. At a recent bank administrative meeting, for instance, she heard these thoughts "popping": "They're going to think I'm a bad leader, that I'm not doing a good job." She identifies those repetitive thoughts for what they are -- "mental traffic." Their frequency alerts her to the active operation of her non-volitional pattern. Making these structural connections is a new experience for Shirley. "The thought-voices are loud and intense; I didn't realize they existed," she told the Center's therapist.

Beginning to appreciate the force and influence of her functioning mentality, Shirley also regards her mental development, originating with childhood conditioning, as a given, a universal to all human beings. Following the step-by-step instruction of the Center's therapist, Shirley builds for herself a mental health skill so she can work with the negative activity continuously manufactured by her non-volitional pattern.

"The habit can dump me into an emotional pit. But then I interrupt myself mentally with the relevant procedure, long enough to regain my common sense. I'm starting to recognize how this is a skill. "

Each week she tapes her therapy session. Between sessions, she listens to it and practices the non-cognitive exercises assigned by her therapist. They give her practice at differentiating between volitional and non-volitional thinking. She identifies the repetitive negative directives as "mental traffic."

However, identifying mental traffic, alone, cannot counteract the impact of the negative directives. That is why Shirley then applies another non-cognitive procedure called "countering" designed to neutralize the non-voltional pattern's impact. [For research articles, refer to the Center's website: http://www.c-ctherapy.org]. As she practices this non-cognitive mental procedure, she becomes less intimidated by her "mental traffic" and, thus, less inclined to obey her own depressive thinking.

"I'm starting to recognize that when I'm tired is when I hear the thought-voices the loudest. Even if I can't get rid of them, I'm not so freaked out because I recognize what's happening and it's normal. Now I'm much more aware of how C-CTherapy® works to my advantage."

TENSION

On another level, she begins noticing behavioral signals -- fluctuations in her tension and energy levels. Now, she recognizes these visceral sensations as signals alerting her that her non-volitional mental pattern is activated. Now, she is beginning to work on herself.

Before treatment, Shirley did not realize that her depression and anxiety produced her chronic tension. As she began to routinely apply the "detection" and "countering" procedures, however, her depression decreased. That is when she became aware of tension as a signal. " Unlike the muscle and head aches I used to get, these tension signals are less noticeable," she said.

The Center's therapist assigned Shirley another exercise: "When you notice tension, listen for your thoughts. What are the thought-voices saying?" With practice, Shirley detected her familiar messages: "You can't do it right -- You've nothing to look forward to." That is when she connected her alcohol consumption with her tension: "If my tension is up, I drink more, and I know my pattern is working."

She recognized another behavioral signal: "Another barometer is when I can't sleep. My thought-voices wake me during the night, worrying about X, Y, or Z -- my daytime worries and aggravations [preoccupations] were disturbing my sleep."

Last year, she did not recognize, nor have the means to relieve her tension, other than her self-medication tactic. This year she picks up on her elevated tension. She knows how it got there and what to do about it.

Shirley consistently applies C-Ctherapy® procedures as soon as she detects either her mental signals or her behavioral signals. That is how she neutralizes their influence on her behavior. She no longer needs to use alcohol as an anaesthetic, she can just have a drink, because she feels like it.

ENERGY LEVEL

When Shirlely began treatment, she had no idea that her personal energy was tied to her sense of well-being. She discovered a truism. She, as every human being, awakes each day with a given reservoir of energy; once spent, it

is gone, replenished only by sleep.

By monitoring her energy level, she began to recognize its value, an asset that either she could spend lavishly or ration conservatively. "When my energy level is high, I feel good; when it's low, I fall for my negative thought-voices." No matter the reason for low energy, she discovered, whether menstruation, flu, or a hangover, it meant she could easily validate her negative thought-voices. To illustrate, she told her therapist,"I was tired last night, because of my period. I tried to ignore my negative thoughts, but they were really loud and I got mad at them. But then I started my countering exercise."

The C-CTherapy® goal is to work with the non-volitional pattern, not eliminate it. "We're not getting rid of the old pattern," the Center's therapist reminded her. "Remember our goal: We're building a way for you to work with yourself whenever your thought-voices flare up. That's why you apply countering exercises whenever you hear the negative directives." Through practice, Shirley learned that trying to eradicate or change her thought-voices only increased her tension and, like a chain reaction, caused her to get mad at herself.

UNDER C-CTHERAPY® SUPERVISION, PATIENT USES, BUT DOES NOT ABUSE ALCOHOL

When Shirley first "confessed" her drinking behavior, she was afraid that she would have to give up drinking alcohol completely; but she could not, in all honesty, make that commitment. Others had told her that if she continued to drink she was "morally sinful" and "disease-ridden." They said the only way to get rid of her disease was to abstain, "to cleanse" herself. This approach, abstinence, left her in a quandary because many times before she had pledged to never drink again. Contradicting her promise made from logic and reason, she kept "falling off the wagon." She did not want to give up her wine, she explained, and was surprised that the Center, unlike cognitive therapy substance abuse programs, did not require abstinence.

