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ALTERED STATES OF CONSCIOUSNESS AS ADJUNCT IN THE TREATMENT OF ADDICTION:

Effectiveness of a single process-oriented intervention - An empirical study with 13 heroin addicts

Scientific discipline: Psychology

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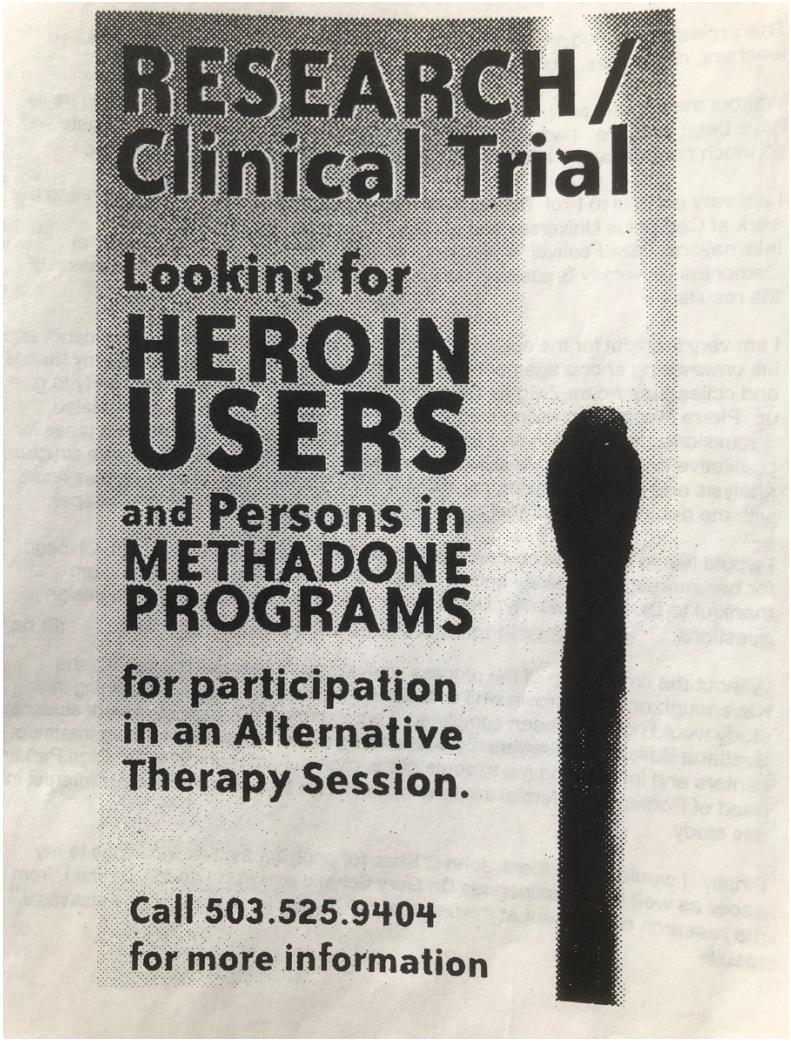
Advertisement in local newspaper (The Willamette Week, Portland, Oregon) looking for research subjects



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Know, O beloved, that man was not created in jest
Or at random, but marvelously made
And for some great end

Al_Ghazzali

Part I: Setting the stage

1.1. Introduction

A central tenet of Process Work, a modern experiential psychotherapeutic model (Mindell 1982-2000) with roots in Jungian psychology, communication and system theory as well as modern physics, holds that addictions may be seen as potentially purposeful behaviors. In the altered state of consciousness the addicted person seems to search for certain experiences which are missing in his/her everyday life. The author advocates that existing measures in addiction medicine are to be complemented with experience-oriented interventions designed to promote the altered state or the "high" the addict is seeking. A set of interventions is proposed to access and establish the particular mind/body state the individual yearns for without drugs and with a sober discovery-oriented attitude. In an interactional process, the altered state is accessed and deepened through the use of body awareness, movement and relationship work until some deeply felt personal meanings emerge.

This study reviews relevant background toward a process-oriented interpretation of addiction and presents empirical and qualitative findings of two experimental sessions with 13 opioid dependent persons. It investigates altered states of consciousness as significant moments of change and inquires the proposed process-oriented intervention for its effectiveness in promoting such experiences (Goldfried 1980). Combining quantitative and qualitative methodologies, the effectiveness of the intervention to achieve experiencing the yearned-for altered state without drugs is investigated. One, by quantitatively assessing the effects of the induced alteration of consciousness on a number of process/outcome measures; and two, by building qualitative categories of the subject's core experiences in response to the intervention. The hypothesis is that for subjects, who have an interest in self-exploration and the ability to focus their attention on the stream of inner experiences, these interventions will have the potential to elicit discrete altered-state experiences. Moreover, these experiences have transformative power and are connected to positive in-session outcome (Orlinsky and Howard 1978; Mahrer 1985; Rice and Greenberg 1984).

The process-oriented interventions presented in this study are unique and, except for Mindell (1985) and Van Felter (1987), nowhere to be found in the literature. First, they are designed to help the client "experiencing" the very altered state of consciousness the addict is seeking through the use of the drug-of-choice - and unfold it more deeply, until its implicit meaning can be directly experienced. Second, these interventions are meant to assist the client in experiencing the root of the addictive craving, that "unknown" which precedes the impulse; thus they create a way of sensing the subtle tendencies that give rise to the addiction. Third, the client is encouraged to transfer this "sentient experience" (Mindell 2000) into a new style of relating in the moment, in relationship to the therapist, in fantasy or role play. Fourth, they explore clients' beliefs about what hinders or stops them from experiencing an altered state without drugs (see Appendix A).

Process work has developed a methodology for re-accessing and unfolding the altered state to find the missing experiences where they are least expected: in the addictive state itself. When approached and unfolded with respect and curiosity, that very state provides answers to the question of what each individual yearns for and needs. For each person, being in that state is a unique and very individual experience. Thus, the addictive state can be understood as a call to specific aspects of self that each addict needs a more conscious relationship with. They are seen as unconscious movements toward experiencing the "missing pieces of reality" (Mindell 1993:114). The more access one has to the particular altered sense of self the substance is calling for, the deeper the sense of inner unity and well-being.

After working with hundreds of people with all kinds of addictions and addictive tendencies, the author began to see how the seeking of the addict, her attempt to transcend the status quo and actualize hidden, seemingly inaccessible experiential potentials, may be one of the central processes underlying addiction. I came to understand addictive states as "big dreams", mirroring disowned individual needs, affects, relationship wants, and social tensions. The author holds that the addict's quest is a kind of spiritual practice, an attempt to get in contact with lesser-known aspects of the self in order to become whole. This quest is not defined by the contents

of experience but involves complementing one's ordinary consciousness with whatever may be missing. Addictions, then, are characterized by an implicit tendency to carry one forward - beyond the limits of one's current awareness, beyond one's momentary identifications, beyond one's edges (Mindell 1985) which condition and set up the very fabric of our normal state of mind.

Although this study deals mainly with addictive processes in individuals, it is important to be aware that addictive states also pertain to what the larger system, the relationship, the family, and mainstream society marginalize. Some altered states spring up as reactions against social, political, and spiritual climates that oppress people. As a "city shadow" (Mindell 1988), the individual addict is often expressing a need for an aspect of experience that is also unfamiliar or unknown to (and being disowned in) the larger community or system: the addict as "city shadow" confronts the status quo by being a voice for social change and spiritual renewal.

In spite of recent advances in the field of addiction medicine and an annual multi-billion dollar federal drug budget, addictions remain an immense social problem and serve as a huge picture screen where we can project our fears and longings and declare what we see to be "other". The author is aware of the complexities of the topic and the limitations of the present research. While it introduces a innovative perspective on addiction, it focuses on subjective experience in individual treatment. The limitations of such an approach are obvious: interventions aimed at treatment of the individual must not forget the social and political context in which addictive tendencies arise. While the origins of addictions may in part be psychological, they are connected to problems in our relationships, in the communities and organizations we live and work in (Mindell 2000). Health and relationship life are two sides of a coin and cannot be isolated. Thus, therapeutic interventions must include relationship, family and larger networks and public open forums. However, since addictions are in part consequence of political and economic decisions, we may need to look beyond treatment that is solely focused on demand reduction. If indeed political decision contribute to the problem we are trying to heal with medical intervention, this politics of repression and oppression needs to be confronted. To avoid the self fulfilling prophecy that the addict

is a sick person or a criminal who either needs help or incarceration or both, a revision of international drug policies may be urgent. Moreover, to avoid the fallacies of "therapeutism" (Szasz 1963), awareness of the mechanics of our economic system and education in the history of drugs and the construct of addiction is prerequisite to dealing adequately with the topic.

The context of addiction goes far beyond the scope of this paper. This dissertation is a study of individual experiences and the effectiveness of a single process-oriented intervention. It researches the use of altered states in the treatment of addiction. Since the addict is self medicating to reach for a particular state of mind, process work methods aim at teaching the client to achieve the state without drugs. This paper puts to test a well-defined set of process-oriented interventions designed to facilitate re-accessing the drug state or the “high” the addict is yearning for and assess the outcome with quantitative measures.

This paper advocates an alternative view on addiction its treatment, one which does not label the client and is not confined to the discourse of pathology and dysfunction. On the contrary, it brings a teleological perspective to the field of addiction work and discovers in the addictive process individual and collective dreams. The study hopes to contribute to our understanding of the process of addiction from a phenomenological standpoint and to benefit clients by influencing the training of therapists, adding the dimension of meaning and purpose in the treatment of addiction. In a final analysis, the search for altered states of consciousness is seen as an expression of the human drive for transformation, of the longing for wholeness, for the union with God (Jung in Adler 1984).

1.2. Switzerland revisited

The author's experiences with addiction are both personal and professional and go back to growing up with two chain smoking parents in a culture where wine, liquor and tobacco are ever-present. Alcohol and tobacco consumption are so much embedded in the Swiss culture that abstinence is viewed with suspicion, despite an annual 3000

alcohol-related deaths (Fässler 1997) and 10'000 deaths resulting from tobacco-related diseases (New York Times, January 15, 2001).

As in other countries, the use of illicit drugs, mostly cannabis, became an issue in Switzerland only in the 60ties. The first death related to a so-called heroin overdose occurred in 1972. By 1986, the "needle park" became notorious and got international attention as 2000-3000 users frequented the location daily to buy, sell and consume heroin and other illegal drugs (Klingemann 1998). Under the threat of HIV, in 1986, multiple harm reduction measures were implemented, including, in 1992, small pilot heroin-prescription programs. Needle exchange programs led to a dramatic reduction in the rate of HIV infected users from 69.5% in 1985 to 20.3% in 1994 (Cousto 1998). However, in 1992, tolerance with open drug scenes became exhausted. The police closed the needle-park in Zurich and a similar park in Berne and arrests for the use of illicit drugs tripled in a few years to 32'032 (Klingemann 1998). In Zurich, in 1997, there were 13'805 police charges for drug offenses or - 3944 per 100'000 of the total population. When compared to Berlin (234), Frankfurt (692) or Munich (348), this figure represented the peak of repression in Europe (Cousto 1998).

In the late eighties and early nineties, the author was working as a clinical psychologist with heroin addicts and their families at a social psychiatric institution in Lucerne. The outpatient clinic provided crisis intervention as well as long-term psychotherapy and was responsible for the methadone program in the Canton of Lucerne. The interdisciplinary team included secretary, medical doctor, psychotherapists, social workers and the medical director of the social psychiatric services. Beyond the different professional backgrounds in social work, behavior modification, cognitive therapy, family therapy, psychodrama, process work, psychoanalysis and object relations, and confronted with the survival of our clients, a perspective emerged that prevention and treatment represented an important yet insufficient approach to the problem in the light of the political, economic, social and spiritual issues underlying addiction. Alternative treatment models were marginalized, harm reduction measures hindered by opposition and spiritual issues not even seriously considered.

In the meantime, our clients confronted us with the hypocrisy and bigotry underlying the public discourse around drugs. Alcohol and tobacco not only are legal and their consumption promoted in ever-present advertisements associated with sex appeal, freedom and happiness, but less harmful drugs like marijuana were demonized and its use a felony. The righteous defense of such dishonest attitudes alienates and marginalizes parts of the community, thus creating many of the problems it pretends to solve. The misery of a core group of demoralized, ill-fed, sick and homeless junkies was taken for prove for the havoc illegal drugs cause. At the same time it was ignored that two out of three heroin addicts in the city of Zurich were socially integrated, held a job, had a home and a family (Künzler 1991, in Amendt 1996). It was also ignored that the social context, the family relations and economic factors play an important part in the careers of heroin users.

The drug users are the ones suffering the consequences of this confusion. At times, they seemed much less befuddled than the helpers themselves. They often expressed messages which held up a mirror and showed us what we tended to neglect and avoid: the pains and ecstasies of living in this world and the struggle for a moment of liberation, peace and freedom in the midst of it all.

However, as a team, working toward a consistent vision for a national drug policy, we were often caught in the struggle of the spirits of the times, all claiming the single panacea to solve the drug problem. The main ideas were:

- a prohibitionist position strictly oriented toward abstinence
- a pragmatic harm reduction approach
- complete liberalization of drug use and commerce

We mostly agreed that it was political decisions that would set the human and social cost of the problem. Only in the mid-80s, the international Mafia had taken hold of the drug markets in Switzerland, along with a drug policy of repression (Klingemann 1998). Arendt, critical analyst of the political, social and economic dimensions of the drug problem, urged that a decision was needed between the two basic tendencies in

international drug policies. One, the politics of repression and two, the movement for liberalization and free trade, if not the Mafia was going to be in charge (1996).

1.3. Time spirits in conflict

Process Work construes the many positions in a discourse as "time spirits", the multiple aspects of the current valid values in a culture. The collective "field", the social, political, physical and emotional climate of a group, or a nation, is segmented into various roles, which are its dynamic structures (Mindell 1995). In the area of addiction and drug policy, "time spirits" are the opposing energies, the polarization, the roles and positions around the issue. Our opinions are related to the time and the locality we live in and represent but one position in the dance of positions that constitute the discourse in a particular "field.

"The roles that people are drawn to play in a field are like the poles of a magnet. If there is one role, another always arises to balance it. A field always needs these polarities to create the tension and the atmosphere…Groups seem to have the tendency to create roles and to remain balanced as much as possible. The tension that arises is normal. It presses us toward knowing one another, towards division, unity and spiritual experience" (Mindell and Mindell 1992:203).

Dialogue is needed among the different voices and every single one needs to be heard and understood for consistent action to follow. Mindell (1992) coined the term "deep democracy" to emphasize the usefulness of the awareness that all roles and positions in the field are necessary and need to be heard and interacted with for the potential wisdom in the field to unfold. Important applications of this thinking arise for dealing with today's world problems, namely, noticing and including positions usually disregarded or neglected and the inclusion of the viewpoints of marginalized or oppressed groups. The field tension is universal and reflected in the polarization between the majority and minority, the rich and the poor, black and white, the police and the drug dealer. These conflicts among the various roles and positions can be understood as an attempt of the larger field to grow, change and evolve. In a group

meeting on drug addiction[1], however, there was such heated conflict between the participants, that resolution seemed very unlikely. When finally a proponent of prohibition was able to express her deepest feelings behind her stance, her despair about her child's addiction and her high dream for a drug-free world, the group was profoundly moved and temporarily united in the shared longing for connection with the sacredness of life.

Some positions in the discourse are closer to CR[2] or mainstream consciousness, others represent disavowed voices. For instance, legalization is a currently a minority position. In the debate on drug addiction, all positions represented need to be heard. Once the conflicts are out in the open, it is the job of the facilitator to hold and unfold the deepest beliefs and feelings behind what looks like rigid positions so that the group can move from conflict to an understanding of each position and experience true common ground. Some of the positions in any debate on drug addiction will be:

- the voice of CR who wants to oppress all NCR experiences[2] in the name of mainstream norms. This side can be voiced by law enforcement officers, drug and alcohol counselors, drug addicts etc.
- the prohibitionist who wants to control harmful drug use and eradicate the problem with law enforcement. This position sometimes is expressed by religious or faith-based groups, well-meaning citizens etc.

- the substance abuser who claims the freedom to ingest whatever he chooses and enjoy whatever NCR state of mind he wants to. This position is represented by the libertarian party and reflects liberal conservative and progressive views.

[1] St.Petersburg, Russia: Addiction Prevention Project, November 1998.

[2] Mindell introduces in Quantum Mind "…two fundamentally different realities - consensus reality or CR for the reality that has consent, and non-consensus reality or NCR for the reality that has been neglected by the present, scientific worldview" (Mindell 2000:25). CR are "…perceptions that correspond with one another" and NCR those "that do not collectively correspond" (ibid).

- a liberal position who advocates liberalization of all drugs in the name of individual freedom and a free market. A position strongly advocated by liberal conservatives like the economist Milton Friedman
- the users and victims, individual and collective minds and bodies, relationships, spouses and children who are hurt by the consequences of drug use.
- medical treatment systems: doctors and therapists who want to treat the sick individual and free him/her from a destructive obsession.

- Mafia, drug cartels and profit-makers around the globe, including pharmaceutical giants whose profits depend to a large measure on prohibitive policies - are the unspoken ghost

Process work developed methods to address the issue on a collective level. Town meetings and large group process (Mindell 1992, 1995) offer a time and place where these popular and disavowed voices can be heard. It is crucial that psychology brings its tools to the social arena and engages not only on a theoretical level or with individuals but in the world. Process work places much emphasis on using conflicts and diversity for large group transformation to build bridges and community.

1.4. City shadows - messengers of change

Although, for the purpose of this paper, the focus is on the individual, the addict in need of treatment is society as a whole (Schaef 1987). Process work offers a communal view of addiction, reminding us that the fringe of society not only reflects the mainstream but that marginalized people have important messages for the culture. This systemic perspective is central to process work as are systemic interventions an integral part of the body of process-oriented techniques. Applications are family and group work in the treatment of addictions as well as in the treatment of psychiatric states (Mindell 1988). An example of process-oriented family work with addictions is below (see 4.5.).

The idea is that addicted persons live NCR experiences or unusual states of consciousness at the edge of norm behavior of a family or group which conflicts with

what the particular mainstream culture can tolerate and integrate. The term "city shadow" describes marginalized people who live NCR roles in society and compensate the dominant social identity (Mindell 1988).

"The shadow is like the city's dream portraying its neglected gods, the hopelessness it will not admit, its suicidal tendencies, mania, addiction, murderous rage and hypersensitivity" (Mindell 1988:162).

These people express a split-off piece of culture in those NCR experiences that cannot be lived consciously in mainstream culture. From a system perspective, the so-called identified patients (IP) in our families, communities or in society mirror its disowned aspects or "its repressed and unrealized psychology" (Mindell 1988:62). The altered states these individuals search for confront the status quo and may bring neglected ways of being and feeling to mainstream awareness. A purposeful perspective may understand these behaviors simply as enlarging and expanding the edges of consciousness and normative behaviors the family, the particular group or society live by. Some of these altered and extreme states spring up as a reaction against social, political, economic and spiritual climates, which disenfranchise and oppress people. For our efforts in addiction work to succeed, these root causes need focus.

Psychology needs to go beyond working with individuals and establish itself in public spaces. In town and community meetings, the new politics of deep democracy uses group process to bring out the various positions in society, like anger, rage, hurt and pain, the abuser and oppressor, to conflict and eventually move toward resolution. From the perspective of "deep democracy" (Mindell 1992), it is important to understand the beliefs and dreams of prohibitionists as well as the needs behind each of the other positions.

1.5. The war on drugs - a time spirit

The "war on drugs", launched in the US by Nixon in 1972, and made global since, pursues the dream of a drug free society by means of law and law enforcement. root causes need to be addressed. Unfortunately, however, instead of having the desired

effect it may foster the harm. Evidence suggests that the attempt to enforce prohibition promotes violence and corruption and contributes to the destruction of inner cities while not stopping people from using drugs. Besides generating an illegal market, it may in fact stimulate interest in drugs, and attract defiant behavior (Szasz 1998). Prohibition turns drugs into an enormously profitable business which creates and strengthens criminal organizations who undermine our economies and democratic institutions (Friedman 1991). With an annual drug business around the world estimated at $500-700 billion dollars, the illegal money from drug business is a huge economic and political force outside of legitimate government control (Fässler 1997).

1.5.1. Racism

One of the most painful effects of drug control is its bias against people of color and minorities in general. It seems that racism rules drug-control enforcement, courts and prison systems in the US. People of color suffer the consequences of the "war on drugs" in grossly disproportionate numbers. Out of two million people incarcerated in the US (ahead of Russia's incarceration rate), 800'000 are black men and women. In the US, on a per capita basis, the conservative economist and Nobel prize winner Milton Friedman (1998) contends, four times as many black males are jailed as were in South Africa during the Apartheid regime). One out of every thirty-five black males overall, or one out of eight black males age 20 -34 were in prison on any day last year (The Sentencing Project 2000; US Justice Department Report, in New York Times, March 26, 2001). African-Americans constitute 14% of drug users in the US but suffer 75% of all prison sentences (Marable 2000; Sklar 1995).

1.5.2. Oppression abroad

Another agonizing consequence of the war on drugs is the fact that, to a large degree, the war is waged outside the US. Military support for paramilitary forces in Latin and South America caused immense suffering among civilians (Friedman 1991). Fighting rebels in countries like Peru and Colombia is admitted "second target" of the drug war (Amendt 1996). Recently, Colombia has become the target of massive US intervention. Trying to eradicate coca plantations, chemicals are incidentally sprayed on grain, fruit and vegetable which ruins the livelihood of the peasants, instigates civil

unrest, strengthens a corrupt regime and finally, does nothing to alter drug consumption at home (DCRNet 2001)[3]. Since last year, 20'000 farmers have been displaced (New York Times, March 17, 2001). In spite of $1.3 billion in mostly military aid to Colombia in the last two years to ensure its cooperation in anti-narcotic efforts, the area of coca production increased by 11% to 336'000 acres (New York Times, March 2, 2001). For the public, these operations demonstrate that the roots of the drug problem lie outside the US, and paste over the fact that demand at home increases, remains stable at best, or drug use patterns alter to include other available substances.

1.5.3. Poverty and abuse at home

Social and economic causes of addiction at home are not confronted with equal determination. The role of child abuse and neglect (Kaufman 1994; Young 1995), oppression and discrimination of minorities (Wallace 1995), in conjunction with poverty, lack of education, of opportunities and unemployment are well known factors that contribute to drug abuse. "Oppression is so pandemic", Mindell (1995:39) holds, "so common in your body, your friends, your environment - that you and others may consider this uncomfortable state-of-mind normal. You may feel compelled to take tranquilizers or use drugs or drink to soothe the tensions." Abuse contributes to and can create addictions as internalized oppression, self-criticism, feelings of worthlessness and lack of self esteem undermine the person's sense of well-being and health (Kaufman 1994). Racism, sexism and an economic system that disenfranchises those of lower rank and class, are collective abuse patterns in mainstream society which drug use masks and perpetuates.

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[3] Andrew Selsky, of Associate Press, tells of his visit in Putumayo province: "The fields in Santa Rosa looked like moonscapes, with only deadened branches of the formerly robust green bushes sticking above the brown ground. Adjacent food crops were shriveled and yellowed from the herbicide, as well as some of the jungle Tribal fish farms were also sprayed, the Indians said." - "All my corn, yucca, and bananas died," peasant farmer Jos Melos complained to the Miami Herald. "What am I going to feed my family?" Drug Reform Coordination Network: The week online with DCRNet, issue 170, January 26, 2001.

1.6. Liberalization

The movement for liberalization of all drug use is another position in the field which has strong arguments and support from different sides of the political spectrum. In the US, the most prominent representative of liberalization is Friedman whose conservative position is grounded in the Bill of Rights, in individual freedom and the belief in the capitalist market. If drugs were legalized, so the argument, criminal organizations would disappear, prison space open up for the truly criminal and, the destruction of society due to racism, oppression and poverty could be reversed.

In Switzerland, in 1993, a popular initiative "For a reasonable drug policy - tabula rasa with the drug Mafia" was launched. It was supported by the Social Democrats, the Greens and by organizations such as the "Association of Parents of Drug Dependent Youth". While representatives of national finance and economy acknowledged the failure of prohibition, their manifesto fell short of endorsing the liberalization pursued by the initiative. The radical changes proposed in the Constitution read as follows: "*All substances currently under the narcotics law are to be legalized. The prohibition model is to be abolished. It will be replaced by government controlled import, production and distribution of drugs*[4]*"* (Berengheti 1996:15). The stated goal of the initiative was to dry out the illicit drug market and its profits to protect society and drug users from fatal consequences of the situation: *"Stop illegal drug markets and by consequence, the coercion of users to drug-related crimes and prostitution"* (Berengheti 1996:16). The initiative sought to replace prohibition by legalization because, in the opinion of the initiands, the mounting repression had proven to be to the advantage of organized crime. The solution was to legalize all drugs and establishing a state monopoly like the one on alcohol. A new article in the Constitution would secure the right to individual drug use, by stating that *"…consumption, production, possession and purchase of narcotics for individual use is not prohibited"* and adding certain provisions for prevention, information on products, age limits for drug use and adverting restrictions. Government and parliament recommended rejection of the bill with reference to the danger of potential increase in drug use and

[4] Translation from the German original by the author.

the binding nature of several international narcotic conventions (1961, 1971, 1972) as well as the not-yet ratified UN agreement of 1988 (Berthengi 1996). The favored strategy was the official four-pillar model of repression, prevention, treatment and harm reduction. In 1998, the initiative was rejected by a majority of 74% (Uchtenhagen 1999, Klingemann 1998).

1.7. Risk reduction

Government controlled risk or harm reduction measures may constitute a middle ground between repression and liberalization around which a consensus, at least in Europe, can form. Since studies show that two thirds of all heroin addicts "mature out" of their addiction independent of treatment (Fässler 1996; Nimsch 1993), the rationale has been to help the addict survive long enough. This move toward government controlled drug programs is demanded by the "Frankfurt Resolution", a conference of several European cities who reject prohibition and demand liberalization of cannabis. Studies of methadone programs have demonstrated positive results in Britain, Switzerland, Holland and the USA; in Britain, the London and the Liverpool models have demonstrated effectiveness of heroin programs (Fässler 1996; Nimsch 1993). Today, the Swiss heroin project –established in 1993 - represents the cutting edge in Europe's search for better responses to the drug problem.

Risk or harm reduction aims at facilitating the survival of the active phase of addiction by providing medical and psycho-social aid. The focus is on cutting down on the number of problems caused by illegality rather than on the substances themselves – prevention of STD, hepatitis B and C infections as well as HIV infections by providing condoms, clean syringes and drug education. These efforts account for a decrease in HIV infection rate to 5-20% from 40-60% in the mid 80s (Fässler 1996). Other aid include street projects, shelters for addicts and homeless, medical emergency rooms for addicts, medical treatment available to addicts and support projects for male and female prostitutes; availability of low-threshold methadone programs and hassle-free rooms to inject heroin under medical supervision. Since 1993, in several cities, research heroin programs provide heroin to a selected group of addicts with positive results (Fässler 1996). A recently published outcome study of the narcotic prescription

projects (1994-1996, based on an initial sample of 1035 addicts) indicates that heroin is a useful substitution treatment. The results show significant improvement in physical health and psychopathology, rapid regress in the use of illicit heroin and cocaine, improved social integration, decrease in criminal activities and, compared to other treatments, a significantly higher treatment retention rate (Uchtenhagen et al 1999).

In their evaluation of the Swiss study, a WHO expert panel confirmed that heroin maintenance was feasible with high retention rates and stable dosages over time in Swiss settings with highly qualified, multidisciplinary teams. Based on methodological concerns, however, the panel concluded that improvements cannot be attributed causally to the heroin prescription but may be linked to the well developed health-care system; the high degree of oversight and the provision of qualified social and psychological services in a rich country (WHO, April 1999).

1.8. Dance of time spirits - is there a solution?

Critics against risk reduction measures speak up from various sides. The abstinence standpoint, with their dream of a drug free society informed by the 19th century temperance movement, view pharmacological treatments and needle exchange programs with disdain. Harm reduction measures compromise the dream by "giving in" to drug use and the harmful consequences associated to it. Drug addiction destroys individuals and families alike and causes havoc in society, therefore, the prohibitionist says, the rational response is repression by enforcing control. Against that position Friedman would hold that individual freedom cannot be compromised, and warn that "…more police, more prisons, military intervention in foreign countries, severe punishment of drug consumers and other repressive measures, turn a difficult situation into a more difficult one" (Arendt 1996:130). In his opinion, the mechanisms of free market would best take care of the international drug problem. Finally, Szasz (1974, 2000) would criticize the medical and pharmaceutical complex for exploiting the situation. In his view, the "pharmocracy" with their vested interest in prohibition is evil - promoting sales of more dangerous drugs often, than the traditional compounds. Pro

liberalization, Szasz also opposes any risk reduction measures since, in his view, they only strengthen the absolute power of the "therapeutic state".