Another difference surprised her. The Center differentiates between moral and clinical issues, leaving the former to purveyors of codes of behavior such as legal, welfare, religious, and enforcement agencies. As a treatment facility, the Center focuses solely upon teaching patients how to work with themselves -- a personal skill. In this way, patients learn to manage their depression and thus remove their need to self- medicate.

Additionally, Shirley learned to recognize items of negativity that dominated her "mental traffic" -- her own complaints about her weight, her timidity, her laziness, her sinful/bad self. Now, instead of validating those subjects, she regards them as just so much mental functioning. Instead of using alcohol to tranquilize herself, Shirley now views her intake as an indicator of her tension level, her mental state, and her coping ritual.

COPING RITUAL

In substance abuse cases, coping with chronic depression assumes characteristics of ritual. Webster's Dictionary defines a ritual as "A set form or system or rites, religious or otherwise."

Shirley identified her own coping ritual. Her depressive reaction triggered her craving for something to look forward to -- her wine -- a reward at the end of each day. "Getting off work is like escaping jail. By mid afternoon I can't wait to leave the boring bank and get on to party time -- like the old family card games and joking with high school friends. I think about going home, whether or not I'll stop to buy a bottle and whether I'll drink it tonight. I think about opening the bottle, pouring it into the glass, sipping while I cook my dinner."

Her need for reward, she noticed, diminished when she felt good, but increased dramatically when she felt bad: If her husband, a traveling sales rep, was at home and attentive to her, she limited herself to two glasses of wine. But if he were away or she perceived him as unfriendly, she engaged the "gears" of her ritual and medicated herself.

SHIRLEY ALTERS HER RITUAL

Before C-CTherapy®, Shirley's depression activated her self-medicating ritual. When deprived of her ritual, Shirley had no way to reduce her aggravation. "It was hopeless," she told the Center's therapist about attempts at abstinence. With each try, Shirley met her own mental opposition. "People won't like me if I'm different. If I don't drink, then I don't belong. I will be just like auntie, an outsider. Auntie never drank and the family all talked bad about her. She never did fit. I'll be just like her - alone and rejected. I may think I'm getting better but I can't win this one."

Instead of abstinence, which failed, she followed the therapist's instruction to modify her reward ritual in small ways. One evening, she alternated each glass of wine with a glass of water. On another she substituted a vodka collins, sipping it throughout the evening. As the therapist made clear, the clinical objective was to deliberately work with the ritual, not to discard, or attack it. For clinical treatment to be lasting, it must address both the patient's depressive habit and her inclination to seek relief through self-medication.

ANXIETY - A REACTION TO CHANGE

Once Shirley equated her depressive reaction with her coping ritual, she felt immediate relief. No longer was her drinking a result of a gene or a disease beyond her personal control. What further lifted her depression was building her C-CTherapy® mental health skill.

Feeling better, however, ignites its own reaction -- anxiety. Shirley did not feel like her usual self -- mentally uncomfortable. Illogical though it is, each time Shirley noticed the absence of her chronic awful feeling, she got anxious -- automatically and unintentionally. In short, feeling good was different, so different that Shirley's thought- voices, suspicious of feeling better, started again. "Very subtly I detected my thought-voices saying," she reported, "'if you're doing so good, why haven't you gpttem rod pf upir bad behavior?' Sometimes this bugs me." for many patients, Initially, the emotional shift to reduced depression, in itself, creates anxiety.

Since 1980, the Center's research finds that this illogical reaction to feeling better, a marked change in the patient's mental functioning, requires clinical comment. The therapist informs the patient that increased anxiety is a common and normal companion to a change in behavior. This reaction to change is a step in the skill- building process. The patient, in turn, recognizes her anxiety as another signal, "When I'm feeling better, I get anxious. Then, my drinking goes up. I worry more about my weight and get mad that I'm not controlling myself." Shirley applied C-CTherapy® procedures to reduce her anxiety while she gradually acclimated to her new state of feeling better.

For treatment to be lasting, it must address this illogical reaction to change. With the foundation of a non-cognitive mental health skill in place, the patient is prepared now to neutralize her negative reactions consistently and move herself, mentally, to feeling good, independent of self-medication.

GLOSSARY

1. NON-VOLITIONAL PATTERN: One of the categories of FUNCTIONING MENTALITY in which illogical and emotional material resides. Characteristically, non-volitional activity is involuntary, emotionally reactive and reflexive in nature.

2. FUNCTIONING MENTALITY: The interplay between two divisions of the mind. The volitional division accommodates the function of logic and reason. The non-volitional, on the other hand, concerns itself with illogical, emotional matters - mentally reactive.

3. VOLITIONAL PATTERN: One of the categories of FUNCTIONING MENTALITY in which logic and reason reside.

4. THOUGHT-VOICES: Thoughts which "pop" into one's mind in an automatic, unheralded fashion.

5. MENTAL VALIDATION: Mentation based upon a mental command, that is, complying or accepting as true a thought-voice that compels one to answer, discuss, convice, or understand and, thus, behave according to its illogical content.

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