These divergent views are integral part of the communal family's attempt to deal with and solve one of the most pertinent problems of our times. In the spirit of "deep democracy", all these voices want to be heard and valued. A step toward resolution can occur when all positions are invited to the table and brought into dialogue in such a manner that the deepest feelings, motivations, dreams and fears behind each standpoint can be expressed and shared.

PART II: Facts and numbers

The study of epidemiological data like incidence and prevalence of addictions is based on, in the US, national surveys among students and in the general population and on reports of drug-related emergency room visits and drug-related fatalities. Incidence refers to the rate of first time users in a period of time, usually a year, while prevalence comprises the overall number of users for certain drugs. In general, the age group with the highest prevalence of drug use are people 25 years and younger, with a tendency toward earlier onset. Some experts hold that the life time prevalence in the US is declining since the early 1980s with a 32% decline by 1991 (Dodgen 2000), however, in the 1990s, drug use seems to have increased.

2.1. The use of illicit drugs around the world

Drug use is an enormous social problem touching on the lives of millions if not billions of people around the world both in developed and developing countries. World-wide, an estimated 180 million people - or 4.2% of all people aged 15 years and older - use illicit drugs. 144 millions consume cannabis, 29 million amphetamines, 14 million cocaine, 13 million opiates, with 9 million people addicted to heroin (UN Office for Drug Control and Crime Prevention, January 2001). The most vulnerable, poor and marginalized groups experience the most negative impact of this drug use across societies with devastating effects on communities, neighborhoods, families and the health of men, women and children.

Table 1: Estimated number of drug abusers (annual prevalence) in the late 1990s -World[1]

	Illicit drugs	**cannabis**	**ATS***	**Cocaine**	**Opiates**	**heroin**
Global (million)	180.0	144.1	28.7	14.0	13.5	9.2
In % of global population	3.0%	2.4%	0.5%	0.2%	0.2%	0.15%
In % of population Age 15 and above	4.2%	3.4%	0.7%	0.3%	0.3%	0.22%

* Amphetamines (metamphetamine and amphetamine) and substances of the ecstasy group

[1] United Nations Office for Drug Control and Crime Prevention. World Drug Report 2000, Table 4, page 70

Heroin is still considered the "problem drug", although heroin abuse in Europe and the US is stable or even declining. However, in some Central and East European countries, heroin use is increasing (United Nations report on global illicit drug trends, January 2000). Cocaine use is increasing in Latin America, Australia, Africa and Europe while stable in the US. Cannabis use is increasing in Europe, stable in the US, the world's largest marijuana market (United Nations World Drug Report, January 2001). Dramatic increases in use of amphetamine-type stimulants (ATS) over the past decade remain a big concern, with ATS representing the main growing sector in Europe, although very recently there are signs of stabilization in the US and in Europe.

2.2. Prevalence and incidence of heroin use in the US and in Europe

Opioid addiction and dependence is a serious health problem worldwide, in the US as well as in Europe, with vast costs to society. Due to its hidden nature, it is difficult to get accurate estimates on the prevalence and incidence of heroin use and thus, considerable discrepancies exist between the various reports. There are an estimated 0.2 to 1 million long-term heroin users in the US (National Institute of Health, November 1997; Johnson et al 2000; National Household Survey, SAMHSA, 1999) and about 1.5 million heroin users in the EU (European Monitoring Center for Drugs and Drug Addiction 2000). Up to 3 million Americans have used heroin in their life time with corresponding figures for Europe where approximately 1% of the population has experience with heroin (1 to 2 % in young adults) (Editorial, New England Journal of Medicine, 2000; EMCDDA 2000).

In the US, heroin incidence (120-140'000 new users each year) has considerably grown over the past decade and is only recently stabilizing (EMCDDA 2000). Intravenous heroin use contributed in a major way to the dramatic increase in the prevalence of human immunodeficiency virus (HIV), hepatitis C and tuberculosis (Editoral, New England Journal of Medicine 2000; National Institute of Health 1997). While the typical user is getting older and suffers serious problems related to health, social functioning and psychopathology, there is some evidence that smoking of heroin may increase among young adults (EMCDDA 2000). Overall, the traditional pattern of problem drug use seems to be changing across the EU: many long-term heavy drug

users combine heroin and cocaine, often together with alcohol, and multiple use of amphetamines, ecstasy and cannabis is common especially among young adults. In Switzerland, for the first time, there are more police charges related to cocaine than to heroin (Amman and Marti in Facts, November 2000).

High-risk groups include young multi-drug users who use amphetamines, ecstasy and other drugs as well as marginalized minorities, homeless young people, institutionalized youth and young offenders, prisoners (women in particular) and sex workers (EMCDDA 2000).

2.3. Drug-related deaths

The number of *deaths related to overdose* is stable in the EU after stark increases in the early 90s. Heroin overdose does often involve heroin, however, the term may be a misnomer since only a fraction of so-called heroin-related deaths are true heroin overdoses. Other fatalities are due to contaminants or polydrug use, in combination with alcohol and tranquilizers (Darke and Zador 1996). Further, stabilization of drug-related deaths may relate to safer usage, and easier access to treatment, especially due to the increased availability of low-threshold methadone maintenance programs. The overall picture, however, is grim: the rate of acute deaths due to "heroin overdose" has almost tripled in the EU since 1985 (EMCDDA 2000).

2.4. Alcohol, nicotine and prescription drugs

More than 75% of men and 50% of women in Western countries drink more than a sporadic drink (Dodgen 2000) and between 5-10% of adult males in the US can be considered alcoholics or alcohol dependent persons. Asian Americans and Jewish Americans have low rates of dependency while among Native Americans, alcohol abuse and dependency is especially high. Lifetime prevalence of alcohol use among high school seniors is at 90% (Bukstein 1995). Smoking, in the West, peaked in the mid-1960s and has been significantly declining since tobacco use has been identified as a major health hazard. Life time prevalence among high school seniors in the US has been decreasing from 73.6% in 1975 to 61.9% in 1993 (Bukstein 1995).

By contrast, the market for prescription drugs is rapidly expanding. As an example, Ritalin use alone has gone up 700 percent since 1990. With the startling increase in the number of children diagnosed with Attention Deficit Hyperactivity Disorder, or ADHD, almost 5 million school-aged children in the US are in pharmacological treatment, most of them with methylphenidate (Ritalin). There is new evidence that children treated with stimulant take up cigarette smoking earlier, smoke more heavily and are more likely to abuse cocaine and other stimulants as adults. A report presented to the National Institute of Health (NIH) shows a significant relationship between the use of central nervous system (CNS) stimulants in childhood and a dependence on tobacco and other stimulants as adults (University of Berkeley, News Release May 5, 1999).

2.5. Substance-related deaths for licit and illicit drugs in comparison (for the US)[2]

Deaths related to licit drug use occur at a much higher rate than deaths related to illicit use. For the US, there are about 2000 annual deaths each due to overdose on heroin, crack and amphetamines; however, many of these deaths are attributable to contaminants and to the combination of illicit drugs with alcohol and benzodiazepines. Tobacco-related deaths cost the lives of close to 400'000 people each year in the US alone and alcohol-related deaths amount to 100'000 each year. Prescription drugs cost more lives than all illegal drugs combined (Drug library 2000).

2.6. The drug problem in Central and Eastern Europe[3]

In some areas of central and eastern Europe, the use of heroin is increasing at a disproportionate rate since 1989 (EMCDDA 2000) while the age of onset is decreasing. Age at onset of heroin use is significantly younger than in EU countries with most at-risk groups being 15-19 year olds (ibid.). Not uncommonly, already 12 year-olds start using opiates. In some cities in Russia, prevalence and incidence of

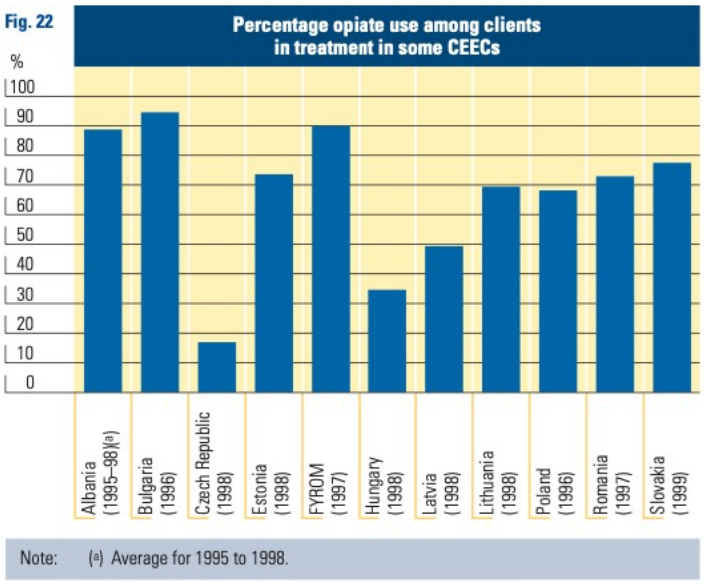
[2] Substance abuse related deaths. Drug library <http://mir.drugtext.org/druglibrary/schaffer/library/graphs>

[3] Central and Eastern European countries included in the study Albania, Bulgaria, Bosnia, Czech Republic, Estonia, Macedonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia.

heroin use have reached epidemic proportions among very young adults (Maikov 2000).

In central and eastern European countries there is a high treatment demand for opiate dependence. The percentage of opiate users among clients in treatment fluctuates between 15% and 95%. In Slovakia, it reaches close to 80%

Table 2: Central and Eastern Europe: Opiate users in treatment



Slovakia reported an increase in heroin use among treatment clients from 37% in 1993 to 86% in 1994. The user population is spreading from an urban environment to rural areas. Again, for Slovakia, this figure rose from 35% of heroin users treated outside of Bratislava to 47-60% in 1995 and 1996 (EMCDDA 2000).

Estimates for life-time prevalence of drug use among 15-16 year olds are not consistently available. However, the figures below indicate generally a high prevalence of illicit use, especially for cannabis, in this age group. In Slovakia there is a reported treatment demand for problem cannabis use (ibid.) with life-time prevalence has increased among 15-16 year-olds from 8% in 1994 to 23% in 1999. By comparison, in the Czech Republic, cannabis life-time prevalence in this age group was much higher with 35% in 1997 but considerably lower in Hungary (11.5% in 1998).

Table 3: Central and Eastern Europe: Life time prevalence of cannabis use

Table 4

Lifetime prevalence of drug use among 15 to 16-year-olds in four CEECs, 1994-99

	Substance	Lifetime prevalence (%)					
		1994	1995	1996	1997	1998	1999
Czech Republic	all illicit drugs	26.4	n.a.	n.a.	43.6	n.a.	n.a.
	cannabis	21.5	n.a.	n.a.	35.4	n.a.	n.a.
Hungary	all illicit drugs	n.a.	4.8	n.a.	n.a.	12.5	n.a.
	cannabis	n.a.	4.5	n.a.	n.a.	11.5	n.a.
Lithuania	all illicit drugs	n.a.	3.2	n.a.	26.0 [a]	13.3 [b]	n.a.
	cannabis	n.a.	1.0	n.a.	n.a.	27.1 [b]	n.a.
Slovakia	cannabis	8.1	12.4	n.a.	n.a.	19.7	23.0

Notes: [a] Vilnius only.
[b] Ninth to eleventh grade pupils, Klaipeda only.
n.a. = data not available

Reliable data concerning HIV, AIDS, hepatitis B and C are lacking, according to the same report and, given the high-risk behavior of heroin users, the risk of an epidemic is present. Useful interventions could introduce education campaigns and harm reduction measures like needle exchange programs, low threshold methadone programs and outreach, provision of housing and medical care. Many countries are developing multi-disciplinary strategies and several international organizations support professional training and demand reduction projects. The expertise in these countries is great and so are the challenges. Treatment facilities and prevention projects have been created. Appropriate resources need to be allocated to the service providers so that training of professionals, prevention and therapy programs are available.

2.7. The cost of illicit drug use

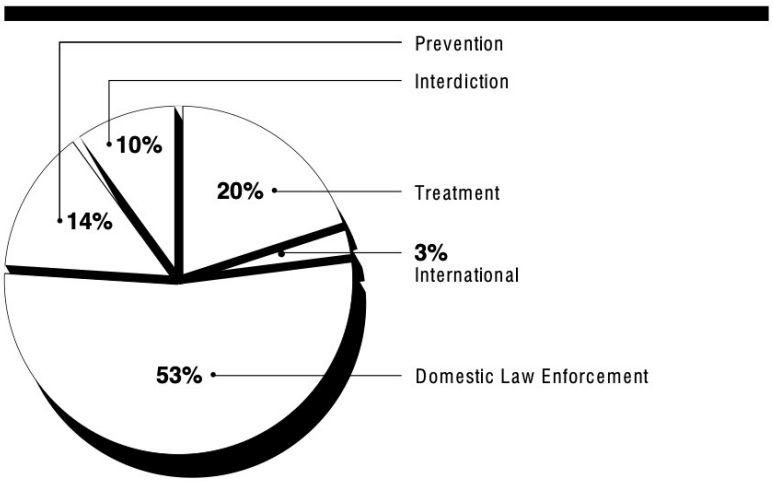
Overall cost of drug abuse to society which includes the cost for health care, drug addiction prevention and treatment, prevention and fighting drug-related crime, and lost resources resulting from reduced worker productivity or death, are estimated at $67 billion annually (United States General Accounting Office 1998; Arendt 1996). Other assessments estimate the cost at between $120 - $150 billion (Rotgers et al 1996).

Ever since Reagan accelerated the war on drugs in 1982 and created a climate of zero tolerance for drug use, experts agree that there is a drug epidemic in this country. Each year the US government, states and private entities increase spending to combat the plague. For 1998, Clinton requested 16 billion US$, $1 billion more than in 1997 to continue the fight (Klingemann and Hunt 1998). Since the early 90ties, federal spending has increased by 64% from $ 9.8 billion to $16 billion in 1998 (United States General Accounting Office 1998). At the same time, prevalence estimates indicated an increase in illicit drug use: while 13 million Americans were users of illicit drugs in 1996, this number rose to 13.6 million in 1998 (National Household Survey on Drug Abuse 1998) and to 14.6 million in 1999 (National Household Survey on Drug Abuse 1999).

The federal budget for drug control efforts is allocated to two general areas, a) *demand reduction* (prevention, treatment and related research) and b) *supply reduction* (law enforcement, interdiction, and international cooperation) in a disproportionate manner. Allocation to treatment is increasing slighter faster than the overall budget. In 1996, of a $14.5 billion budget for drug control efforts, 63% went to domestic law enforcement, 19.4% to treatment and 13.6% to prevention (Klingemann and Hunt 1998). For 1998, of $18 billion federal budget, still the largest share of 53% went to domestic law enforcement, 20% to treatment, and to prevention, 14%. The remainder was allocated to interdiction and international efforts (United States General Accounting Office 1998). Two thirds of the funding for demand reduction goes to the Department of Health and Human Services (HHS) to support grants to the states and the Department of Veterans Affairs (VA) to support drug treatment and medical care for veterans (ibid.).

Table 4: Distribution of federal drug control spending for the fiscal year 1998

Figure 1: Distribution of Federal Drug Control Spending, Fiscal Year 1998



Source: ONDCP, The National Drug Control Strategy, 1988: Budget Summary.

2.8. A new trend in the USA

The above numbers demonstrate that until now, the US strategies to combat problem drug use placed much emphasis on repression and incarceration. In the US - in state and federal prisons, 1/4 of all inmates are incarcerated for drug offenses (NIH 1997). In California alone, one third of its prison inmates are drug delinquents; 36'000 persons are incarcerated each year for drug-related crimes. In a landmark decision in November 2000, California instituted a dramatic change in its drug policy. As an alternative to incarceration, drug offenders will be offered a one-year treatment program. Cost reduction is one obvious factor for this change of mind in drug politics: treatment is much cheaper than incarceration. Under the new law, California will be saving 290 million dollars a year (Pieth, in Schweizer Sonntagszeitung, November 2000), not counting the cost for prison infrastructure. A recent cover story on addiction in Newsweek magazine gave further evidence of this trend for change. Even hard-liners in the war on drugs, according to the report, begin to see that incarceration is no way out of the drug problem (Newsweek, February 12, 2001).

In spite of the uneven allocation of funds, the existing treatment system in the US is an impressive structure. More than 5000 facilities, from hospitals to residential units,

methadone clinics, therapeutic communities, outpatient programs, and correctional institutions offer multiple treatment modalities. However, treatment demand far exceeds existing treatment availability. It is estimated that in the US only 15%-20% of drug abusers receive treatment (Hunt and Sun, in Klingemann et al 1998). Inappropriate funding and high threshold programs geared toward abstinence are some of the reasons limiting access to health care for drug users. For treatment to become a feasible alternative to incarceration, sufficient treatment places need to be available which requires, by consequence, redistribution of funding to demand reduction strategies. Interdiction and law enforcement come at very high cost for society and drug users alike for prison is verifiably ineffective in promoting and improving health of the population (Marlatt et al 1993). Once appropriate funding is secured, the current treatment situation demands either more of the same treatments with their often lamented low efficacy and / or new ideas and innovative alternative treatment approaches to deal with problem drug use.

Part III Definition of Addiction and Treatment Effectiveness

As definitions of addictions or dependencies include a wide variety of human behaviors, so-called substance and process addictions, including various forms of relationship addictions (to the diagnosis of society as an additive system (Schaef 1989, 1990), they become no less problematic and confusing - but more. Many disciplines contribute to current thinking about these complex human activity to engage in an intimate relationship to a inanimate substance or symbol or activity / process: politics, spirituality, medicine, psychology, sociology, chemistry, physiology, law, politics, sociology, biology, and witchcraft (Shaffer 2001). A word of caution: the use of the label "addiction" tends to reify the underlying process into a frozen state which has the quality of a hypnotic induction on the person. Since the process-oriented approach aims at "melting the ice" - and unfolding the underlying subjective stream of experiences - the term is better avoided in treatment (Mindell 1989c).

3.1. Disease Model of Addiction

The most widely accepted model is the so-called disease model which holds that addiction is a disease just like other medical conditions. While multiple factors contribute to the etiology of addiction, the focus is on biological causes of illness, the neurophysiological and biochemical processes underlying the dysfunction in the hope of developing pharmacological treatments. The success of methadone maintenance programs in stabilization of the addictive process has empowered the biochemical perspective (Dole and Nyswanger 1988).

Advances in neurobiology of opiate dependence led to the definition of addiction as a brain-related medical disorder with characteristic chemical and physical changes in the brain (National Institute of Health 1997). There is debate whether heroin use begins on the bases of a pre-existing medical problem or whether psychological and economic problems are main causal factors. The current scientific view holds, however, that long-term opioid use turns into a medical disorder, which engenders tolerance, withdrawal, compulsive drug use. There is however, recognition that psychological and behavioral aspects are part of the problem of addiction. The diagnosis of drug abuse is

usually made in the event of health and social impairment, legal and interpersonal problems.

"Opioid dependence (addiction) is defined as a cluster of cognitive, behavioral, and physiological symptoms in which the individual continues use of opiates despite significant opiate induced problems. Opioid dependence is characterized by repeated self-administration that usually results in opioid tolerance, withdrawal symptoms, and compulsive drug taking. Dependence may occur with or without the physiological symptoms of tolerance and withdrawal" (National Institute of Health 1997).

3.2. Biochemical definition

The biochemical perspective is in the background of the current medical approach to describe, define and treat addictions. Drugs interact with neurotransmitters, which are responsible for biochemical transmission of the electrical impulse across synapses to communicate information between brain cells or neurons. A closer look at these drug/neurotransmitter interactions are paramount to further our understanding of brain chemistry / biology which, so the hope, will lead to new pharmacological treatments in addiction medicine.

Drugs interfere with either the production or release of neurotransmitters, with neurotransmitter interaction with receptor sites, or with re-uptake of neurotransmitters in the synapses, the tiny gaps between outgoing nerve endings, the axons, and incoming nerve endings, or the dendrites. In each case, altered transmission leads to decrease or increase of stimulation with typical effects on the person's experience. Interestingly, biological psychiatry, addiction medicine and research in altered states of consciousness complement each and rekindle the interest in mind/body states, subjective experiences and brain states (for more information, see for instance Gardner 1999; Goldstein 1994).

3.3. Dual Diagnoses

Psychiatric studies demonstrate that up to 60% of substance users who seek treatment have psychiatric co-morbidity (Dodgen 2000). The prevalence rates of

diagnosis range from 28.3% anxiety disorders, 26.4% affective disorders or depression, 17.8% antisocial personality disorder, and 6.8 % schizophrenia in substance abusers (ibid.). The high percentage of substance users who have dual diagnoses lends further support to the definition of addiction as a mental disorder.

3.4. Diagnostic criteria for psychoactive substance dependency

3.4.1. DSM-IV

According to DSM-IV psychoactive substance dependence is a disorder comprising in essence a "cluster of cognitive behavioral and physiological symptoms indicating that the person continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that usually results in tolerance, withdrawal, and compulsive drug-taking behavior" (DSM-IV 1994:176).

At the core of the medical-psychiatric definition of dependency lie pharmacological concepts such as tolerance and withdrawal symptoms. "Tolerance" is a condition, in which progressively larger dosages are required to achieve a desired effect; "withdrawal" symptoms are a consequence of lower blood or tissue concentration due to decrease in drug intake which leads to dysphoria, nausea, muscles aches, sweating, diarrhea, fever, insomnia (DSM-IV 1994. However, neither tolerance nor withdrawal is a necessary or sufficient condition to warrant a diagnosis of substance dependence. Cannabis, even when heavily used, does not lead to tolerance nor withdrawal; post-surgical patients on morphine may develop tolerance and withdrawal symptoms, however, without any signs of compulsive drug use. Diagnostic criteria include next to tolerance and withdrawal a compulsive element. First, the person self-administers the drug over longer periods of time and in larger amounts than intended; second, efforts to reduce drug use do not work. Further, drug use and activities connected to it become the central focus to the detriment of other social, occupational or recreational activities (ibid.).

However, many features of psychoactive substance dependency are a consequence of conditions other than the use per se. Illicit drugs are expensive and access is

difficult or dangerous which promotes frequent withdrawal, criminal activities with neglect of CR concerns. As the prohibitionist morale is internalized, intolerable guilt, shame and inferiority feelings ensue which -in turn -reinforce the need for relief by means of self-medication.

3.4.2. ICD-10

The World Health Organization's International Classification of Mental and Behavioral Disorders (WHO 1993) is the standard diagnostic manual in Europe. In substance-related disorders both ICD-10 and DSM-IV emphasize cognitive behavioral and physiological changes, compulsive self-medication as well as (somatic) tolerance and withdrawal. ICD-10, in its definition of the dependency syndrome seems to accentuate loss of control and craving, the urge or overwhelming desire to use the substance.

"(The dependency syndrome) comprises a group of physical, behavioral and cognitive phenomena, which lead to the use of substances or a class of substances to the detriment of other behaviors, which previously were more valued. A decisive characteristic of dependency often is the strong, sometimes overwhelming desire (urge) to consume psychotropic substances (medically prescribed or not), alcohol or tobacco" (ICD-10 1993:92) [1].

Diagnostic criteria (three or more of the following) according to ICD-10

1) strong desire or urge to consume substances
2) less control to begin or end to consume nor amount used
3) physical withdrawal symptom
4) evidence of tolerance
5) increasing neglect of other leisure activities or interests in favor of substance use
6) continuous use in spite of evidence of damage, i.e. liver damage, depression, cognitive impairment due to drug use.

ICD-10 classifies psychological and behavior disorders induced by psychotropic substances according to their severity (intoxication, abuse, dependency syndrome,

withdrawal symptom, with delirium, psychotic and anamnestic syndromes etc.). These disorders are to be associated with a range of substances (F10-F19) -alcohol, -opioide, -cannabinoide, -sedatives and hypnotics, -cocaine, -stimulants, -hallucinogenics, -tobacco, -solvents and -multiple drug use and other psychotropic drugs. The first two digits of the classification code for drug-related problems (F) stand for the substance, the forth and fifth digit are clinical descriptions of psychological and behavioral disorders associated with the use (F1x.0-F1x.9).

Accordingly, based on ICD-10 classification, the opioid dependent persons in the present study have the following diagnoses (F11=opiates; Fxx.2=dependency syndrome, Fxx.x1-5=subclassification of dependency syndrome):

F11.21 dependent, currently in residential treatment program (8 persons)
F11.22 dependent, currently in methadone program (3 persons)
F11.25 active users (2 persons)

3.5. Genetics

Studies showed both genetic and environmental contributions to drug use. The increased risk among first degree relatives of drug using parents compared to controls is, for substance use (7.6 fold), for alcoholism (3.6 fold), for antisocial personality (7.6 fold), and for unipolar depression (5.1. fold) (National Institute of Health 1997). Studies on family traits show that alcohol use runs in families with approx. 25% of sons of alcoholic fathers becoming alcoholic themselves. Studies on adoptees have found that sons of alcoholic fathers tend to become alcoholics irrespective of whether non-alcoholic parents adopted them or whether they grew up with an alcoholic father. Twin studies demonstrate that concordance for alcoholism in monocygotic twins (MZ) is higher than for dizygotic twins (DZ), albeit well below 100% (Collins and DeFiebre 1990). Not unlike research in other areas of mental health, i.e. schizophrenia, the mainstream approach searches to identify those biological markers which would indicate vulnerability to substance use, and suggests physiological, neurological and psychological bases for the predisposition to drug abuse (Dodgen et al 2000).

[1] Translation from German edition by author, pp. 92-93.

3.6. What is addiction after all?

As perspectives on addiction have become more complex, the construct of addiction has proven less and less useful. One of the main difficulties remains the fact that some drugs which are declared illegal (heroin, morphine and cocaine) may be more benign pharmacologically than the pharmaceuticals that replace them or legal drugs such as alcohol and nicotine. While the pharmaceutical market has doubled from 1996-2000 to an annual $145 billion, and the painkiller market tripled to $1.8 billion, today more people are dependent on painkillers and tranquilizers than on heroin. The emergency room visits in that same period doubled for painkillers alone (Newsweek April 9, 2001).

The medical definition uses the term "dependency" - the focus is on the compulsive need to experience the psycho-somatic effects of the drug, with pharmacological effects and consequences on social life being central part of the definition. While the focus is on biological and neurological changes or damage (New York Times, March 6, 2001), there are admittedly substantial societal and cultural influences on etiology and consequences of drug use.

Are *drugs* addictive? Cigarette packs warn us that nicotine is addictive and can damage your health. The positive correlation between smoking and related deaths beyond doubt, yet some smokers do not develop cancers, others do not get addicted. So then, the substance itself may have a destructive and addictive potential but does not in itself be the sole cause of destruction or addiction. Rather, the issue lies with genetics/biology and in the *interaction* of drug/person; addictive tendencies arise in form of special relationships to substance/process. Some people are put on morphine after operations and never experience the physiological processes of addiction, i.e. craving / withdrawal. Moreover, persons dependent on licit drugs like nicotine or alcohol may not have any anti-social behaviors typically associated with drug abuse. However, in times when tobacco was illicit, the behavior of nicotine addicts turns more anti-social (Shaffer 2001).

To complicate matters further, some drugs produce physical and /or psychological dependence and withdrawal symptoms. Yet, some activities like gambling, love, romance addictions do that too. Evidence points to the possibility that addictive processes may result in neuroadaptation, which would explain for craving, tolerance and withdrawal symptoms in process addiction. Shaffer (2001) points out that a quantitative shift is an important characteristic of addiction: things that were very important in life play a lesser role while the relationship to the object of addiction takes central stage. In his relational definition, Addiction is an intense *relationship* with an activity that has adverse biological, social and psychological consequences for the person/environment (ibid.).

While process work perspective agrees that addiction is characterized by circular causal processes between person, drug and environment, however, it also stresses the *final causes* of the addictive drive. The person is not so much in the search of the object as Shaffer holds (ibid.) but yearns for powerful experiences, which are missing in life. These great dreams of the person are organized by a transpersonal pull for completion, belonging and union. This, in a sense, is expressed by Elster: "Craving is not due only to the push from dysphoria but also to the pull for euphoria" (1999:xii).

3.7. Classification of drugs

There are many classification systems to categorize drugs. To the contrary, the medical classification describes drugs by their pharmacological action onto the central nervous system (Dogden et al 2000).

1 Narcotics

Opium and natural opium derivatives such as morphine and codeine as well as synthetic opiate derivatives such as heroin or methadone and modern designer drugs such as fentanyl. Fentanyl is several times more active than heroin and, today is widely used as a morphine substitute in hospitals. Other related synthetics with potencies up to 2000 times the activity of heroin, are alphametyl fentanyl and parafluor fentanyl (Escohotado 1999).

2 Depressants

Central nervous system depressants such as alcohol, barbiturates and benzodiazepines and solvents. Barbiturates include anesthetics (Pentothal) and sedative-hypnotic agents (Luminal).

3 Stimulants

CNS stimulants such as amphetamine, metamphetamine, cocaine, caffeine and methylphenidate (Ritalin).

4 Psychedelics

Psychedelics include a wide variety of substances, naturally occurring in plants and mushrooms, and as semi-synthetic and synthetic products such as THC, LSD, mescaline, psilocybin, DMT, 5-MEO-DMT. MDMA or ecstasy, represents yet another class of drugs sometimes called enactogenics (in touch with oneself) for the feeling access they seem to facilitate.

3.8. Effectiveness of treatment

Psychotherapy has proven helpful more so than not. However, in the context of the dodo bird verdict: all have won and all must have prizes (Luborsky 1975; Smith et al 1980) - the equivalence of psychotherapies regarding outcome suggests that therapies share common factors which are, in fact, the active ingredients (Lambert and Bergin 1994). Process-outcome studies have yielded positive correlation of a) relationship quality, b) therapist attitude and skill, c) client openness and d) treatment duration to outcome (Orlinsky et al 1994). At core, common *therapist* characteristics may be the common factors which make therapy work (Orlinsky et al 1996). Studies have consistently recognized the central role of the therapeutic alliance for positive outcome independent of conceptualization and instruments used to measure it (Horvath and Greenberg 1994). This holds true for drug treatment outcome as well (Miller 1992; Najavits et al 1994).

What is the treatment situation for substance abuse? First, most persons with substance abuse disorders in the US do not seek treatment - with estimates ranging

from 8% to 30% of users in treatment (Rotgers et al 1996). Second, treatment assessments of drug abuse for mainstream treatments (12-step, therapeutic community, methadone maintenance) indicate a 30-40% relapse rate within a year after treatment termination in spite some efforts at after care. Recently, however, the understanding is increasing that drug careers are characterized by lapses and relapses so that each treatment augments rehabilitation on the slow path to recovery. Course of addiction and treatment outcome, according to some, are comparable to other chronic diseases (McLellan et al 1996).

There is a clear trend toward utilization and integration of techniques from different types of therapies. Cognitive-behavioral techniques such as relapse prevention (Marlatt and Gordon 1985; Childress et al 1993), motivation-toward-change interviewing (Miller and Rollnick 1991), and cognitive therapy which aims at modification of dysfunctional beliefs and cognitions (Beck et al 1993) are perhaps most effective new attempts at substance abuse treatment (Rotgers 1996). Integrative approaches combining psychoanalytic therapy, family therapy, cognitive-behavioral strategies and 12-step programs are more common and what was quite unthinkable before long is clinical reality today (Kaufman 1992). Long-term therapeutic communities (TC), often the setting for treatment of adolescents, in the US, involve exposure to AA and NA philosophy, encounter methods and reliance on counselors who themselves are in advanced stages of recovery (Bukstein 1995).

3.9. Large multisite treatment studies

Several large, multisite studies with data on 10000 - 44000 clients have demonstrated the effectiveness of drug treatment on several pre/post treatment measures. The four most common forms of drug abuse treatment (long-term and short term residential treatments, methadone programs, and outpatient drug-free programs) are all effective in reducing drug use. That is the major finding the Drug Abuse Treatment Outcome Study (DATOS) which followed 10,010 drug abusers in nearly 100 treatment programs in 11 cities who entered treatment between 1991 and 1993. "DATOS is the largest study of drug abuse treatment outcomes since the early 1980s and the most important

in the last 10 years in terms of telling us how treatment programs are doing" (Fletcher, in Mueller et al 1997:1).

Outcomes were positive for drug use, illegal activities, employment, and suicidality (depression). When drug use for the 12 months before treatment was compared with drug use 12 months after they stopped treatment, decline in overall drug use was evident across programs. There was a significant decline of heroin users from pretreatment (89%) to one-year follow-up (28%) for methadone programs (Hubbard et al 1997; GAO 1998).

Other major studies come to similar positive conclusions. The Treatment Outcome Prospective Study (TOPS) (Mueller et al 1997; GAO 1998) reported that across treatment type, 40-50% of users who spent three months in treatment, are drug abstinent at one year follow-up. Drug Abuse Reporting Program (DARP) (Sells et all 1980; Simpson et al 1980) found abstinence in the year following treatment reported by 64% of heroin users in methadone programs, 61% in therapeutic communities and 56% in drug free outpatient programs. Since these numbers rely on self-reports, however, they may be grossly overstated. National Treatment Improvement Evaluation Study (NTIES) found a significant reduction in crack cocaine use in the year after treatment (GAO 1998). Significant drops in criminal activity were also reported in all these outcome studies (ibid). Significant drop-out rates are common, with methadone programs usually having the best retention rates. Across studies, researchers found consistently that the longer treatment the better outcome (GAO 1998).

Researchers noted that outpatient treatment reduced drug use as much as residential treatment although cost varies broadly. According to a cost analysis, outpatient methadone and drug-free treatment costs $13-$15 per day versus $50 (long-term) - $130 (short-term) per day for inpatient treatments (NTIES brief report, in GAO 1998). Nevertheless, inpatient treatment is required for many clients with severe psychiatric and / or drug abuse problems.

3.10. Studies at Philadelphia Veteran's Medical Center

A decade of research at the Philadelphia VA Medical Center has repeatedly suggested strong positive association between treatment duration and improvement across most clients and measures (McLellan et al 1982; McLellan 1986, in Yalisove 1997). In addition, the "psychiatric severity" - obtained from scores on the Addiction Severity Index (McLellan et al 1980) - was detected as the best predictor of treatment response. Patients with few problems at admission do better than patients with severe problems on outcome measures. For the 15-20% of the opioid dependent persons who typically demonstrate severe impairment, longer retention in methadone maintenance programs resulted in some additional benefit. For the same clientele, however, therapeutic communities proved counterproductive (McLellan 1986). Another main finding showed that for high-severity patients a weekly psychotherapy session added on to regular psychosocial services provided with the methadone program, led to significant regress in drug use, criminality and psychiatric severity (Woody et al 1983). In brief, clients with less severe psychiatric problems can profit from methadone maintenance programs or therapeutic communities, while severely disturbed clients cannot. In addition to methadone, which increases treatment retention, these patients need additional high quality psychotherapy. A recent study confirmed the necessity of psychosocial services for effective substitution treatment (Arndt et al 1997).

3.11. Outcome studies: summary

Overall, mainstream drug treatment effectiveness can be summarized as follows:

1) Successful treatment depends on therapist attitude more than on therapeutic orientation. A positive working relationship or therapeutic alliance, therapist empathy and genuineness, have been identified as most important factors in drug treatment, especially since treatment motivation and retention are persistently problematic with this population (Miller 1992, Petry et al 1999; Dodgen et al 2000).

2) Research demonstrates positive outcomes in the treatment of heroin addiction with methadone maintenance programs in reducing drug use, criminal activity and improving social functioning and health. For high severity clients, enhancement of

program with psychotherapeutic interventions is necessary (McLellan et al 1986, 1993; Institute of Medicine 1990; GAO 1998; Dole 1999; O'Connor 2000).

3) Cognitive-behavioral treatments such as relapse prevention, social skills training and community reinforcement or contingency management programs, show promise in treatment of heroin and cocaine addiction (GAO 1998; Dodgen et al 2000). However, for relapse prevention, results need yet to be validated (Wilson 1992; Childress et al 1993).

4) Family-based treatment interventions are being evaluated with promising results for adolescents (Bukstein 1996). A recent review found family therapy effective for treatment retention, reduction of drug use and problem behaviors (Howard et al 1995; Stanton et al 1997; GAO 1998).

Last but not least, spontaneous remission is a common pathway to recovery with substance abusers. About one third of substance abusers eventually resolve their addiction and mature out of it (Rotgers 1996).

3. 12. Minorities in treatment

Studies show that minorities not only are disproportionately affected by drug and alcohol problems, mainstream treatments seem to be less effective in this population (Closser and Blow 1993). Social and economic factors, racism, poverty, unemployment and low self-esteem increase likelihood of drug use (Schinke et al 1988).

In the treatment of specific populations it is important to recognize differing treatment needs depending on race, gender, ethnicity or culture. Treatment approaches must take into account rank and power differentials, majority / minority relationships and predominant group-dependent communication styles. Just as social, psychological and spiritual rank (Mindell 1995) contribute to the etiology of addiction, rank differences on these axes influence, in the positive or negative, drug abuse treatment. There is likelihood that the issues the drug dependent person faces in the street are

being repeated on a overt or covert and subtle level in the therapeutic relationship. Different structural rank in the treatment setting needs attention but especially differential status based on skin color, gender, sexual orientation and/or ethnic group. Unawareness of collective rank and power issues can fuel the addictive cycle, foster impasse, attrition from treatment and cause hurt which supports substance use to numb the pain.

Therapists must educate themselves in the history, values and attitudes of minority groups and understand culturally determined variables such as physical distance, eye contact, speech patterns, touch, time and use of language and slang. Moreover, the most useful therapeutic interventions model the essence of the behavioral style of a given culture or subculture to be either directive or non-directive, confrontational or action-oriented (Bukstein 1996). For African-American, self-efficacy models and empowerment of self works better than confessing powerlessness (Williams 1992) as well as exploring congruence of own behavior with cultural values. Facilities need African-American staff since youth especially need role models who emphasize spiritual, familial and communal awareness (Bukstein 1996). Edges to treatment among African-American women are responsibilities as wives and mothers at home, fear of loss of children, lack of money, shame, and perceived need for the substance to deal with stress (Dodgen et al 2000). In Hispanic population varying levels of acculturation and alienation from language, culture and ethnic background present central treatment issues. Group-orientation and allegiance to extended family are pronounced in Hispanic culture and therefore, inclusion of social network in treatment is necessary. The main barriers to treatment usually are language, finances and absence of Hispanic role models at the treatment facility (Westermeyer 1995). Very high rates of substance abuse are reported among Native Americans. Geographic and cultural isolation is more pronounced than for other minority groups and bicultural skill level can be lower. Traditional values do often not permit self-disclosure and modification of AA groups is necessary (Bukstein 1996). Participation in Native American Church rituals have shown effective in renewing cultural identity and reducing substance use. Substance-use among Asian-American is usually low, however, the wide range of cultures, languages, beliefs and traditions make Asian

population very heterogeneous. Resistance to disclosure of personal issues and accordingly, to therapy, can complicate treatment of substance use disorder (Bukstein 1996). Inclusion of folk healers, elders and spiritual teachers can be of immense use in the treatment of some of the minority populations. Among homosexuals, studies show, substance abuse may be as high as 30% (Cabaj 1998). The stress and pain of living in a homophobic environment as well as one's own internalized reactions, especially during adolescence, make substance use common in this population. Staff recognition of cultural and internalized homophobia and sensitivity in dealing with ambivalence in homosexual youth is crucial for treatment success.

Part IV: Theories of Addiction

Addiction theories consider biological, psychological, relational, social, cultural, and spiritual conditions as well as adaptive strategies in the process of addiction. There is agreement on the multifactorial nature of addiction: biological vulnerability, developmental problems, social pressure, access to drugs, and a lack of meaning in life (Frankl 1978) within the governing socio-political and economic climate (Amendt 1996) form an interwoven tapestry of factors that contribute to addiction.

In The meaning of Addiction (1985) Peele understood addiction as a strategy to cope with internal and external pressures and advocated that craving, withdrawal, and tolerance were not reducible to pharmacological effects of a drug alone but cultural, societal, psychological and experiential factors as well. Further evidence that narcotic use not necessarily lead to addiction and that non-substance addictions (e.g., to gambling, sex, relationship) had effects comparable to those of substance addictions suggested an underlying process which includes substance and process addictions. For him, the central drive fueling addiction was the search for potent experiences. The addict wanted "to achieve a desired feeling - a state of being - that is not otherwise available to them" (1985:129).

While this perspective is close to a process-oriented understanding, it offered little concrete direction for therapeutic action. Process work developed specific techniques to make the yearned-for states accessible without the use of drugs and teaches the client strategies to achieve the desired feeling state. The goal is for the client to develop a much deeper relationship with the yearned-for state than the drug can provide.

Important psychodynamic theories and systemic approaches to the treatment of drug addiction are following below. Most modern views, analytic and systemic, understand drug addiction as an adaptive strategy. While psychoanalysis has provided helpful models to understanding addiction from the standpoint of drive theory, ego psychology, object relations and self psychology, the perception is widespread that

substance abusers are unsuitable for analysis due to severity of the underlying disturbance and given poor outcome results (Leeds and Morgenstern 1996). Family and systems therapy approaches, on the other hand, have recently received attention because of evidence for treatment effectiveness with substance users (Lawson, in Lewis 1994).

Process work, in contrast, while building on the self-medication hypothesis as well as on a system perspective, understands drug use in the context of a psychosocial and spiritual search and does not condone the language of pathology and dysfunction. It embraces a final or even, teleological perspective that goes beyond the adaptation models.

4.1. Psychoanalytic theories: addiction as adaptive strategies

In the view of psychoanalytic theory, drug addiction is not a root problem but secondary to or one possible consequence of underlying psychopathology. Early libidinal theories emphasized fixation in the oral phase of psychosexual development and drug use motivated by the search for pleasure. Freud explained addiction from the perspective of drive theory: oral fixation, latent homosexuality and other inner conflicts are root causes of addiction. In his view, drugs substitute for infantile sexual gratification. According to Freud (1905), the primary addiction is to masturbation while drugs serve as a substitute. The acting out leads to guilt and anxiety and finally, to lower self esteem. To relief these feelings, in turn, the drug is used and the vicious cycle of addiction sets in (Kaufman 1994).

Rado (1926) unified various addictions as "pharmacothymia" - pointing out that the impulse, the craving for the drug was the single common factor underlying all addictions. Drug use follows the pleasure principle, both to enhance it and also, to alleviate pain. The original elation experienced with the drug is experienced as a "pharmacogenic orgasm". The addict comes to crave a magic state that cures and gives pleasure. Mood alterations follow and depression becomes more prominent. For Rado (1933), drug use is self treatment against an initial tense depression, which,

however, with continued use, reinforced by guilt and remorse in a cycle which only leads to further and severe depression and turning away from reality (Yalisove 1997).

Glover (1932) highlighted the aggression suppression effect of the drug. Drugs are used to ward off tensions, anxiety and rage, however, in the destructive habit the underlying aggression is acted out. For Glover, the symptom is a progressive movement, an attempt at restitution or "an advance from the unconscious situation it covers." (Glover, in Yalisove 1997). He was first to point to the importance of the early mother-infant relationship and anticipated modern theories emphasizing self and object relations. Fenichel (1945) saw addiction as an attempt to avoid depressive breakdown and satisfy oral longings but also stressed the impairment of ego and disturbed object relations. In the adolescent drug user, relationships are problematic, remain fragile and few and, increasingly, the drug effects replace the satisfaction of the need for sex, security and self esteem (Kaufman 1994).

Chein, Gerard, Lee and Rosenfeld (1964) studied inner city users and concluded that heroin addiction is the result of personality disturbance and maladjustment. They emphasized the role of drugs to cope with unbearable anxiety in the transition between adolescence and adulthood. When adolescents need to assume a productive role and cope with reality in a bleak environment, lacking adequate role models, motivation for drug use sets in. Detachment is sought in a nirvana-type high. Moreover, drug use provides the addict with a new social identity and a career - thus overcoming inner emptiness. Drug use is understood as adaptive and functional, as a coping strategy to deal with affect states and consensus reality (Kaufman 1994).

Later developments proposed a psychodynamic interpretation of addiction based on *object relation theories and self psychology.* Kernberg and Kohut interpret addiction as a symptom of a borderline or a narcissistic personality organization. For Kernberg (1975), a very frustrating mother-child relationship can lead to severe identity problems later in life. The noxious point in normal development is found in the separation/ individuation phase when the caretaker reacts to the first tentative independent moves of the child with disapproval. If the silent gaze of the mother demands recognition

herself, then the child's individual development is negated and a false self, in the image of the mother, sets in. Later, the drug fits into the self system to restore the mirror for the self to be adored in and seemingly allows a return to the unbroken wholeness with the self / mother (Cirillo et al 1999). Kohut (1977) holds - from a theory of development of self structures - that in case of severe frustration in the earliest relationship to the mother, the child will perpetuate both the ideal image of the mother and his own grandiose self to reduce the emotional stress of trauma. The search for an object, inanimate, which elates the mood and relinquishes the feelings of one's own limitations, becomes a possible solution to the necessity of growing up. In short, for Kohut, vulnerability and traumatic absence of good-enough parenting may lead to addiction.

Wurmser (1974, 1984) builds on drive-theory and, while advocating treatment combination with self-help groups, pharmacotherapy and family work favors psychoanalytic treatment of substance abusers. For him, compulsive drug use is an attempt at self-treatment of an underlying severe emotional disturbance. *Preconditions* are found in massive narcissistic problems, a grandiose sense of self and intense frustration if ideals are not reached, as well as in characteristic family patterns, peer group behavior and inner city poverty. *Specific causes* may be found in an experiences of intense disillusionment, rage and depression in an "actualization of the life long conflicts between omnipotence and grandiosity, meaning and trust" (Wurmser, in Yalisove 1997). The drugs are used to strengthen the defense against affective storms or dysphoric moods. *Concurrent causes* may be seen in attempts at liberation from oppressive authority figures expressed as protest and rebellion. According to Wurmser, drugs are used as a means to overthrow this inner authority figure or critic in a act of magical domination (in Kaufman 1994). Responsible for an exceptionally harsh inner critic are "unusually severe real exposure to violence, sexual seduction, and brutal abandonment." (Leeds and Morgenstern 1993:72). Self-treatment in the service of affect defense aims at alleviating feelings of loneliness, emptiness, depression, meaninglessness, boredom as well as rage, shame, hurt and a sense of rejection. Further, self treatment medicates against ego deficits by providing a substitute sense of meaning, goal-directedness and value-orientation. Also, drug use

removes discomfort stemming from an inability to symbolize emotion which remain undifferentiated and vague and get somatized rather than expressed. Addiction is often desperate search for the love object projected onto the drug, narcissistic self-gratification and, last but not least, in its destructive potential, represents a protracted suicide attempt (Wurmser in Yalisove 1997). Since the client suffers from too much superego not too little, a warm, kind and flexible therapist attitude and a strong emotional presence is most useful in his view (Leeds and Morgenstern 1993).

Krystal and Raskin (1970) explored the addict's difficulties to deal with overwhelming, preverbal and unclear affective states and point to the tendency to somatize these undifferentiated feeling states, depression and anxiety. "Their emotions came in vague, undifferentiated, somatic form, i.e. they experienced sensations and not feelings. They were not able to put feelings into words, and therefore could not be using them as signals to themselves" (in Yalisove 1997:109). This inability to symbolize feelings, or alexithymia (Sifneos 1967) or hyposymbolization (Wurmser 1974), conjoint with a tendency to somatization is typical for a wide range of clients, and found in trauma survivors as well as psychosomatic patients. Their difficulty in reading affect states and emotions cause anxiety which the addict tries to eliminate with drug use.

In yet another theory to explain addiction, Krystal holds that addicts experience the drug symbolically as a maternal object (users in the US often call heroin, mother). They have great difficulties in accessing the mothering part in the "absence of the ability to comfort and soothe oneself (Krystal 1978) and handling positive and negative emotions about self and others.

Relationships, however, are highly ambivalent. The addict craves to be united with the love object and at the same time dreading it. The search for an experience of oneness with the love object is usually disavowed because of the barrier against aggression (Krystal, in Khantzian 1985). The trouble with accepting love and nurturing goes together with warded off aggressive impulses, envy and rage. Similarly, a deep ambivalence ties the addict to the drug who, in the drug use, reenacts the relational

drama of rejection/separation (withdrawal) and fusion (high) with drug use. Krystal explains that an inadequate or missing mothering leaves the addict helpless in dealing with frustration tolerance and there is a regression to the state of a child who uses the soothing effects of the drug in lieu of relationships or self-care. Fears of ultimate disintegration threaten the ego and are medicated with the drug in further avoidance of relationship. In accord with the view that severe addicts function on a borderline level, Krystal is pessimistic about the treatment of substance abusers. He advocates therapeutic focus on self-care and affect tolerance and working through aggression and relational ambivalence (Leeds and Morgenstern 1993).

Khantzian has developed a group psychotherapy treatment approach for substance users (Khantzian, Halliday and McAuliffe 1990). He stresses that deficits in "ego" or "self" structures, less so conflicts, are at the root of substance abuse disorders. He proposed the *self medication hypothesis* of addiction which posits that the pharmacological effects of the drug interact with the emotional state of the individual in such a way as to ease the distress. As such, addictions represent an extraordinary solution to the problem. It is the compulsive urge for *relief* that explains the addictive potential of drugs for some people; they become addicted to treat themselves against disruptive emotional states. Drugs seem to help to cope with an overwhelming inner life and provide defenses against hurt, rage, shame and loneliness.

Khantzian (1974, 1985, 1990, 1995) who relies on ego psychology, object relations theory, self psychology and psychiatry, notes that within a bleak social environment, impaired ego and self development lead to specific ego vulnerability and disturbances in the sense of self manifesting in difficulties with drive and affect defense.

"In attempting to adapt to one's emotions and one's environment, the action of the substance and the immersion in the drug subculture could be used to mute, extinguish and avoid a range of feelings and emotions. Rather than settling for more ordinary defensive, neurotic, characterological, or other adaptive mechanisms as a way of dealing with distress, substance users adopt an extraordinary solution by using a powerful drug" (Murphy and Khantzian 1995:164).

Psychiatric studies show that significant psychopathology is associated with severe use of illicit drugs: prevalence of concurrent personality disorders is between 60% up to close to 100% depending on the study and includes borderline personality, narcissistic personality and anti-social personality disorders (Khantzian 1985; Kaufman 1995; Yalisove 1997; McLellan 1980).

The underlying lack of self-comfort or well being make a person prone to drug use. Painful affect states seem overwhelming and often remain vague and inadequately regulated. One particular difficulty with affect regulation is alexithymia manifesting as undifferentiated feeling states or, which are tolerated largely by expression through action, symptoms or addiction (Khantzian 1995).

Through the lenses of self psychology, Khantzian suggests problem in four areas of self that affect drug dependency: affect life, self -esteem, relationships, and self-care (Murphy and Khantzian 1995). Impaired feelings of self worth in the absence of a nurturing parenting relationship pattern lead to conflicts around needs and wants. Aspirations and longings are disavowed as well as the needs for dependency and nurturing. The repression of these needs lead to depression, feelings of emptiness and cut off from others. The inability to reach out and actively pursue one's needs makes people vulnerable to drug use (Khantzian 1990; 1995).

Both Wurmser and Khantzian believe that opiates have an anti-aggressive and anti-regression effects, while cocaine use is often used as a treatment attempt against fatigue, depression, hyperactivity attention deficit disorder, to increase self esteem and frustration tolerance. In their view, addiction has a progressive action, against the regressive pull "counteracting disorganizing influences of rage and aggression on the ego" (Khantzian 1985: 1260). However, what was once discovered as a treatment, more often than not turns into self-destruction.

Khantzian's research into the "drug-of choice phenomena" or "self-selection" process, the case studies he presents, are pertinent to the process work approach. He believes that much can be learnt from addict's self report of their subjective experiences, not

only about problem state of mind but also about solutions, however short-term, via a particular drug. As he listens to addicts and studies accounts of their subjective experiences with drugs, he hears the story of how severe emotional trouble, suffering in relationship and in the world is fought against with a particular drug. He also discovers unexpected solutions in reports of heroin and cocaine addicts:

"A successful 35-year old phycician described how defensive and disdainful he had become since his early childhood as a consequence of his mother's insensitivity and his father's crual and depraving attitude toward the patient and his family, desapite their significant affluence. He said he became dependent on opiates when his defense of self-sufficiency began to fail him in a context of dissappointing relationships with women and much distress and frustration working with severly ill patients. More than anything else, he became aware of the calming effects of these drugs on his bitter resentment and mounting rage. He stressed how these effects of the ddrugs helped him to feel better about himself and, paradoxically, helped him to remain energized and active in his work" (Khantzian, in Yalisove 1996:436).

In his remarks, Khantzian points out how the self medication with heroin fights a pattern of rage and aggression linked to early childhood trauma, stemming from abuse and violence both in the family and in the environment. Experiences of being both victim and perpetrator of violent actions these clients discover the positive effects of the drug of choice: opiates make them "feel normal, calm, mellow, soothed, and relaxed" (ibid:435). On the other hand, the anti-depressant effects of cocaine boost energy and activity level and increase self-esteem. Cocaine users may treat themselves for mood disturbances and attention-deficit/hyperactivity problems as the effects of the drug improve attention and help focus on relationship and work life with more satisfying results.

"Originally when I evaluated this man, I thought he was using the stimulating properties of the drug as an augmentor for his usual hyperactive, expansive manner of relating. He finally convinced me to the contrary when he carefully mimicked how he put down several lines in the morning, snorted it, and breathed a sigh of relaxation and then described how he could sit still, focus on his backlog of paper work, and complete it" (Kanthzian, in Yalisove 1997:437).

The self-medication hypothesis provides a useful motive for considering treatment alternatives such as the kinds of process-oriented interventions proposed in this study. These interventions evoke and deepen the kind of experience Kanthzian's client searches for so desperately, by unfolding and completing the experiential patterns in the background - the altered state that is trying to happen, as well as the felt tendencies that give rise to that state - until a felt resolution emerges.

Another psychoanalytic approach relevant to process work theory and application understands all addictive behaviors, substance as well as process addictions, as psychosomatic disturbances (McDougall 1989). Inner distressful affect states are externalized and somatized in the body as psychosomatic symptoms and addictions. At core, addictions are a "psychosomatic attempt to deal with distressful conflict by temporarily blurring the awareness of their existence" (McDougall 1989:19). In reaction to an undifferentiated emotional life, in alxithymia, diffuse affect states are acted out rather than symbolized. In short, symptoms and addictions serve as a shield which ward off feelings, which would be threatening if consciously experienced (Leeds and Morgenstern 1993). For McDougall, addiction help overcome an inner feeling of emptiness and deadness and are part of a "false self" with which to secure inner balance. She is more optimistic about the treatment of substance users than other analysts and advocates working on developing an inner life with an eye on upcoming anxieties and fear which increasing awareness of emotions and affects may bring up.

Finally, Kaufman (1994) represents a pragmatic, integrated and very well informed approach to addiction treatment. He combines the analytic paradigm and understanding of the social and individual experiences leaving an individual vulnerable to drug use with the 12 step program, cognitive-behavioral methods, family and group therapy. The treatment model encompasses 3 stages. Stage 1 aims at achieving abstinence and includes assessment of issues and motivation, establishing a treatment plan and contract, detoxification and reinforcement of abstinence with the help of a 12-steps program or, in some cases, pharmacotherapy (methadone). Stage 2, or early recovery, employs cognitive behavioral strategies, education about conditioning factors in addiction, identification of cues that trigger relapse and craving,

establishing of a rapport system (family, network, AA), an action plan for handling craving and building of strategies to prevent early drop out of program. At stage 3, in advanced recovery, an interactive therapeutic approach is seen as most useful in uncovering the role and meaning of substance use for each person. Working through grief that comes with the loss of a life style and early traumas, letting go of narcissistic behaviors, increasing self care and finally, a since qua non of recovery, the establishing of intimate relationships while also being independent.

4.2. Behavioral/Cognitive approaches

Behavioral approaches to drug treatment are based on the learning principles of classical conditioning (Pavlov 1927), operant conditioning (Skinner 1953), cognitive theory (Beck 1979, 1993) and / or social learning theory (Bandura 1977). Behaviorism postulates that behavior to large degree results from person-environment interactional learning processes and that these same learning processes can be utilized for behavior modification (Rotgers 1996).

The principles of classical conditioning, held responsible for maintaining additive behavior, explain how environmental cues become associated with drug cravings. Since Pavlov demonstrated that classical conditioning is basic to learning by a process of association of conditioned stimuli to response of interest, behaviorists have studied the power of environmental cues in eliciting drug craving. These external (or internal) cues or triggers have been conditioned by repeated association with drug use to elicit the physiological response. Experiments by Wikler (1961) demonstrated that presentation of drug paraphernalia can provoke withdrawal symptoms in heroin addicts, and experiences of "high" when injecting inert placebo solutions (Rotgers 1996). Most inpatient and residential treatment programs use relapse prevention techniques from several treatment procedures that have emerged from the theory of classical conditioning. One, cue exposure will extinguish the association between trigger and craving response over time in the absence of actual drug use, that is, without the provision of the unconditioned response (Childress et al 1993). Second, stimulus avoidance will facilitate maintenance of abstinence by interrupting the conditioned link between stimulus and response (Bickel et al 1988). Therefore, it

makes sense to "stay away from people, places and things" which is advice given to AA members (Odgen 2000). Third, deep muscular relaxation or biofeedback methods (Monti et al 1989). And fourth, covert sensitization techniques which involve pairing of uncomfortable situations and feelings with exposure to drugs (Rimmele et al 1989), and finally, fifth, aversion interventions which pair noxious stimuli, such as shock or nausea, with craving or impulse to use.

Drug use can also be understood on the bases of operant conditioning theory. According to the operant conditioning model, environmental responses or contingencies determine occurrence and frequency of behavior and may perpetuate drug use. The reinforcing elements are a) immediate mood-enhancing effects of the drug, the high the user experiences, as well as b) fast elimination of withdrawal or other negative affect states to a "normal" level of baseline functioning. In practice, the community reinforcement approach is a widely used and effective treatment approach on the bases of operant conditioning: desirable behavior - treatment compliance, reduction of use etc. - is supported and enhanced through token economy, a consistent system of rewards.

Bandura's social learning theory (SLT) places the role model in the center of learning processes. In teaching addictive behaviors, community, family and peer groups are risk factors as they can model life styles which include substance use. Modeling can be used effectively in treatment, as it appears to produce rapid learning and behavior changes through observation and actual performance of the target behavior (Rotgers 1996). New behavior is acquired and memorized most competently when practice engages all modalities or senses, cognition, emotions, and movement. Treatments based on SLT include social skill and assertiveness training, refusal skills, anger management, relaxation and coping skills (Dodgen 2000).

Beck et al (1993) have emphasized the power of cognitive processes in initiating and maintaining substance abuse. Cognitive therapy focuses on identification and modification of dysfunctional thoughts and underlying core beliefs. Anticipatory, relief-oriented and permissive beliefs get activated in specific internal and external situations

and trigger use-related beliefs (ibid.). The therapeutic process of examining beliefs and thoughts and replacing them by more adaptive ones relies on thought recording, advantage and disadvantage balance sheets and in daily practice. According to Rotgers, some of the disadvantages of the cognitive-behavioral model are its lack of emphasis of a spiritual world view as well as poor outcome evidence for some of the procedures to effect long term change (1996).

4.3. Client-centered approaches

This research relies in part on the client-centered construct of "experiencing" to account for change processes. Client-centered therapy (Rogers 1961) is a non-directive approach to change, which relies on therapist variables of positive regard, empathy and congruence as necessary conditions to facilitate "the client's experience of exploration".

Motivational interviewing is an application of the client-centered approach to drug treatment. It is based on the recognition that motivation is the prerequisite for movement toward health and that people go through different phases on the continuum of readiness-for-change (Prochaska and DiClemente 1986, 1992). Motivational interviewing acknowledges that people are ambivalent about change. Rather then confrontation, the therapist seeks to increase motivation and engage the client where she/he is on the motivational continuum. "Motivation for change does not simply reside within the skin of the client, but involves an interpersonal context" (Miller and Rollnick 1991:35).

In other words, the problem with client attrition and therapist frustration in drug treatment may have to do with inappropriate therapist interventions. What is commonly viewed as resistance and denial, in this context, may be therapist blindness to feedback. Research shows that a confrontational therapist style in drug treatment does not work well. In fact, the greater the level of confrontation, the greater the likelihood that the client was drinking again one year after treatment (Miller et al 1993).

The principles for enhancing motivation for change facilitate positive therapeutic alliance: therapist expression of empathy, i.e understanding of client's ambivalence; exploration and amplification of client awareness of discrepancies between goals, values and behavior; avoidance of arguments and labeling to decrease resistance and frustration; rolling with the client's resistance; support self empowerment, the client's confidence in his/her plans and outcome (Bell and Rollnick 1996). Therapeutic strategies involve exploration of a typical day, advantage and disadvantages about use, client concerns and provision of information if the client wants it.

These guidelines accord well with the main process-oriented principle of feedback orientation. Feedback may be the single most important factor to enhance therapeutic alliance - which, in turn, is one of the main motors for change not only in therapy but also in addition treatment. Another crucial factor, particularly in addiction treatment, may be an explicitly spiritual orientation. Process work not only embraces Jung's spiritual worldview but designed specific techniques facilitate the discovery of transpersonal meaning in symptoms and addictive processes.

4.4. Family Therapy - addiction as a homeostatic functions

In the perspective of family therapy and systemic models the person is part of a context and that individual change requires change in interactional patterns with and in the relationship to the particular context. Where psychodynamic perspective searches for pathology in the individual as a result of early developmental problems, the focus on systems discovers addiction / disturbance not within the patient but within a particular family structure, the patterns of communication or dynamic interactions between family members. The dysfunctional behavior or the addictive tendency is elicited and reinforced by a system about which it is a "comment" (Schwartzman 1975). The homeostatic model views adolescent drug addict or the identified patient as a functional equivalent of the stability of the relationship between the spouses. The identified patient reacts symptomatic to prevent marital conflict and divorce and his negative feedback regulates homeostasis. Modern system epistemology perceives the addictive behavior not only as negative feedback reinforcing the tendency to

homeostasis but recognizes its evolutionary potential to induce changes (Dell et al 1981).

4.4.1. Psychodynamic family therapy

Psychodynamic approaches to family therapy include, among others, Ackerman (1958), Bowen (1971), Borosmenyi-Nagi (1973) and Kaufman (1992). Aimed uncovering the influence of past patterns on present functioning, cognitive and affective encounter with the past are utilized to effect insight. Bowen emphasizes cognitive change and affects are to be kept to a minimum. Conflicts between parties lead to the use of third parties (drugs) to relieve tension. Self-knowledge of therapist to track feeling responses and countertransferential reactions as well as thorough assessment of the family history to help the family break dysfunctional interactions and the projection / transference of personal material on other members. Genogram and family chronology are instruments used to plot characteristics, relationships and events in family historical perspective. Kaufman (1992) recommends as a first step utilizing the family to help initiate detoxification before attempting treatment. If abstinence cannot be maintained, pharmacological treatment may be necessary to enable family therapy to occur.

4.4.2. Structural approaches

For Minuchin (1974, 1992), the problem is located in specific feedback loops or transactional patterns between individual and environment and, in individual responses to those particularities. Family structure refers to implicit demands that organizes the manner the family interacts (Kaufman and Kaufman 1992). Rules govern interaction and family subsystem, which are formed by generation, interest or function. In response to stress, some families become rigid and the system as a whole unable to cope. The focus of structural family therapy is on identifying dysfunctional interactional patterns and challenging them. Therapy moves from the identified patient to the symptom and the various family members and facilitates alternate experiencing in the family. In case of family dysfunction, a new family organization is achieved by restructuring interactional patterns and establishing clear boundaries between subsystems. The goal is to enable the family to provide an optimal matrix for the sense

of autonomy and the sense of belonging to develop, both which are essential for individual well being and for dealing with stresses.

Therapeutic strategies include joining the system and inducing change. Techniques to challenge the homeostasis include a contract, probing or balanced input from blending in with the family to increasing stress, facilitate direct communication between members, making boundaries and giving homework and paradoxical tasks. Therapists may manipulate the family mood by taking over affective states to force a change in atmosphere. For Minuchin, joining the family is prerequisite for therapist leadership necessary for reality reconstruction and to establish new rules that support individual growth and family system evolution.

4.4.3. Structural strategic family therapy

with drug addicts (Stanton 1977; Stanton and Todd 1992) relates addictive behavior to the transitional process between adolescence and adulthood and the problems associated to it in the absence of adequate role models. The concept of pseudo individuation describes the relationship of the addict to the family. Choosing a drug career is an adolescent protest against norms and attempt at separation from the family. The addict remains, however, in close relationship to parents, often to the mother, and prolonged co-habitation is common (Kaufman 1994; Cirillo et al 1998). Therapeutic strategies rely on structural interventions and on Haley's strategic approach (Haley 1977) which includes a specific plan, extra-session events and paradox interventions. Stanton describes typical family patterns found with drug abusers. One such patterns revolves around a very close, dependent mother-son relationship and an absent distant father. 50% of parents of adolescent drug users have a drinking problem. Fathers tend to be upset by the behavior more so than the mothers who tend to act protective of the child. In many cases, there is an atmosphere of permissiveness together with a sense of powerlessness and blame on external people and forces. The role of the addict is understood in its homeostatic function to maintain family or marital stability serving a "noble sacrificial purpose" (Stanton, in Kaufman 1992:50). The identified patient is the intermediary in all familial transactions. The strategic model focuses on the symptom and engages the larger family network in

therapy making them responsible for clearing up the problem. As soon as the drug users assumes a more responsible role, goes to work, leaves the family or is otherwise not available anymore, conflicts between spouses usually come to the foreground which then need to be resolved (Haley 1980).

4.4.4. Communications therapy

Bateson (1956), Haley (1977), Satir (1972) are representatives of the communications theory and therapy. In this view, the symptom has a homeostatic function to maintain the family stability. The focus is on incongruent messages in which the intended message is in conflict with unintentional, often non-verbal signals. Bateson (1956) identified a pathogenic pattern in the so-called "double bind", a sequence of communication involving a pragmatic demand and another mutually exclusive message. The formal sequence of the double bind is (in Kaufman 1992:310): 1) two different messages given simultaneously, frequently one verbal and one non-verbal. 2) the receiver of the message is intimately involved with the sender (in a lower rank) and cannot become detached from the message. 3) the messages are mutually exclusive. 4) the receiver is not permitted to comment on the double bind or express his or her feelings about it. Double bind communication has been proposed as a causal factor in the etiology of schizophrenia and, by extension, drug abuse. The drug-state provides, like an extreme state, a path to leave the problematic field of communication. Communication therapy facilities clear communication and the therapist assumes the role of a communication trainer, establishing rules and teach people to listen, not to use third parties, to let other speak, not to read minds and to follow communication in a linear manner.

The communications approach (Bateson 1973, Watzlawick 1967) has influenced modern therapies like neurolinguistic programming (Bandler and Grinder 1975, 1976) and subsequently, process work and inspired application of communication theory to working with dream and body, relationship and groups. Noticing signals and double signals in the corresponding channels helps the therapist support the client process and discover structures in the flux of process on which to base his interventions.

4.4.5. Behaviorally-oriented family therapy

Almost all therapy including family work involves the use of behavioral techniques. Stuart (1971) and Wood (Wood et al 1977) represent behavioral approaches based on classical and operant conditioning. -The symptomatic behavior is understood as being maintained and constantly reinforced by the parent responses. The parents are taught to extinct their reinforcing behavior and instead, reinforce the desired behavior. Wood believes that punishment counterproductive as it may serve the child as a alternative to the desired behavior which, in turn, would be an experience of defeat for the child. If parents join and give one clear message without leaving room for any alternative behaviors, the child would learn best and acquire new behavior.

Noel and McCrady 1984 (in Kaufman 1992) list some behavioral techniques with drug use. In the case of an alcoholic spouse, behavioral therapy teaches the couple what behaviors maintain the drinking problem and helps them keep track of the quantity of drinking. Sessions are devoted to identifying and working on relapse triggers and replacing them by affirmation or imagery techniques with positive associations. Self-contracting for goals, reviewing positive consequences of abstinence and establishing rewards for achieving these goals may be at the center in other sessions. Cognitive-behavioral strategies include rehearsal in fantasy of resisting urges to drink, changing irrational or negative thoughts, learning alternate behaviors in lieu of problem behavior and role playing of situations in which the client refuses a drink. Global techniques include skill and assertiveness training, homework assignments, including reinforcement through daily practice of these techniques.

Process work makes ample use of behavioral techniques and, in fact, the intervention presented in this paper could be understood from the point of view of operant conditioning and social learning theory. With the help of a role model the client is learning to recall a feeling state, grounded in body experience, practice and transfer it to real life situations in fantasy, imagery and role play. In addition, the work includes extinction of the link between drug and effect by repeated exposure, associating drug use and pain and establishing and practicing alternative behaviors.

Love Dogs

One night a man was crying,
Allah! Allah!
His lips grew sweet with the praising,
Until a cynic said, "So, I have heard you
Calling out but have you ever
Gotten any response?"

The man had no answer to that.
He quit praying and fell into a confused sleep.

He dreamt he saw Khidr, the guide of souls,
In a thick green foilage.
"Why did you stop praising?"
"Because I never heard anything back."

"This longing
you express *is* the return message."

The grief you cry out from
Draws you toward union.

Your pure sadness
That wants help
Is the secret cup.

Listen to the moan of a dog for its master.
That whining is the connection.

There are love dogs
no one knows the names of.

Give your life to be one of them.

Rumi

PART V: Process Work with Addictions

5.1. Process Work

"The governing idea behind my work is a mixture of scientific realism, phenomenological respect for individual experiences, and the suspicion that everything that happens contains the seeds of our totality" (Mindell: 1989: 53)

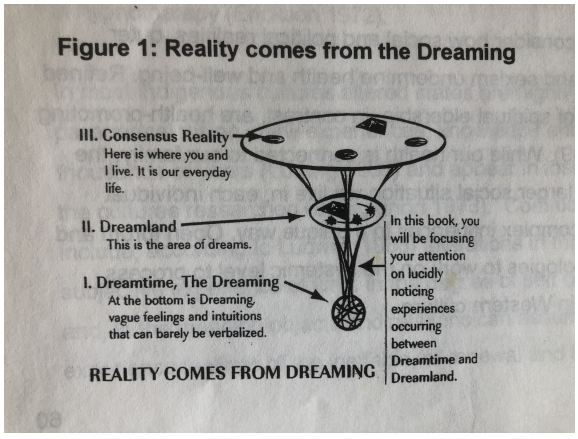
Process work is an innovative approach to experiential psychotherapy, dream and bodywork, conflict resolution and large group work. An elegant framework organizes psychotherapy, creativity, spirituality and politics into a unified approach to personal and collective development. From awareness of rank and power differences in relationship and global dynamics to the recognition of individual and collective expression in symptoms, extreme states and addictions, process work inspires a fresh look at change processes. It has developed a sophisticated body of theories and applications as well as techniques for working with the entire spectrum of human processes.

Developed in the 1970s and 1980s by Dr. Arnold Mindell, process work strives to follow the process - the flux of human experiences - especially the ones perceived as problematic or painful. Unintentional processes such as symptoms, relationship problems, extreme states of consciousness, addictions, group conflicts and social tensions, when approached with curiosity and respect, can lead to new meanings and release powerful energies which are vital for our personal and collective growth. A central tenet of process work holds that the solution to a problem is contained within the disturbance itself or, the process is its own solution. Whether it appears as an inner conflict, a symptom, an addictive tendency, a tension in relationship or as a group disturber, the final perspective of process work views all experience as potentially meaningful and purposeful when unfolded, explored and understood. This final perspective arose from the psychology of C.G. Jung who held that the keys to the future are present in every situation and postulated an immanent movement toward wholeness called individuation. For Jung, the *causa finalis* of processes demonstrate purposefulness, a pull from the intents of the unconscious field (Jung 1979).

Process oriented methodology complements a medicine oriented toward illness and the causal factors or pathogenesis. The focus of process work is on what moves a person in the direction of ease (Antonovsky 1987). This is not to say that allopathic medicine is not very necessary. Yet life on the whole wants to be lived and it is when we believe in the totality of our experiences and follow them with interest, curiosity and mindfulness, that we find meaning and purpose, community and a magic in life that enlivens us and boosts our energies.

The spiritual principle which organizes process work philosophy and informs feeling attitudes and techniques of practitioners, is called "Dreaming" (Mindell 2000), perennial philosophy's mystical source of reality. It is the life force of indigenous peoples, the Tao that cannot be spoken, the unbroken wholeness out of which material reality arises. Process work is a training of focusing onto the subtle levels where processes emanate from, on barely noticeable dream-like tendencies and "sentient experiences" at the edges of awareness. With lucid awareness one can notice that experiences are preceded by even subtler tendencies, by the Dreaming (Mindell 2000). Usually, we marginalize much of our pre-conceptual experiencing to the effect that these subtle tendencies are amplified and reappear as dreams, body symptoms, relationship difficulties, addictions and other unusual states of consciousness. Mindell calls this level of process coagulation dreamland - our conscious awareness cannot but notice the louder more extensive signals of dreamland, now separated into body and dream, into a "this" and a "that".

Figure 1: Reality comes from the Dreaming



As processes / experiences rise from the non-dual world of oneness to the dual world of separate reality where our normal awareness functions, we begin to notice body and mind as distinct phenomena manifesting in dreamland as dreams, symptoms, conflicts or addictive tendencies. Mindell called this entity which is both dream and body at once, the "dreambody" (1982). He discovered empirically that body symptoms and nighttime dreams are symmetrical expressions, which carry equivalent meanings (1985). When amplifying the experience of a tumor with a cancer patient, the person began to feel and act explosive - just what his night time dream wanted when he dreamt his medicine was an exploding bomb. Never having been able to explode and express himself sufficiently in life, the Dreaming expressed his almost forgotten need. The dreambody stands for the "total multi-channeled personality" which is trying to grow and develop in life. "When it signals to you in the body we call it a symptom, when it signals to you through a dream we call it a symbol" (Mindell 1985:39). In analogy, when the Dreaming signals to you a tendency to certain foods, an attraction to particular substances or processes, we usually call it an addiction. However, in the altered state there lies a deeper need for a particular feeling, a longing for an experience not readily available to our everyday mind. In working with addictions, it is central to reconnect to our deepest yearnings and to noticing what we marginalize and neglect. The "high" serves as a door to entering the stream of inner experiences and to carrying it forward. As the therapist and client notice and make conscious those emerging patterns in a client's experiences, the co-creative dance unfolds and wonder, awe, humor and compassion make room for our humanity.

Finally, it is equally important to consider how social and political realities, outer oppression, internalized racism and sexism undermine health and well-being. Refined psychological rank and a sense of spiritual eldership, in contrast, are health-promoting factors (Mindell 1995; Morin 1999). While our health is connected to our family, the community atmosphere and the larger social situation we live in, each individual responds to these multiple and complex influences in a unique way. Open forum and large group process are methodologies to work on the systemic level to process oppression and abuse endemic in Western culture.

5.2. Altered states of consciousness

"There is in all of us a desire, sometimes latent, sometimes conscious and passionately expressed, to escape from the prison of our individuality, an urge to self-transcendence. It is to this urge that we owe mystical theology, spiritual exercises and yoga - to this, too, that we owe alcoholism and drug addiction" (Huxley 1964:338).

One premise of Process Work holds that our normal everyday consciousness is but one state of mind and that individuals seek altered states in an attempt to transcend the status quo. These ideas build on decades of research in the field of psychology on experiences with altered states of consciousness (ASC). One of the starting points lies in the empiricist attitude of William James (1902), who, early on, noted the myriad states of mind and their potential:

"It is that our normal waking consciousness, rational consciousness as we call it, is but one special type of consciousness, whilst all about it, parted from it by the filmiest of screens, there lie potential forms of consciousness entirely different. We may go through life without suspecting their existence; but apply the requisite stimulus, and at a touch they are there in all their completeness, definite types of mentality which probably somewhere have their field of application and adaptation." (James 1976:305).

There seems to exist a universal passion in humans to occasionally alter the baseline state of mind (Weil 1972), a basic striving toward self-transcendence in the search for meaning (Frankl 1968; Carroll 1993), a pull toward actualizing our highest possibilities (Maslow 1975), an innate tendency toward wholeness (Jung 1981). The use of altered states of consciousness as an conspicuous dimension in human change has been recognized in modern humanistic and transpersonal psychotherapies alike (Maslow 1964; Tart 1972; Grof 1980, 1988; Mindell 1981,1993; Walsh 1995) as well as utilized in hypnotherapy (Erickson 1972).

In most indigenous cultures altered states are highly valued as avenues for healing, paranormal vision, new experiences, knowledge and well-being of the community for thousands of years (Ludwig 1966) and appear in institutionalized form in some 90% of the cultures researched (Bourgignon 1973). Common features of altered states include, according to Ludwig (1966) alterations in thought patterns and perception, in subjective experience of time, in the degree of self control, in emotional experiencing and, in the meaning objects and relations can assume. Subjects in altered states often experience feelings of the ineffable, of renewal and transformation. Similarly, Walsh

(1995) lists key dimensions of altered states. They are changes in attention/awareness and concentration, in communicative ability, in the degree of self control, in the level of arousal and the sensitivity to sensory perceptions, in the sense of identity and in affective experiences of pleasure and pain and, finally, in content of experience.

For Charles Tart, the altered state (as well as the normal state) is an experiential reality. People know with certainty when they are in a normal state and recognize many altered states, past or present, readily. "For any given individual, his normal state of consciousness is the one in which he spends the major part of his waking hours", whereas an altered state is "one in which he clearly feels a qualitative shift in his pattern of mental functioning. . ."(1972:1). Tart introduces a useful and precise terminology of different states of mind. He defines a discrete state of consciousness (d-SoC) as "a specific pattern of functioning of the mind, recognizing that this pattern may show a range of variation in its specifics while still remaining the same overall pattern" (1983:14. Further, a discrete altered state of mind (d-ASC) as a "radical alteration of the overall patterning of consciousness, such that the experiencer (or perhaps an observer) can tell that different laws are functioning, that a new overall pattern is superimposed on his experience" (ibid.).

A state of mind thus is likened to a pattern, a style of overall functioning, analogous to a personal paradigm governed by (often) unconscious assumptions, sets of rules and implicit belief systems that stabilize and at the same time limit awareness in a given state. Identifying different experiential patterns and associated verbal and non-verbal behaviors clients present, and especially, their variations, limits, and transitions into alternate states, is instrumental in exploring experiential meaning in therapeutic work with addictive states. In the present study, the sober normal state and the longed-for altered state represent two prominent and distinct states of mind -both identifiable to the human observer -who is considered the best instrument for pattern recognition in psychotherapy process research (Rice and Greenberg 1984).

In psychology, Charcot and Janet have described spontaneously occurring altered states in the late 19th century. In the earliest form of psychoanalytic treatment, Freud

accessed dissociative states with hypnosis in the treatment of hysteria (Breuer and Freud 1892). Jung's concept of "complex" pointed to constellations of internalized affective-cognitive schemata or inner parts of self (1904) which can unwittingly possess a person. Federn (1952) researched "ego states", characterized by dissociation, in his study of extreme states of consciousness while object relations theory introduced the idea of a myriad of internalized parts as self and object representations (Jacobson 1964). Various personality disorders are characterized by patterns of typical state changes (Kernberg 1975; Masterson 1988), dual or multiple-identity processes (Searles 1986) or sudden shifts in identity as in multiple personality or identity disorders. Recently, Krippner et al reviewed dissociative states and the problems associated with dissociative narratives and their potential use in psychotherapy (1997).

The therapeutic use and spontaneous occurrence of altered states leave no doubt that psychotherapy needs techniques to access them in order to make facilitate development. There is evidence from altered state research (Tart 1983) and from psychobiology (Rossi 1993) that intense emotional experience, which occurs in particular states of mind create state-bound systems. They, in turn, can only be influenced when in that specific state: change occurs when we re-access that particular state and in that state, restructure old programs or imprint new patterns.

Thus, altered states have tremendous potential and may be one of the basic ingredients in the change process. Therapeutic interventions aim at unlocking the sensory-grounded, cognitive-affective and relational potentials by focusing attention, enhancing and deepening the client's awareness of such state-specific experiential patterns. The "high" the person yearns for often is a positively-toned feeling state; a sense of belonging, a feeling of safety, warmth, joy, happiness or love. Having an intimate experience of positive feelings or, activating the corresponding cognitive-affective schemata, are important steps in the developmental process (Ciompi 1982; Mascolo & Griffin 1998). They contribute largely to our sense of purpose in life, to motivation, interest and excitement and, last but not least, better performance (Greenberg & Paivio 1997). In this spirit, the client will be more open to dealing with

inner hurt, abuse, self-criticisms, depression and suicidal tendencies that come with severe addictions.

In modern psychotherapy (Perls 1951,1969; Mindell 1982-2000) it is commonplace to work with various parts or dream figures and, negotiating disagreements and conflicts between aspects of self, until resolution occurs. Some of these ego or self aspects may be less known, less consciously represented yet having impact on client behaviors, feelings or experiences. The therapeutic work brings attention to these disavowed parts and awareness of affective-cognitive states associated with them can bring about resolution or integration into the main land of the narrative of self.

Metaskills

Some of the most important factors in the facilitation of an ASC include set and setting. Ludwig describes them as "cultural expectations, role-playing, demand characteristics, communication factors, transference feelings, personal motivation and expectation (mental set), and the specific procedure employed to induce the ASC all work in concert to shape and mold a mental state with a unique flavor of its own" (1966:227). The process-oriented interventions presented in this thesis are inseparable from these common factors (Frank 1974; Karasu 1986) and include therapist empathy and warmth, the infusing hope and expectation, and the furthering of beliefs, such as meaningfulness of behavior and possibility to experiencing desired states without the use of drugs. The feeling attitudes or metaskills of the therapist are central and, when used consciously, a therapeutic instrument often more important than the specific technique employed (Mindell 1995). To intervene effectively, therapist metaskills and techniques enhance client mental set as to facilitate an event – a special moment in time or *kairos* (Kelman 1969) - during which "imprinting" of a new and important affective experience can have maximal effect.

Observing and experiencing altered states

How then can we bring about changes in client states and what are indices of such good changes? In the process-oriented model, being-in-experiencing of an altered state and, simultaneously, mindful attention to the experience is an auspicious

moment for client movement, change or progress. Mindell advises to stay sober during altered states of consciousness in order to be able to "consciously intervene with spontaneous experiences, combining altered states with wakeful interventions" (1993:83). The author proposes that experiencing altered states, when accompanied by an inner mindful witness, are change events. They can make a “good hour” (Orlinsky and Howard 1967), they are “good” (Hoyt 1980), “significant or critical” (Elliott 1983) or “very good” (Mahrer (1987) moments - indicative of client movement or change. The desired states have been characterized as exceptional, peak, as new being states or new personality states (Mahrer 1996). They are brought about by a “sharp and complete shift in client attention” (Mathieu and Klein 1984:215). In experiential therapy this “felt shift, or referent movement is the ‘peak’ moment when change and growth are possible” (Mathieu and Klein 1984:240).

Oftentimes, even subtle shifts in awareness/experiencing open up new potentials and prepare the ground for further movement to follow. For the purpose of the study, process work definitions of states of consciousness, i.e. primary and secondary processes, will be defined below.

5.3. Addiction as spiritual search

"The sway of alcohol over mankind is unquestionably due to its power to stimulate the mystical faculties of human nature, usually crushed to earth by the cold facts and dry criticisms of the sober hour. Sobriety diminishes, discriminates and says no; drunkenness expands, unites, and says yes. It is in fact the great exciter of the Yes function in man.. It makes him for the moment one with truth. Not through mere perversity do men run after it - it is part of the deeper mystery and tragedy of life" (James 1976:304-305).

In the treatment of addiction, the recognition of the potential of so-called spiritual or meaningful experiences to initiate positive change toward abstinence has a long tradition. It flows from C.G. Jung through Bill W. to the Alcoholics Anonymous (AA) movement and the 12 steps, the most successful model in the United States for overcoming alcohol addiction (AA 1953, 1976; Ellis and Schoenfeld 1990). In his famous letter to Bill W., Jung made a remark that would become instrumental in the foundation of AA:

"You see, the alcohol in Latin is *spiritus* and you use the same word for the highest religious experience as well as for the most depraving poison. The helpful formula therefore is: *spiritus contra spiritum*" (Adler 1984: 198).

In the same letter, Jung expressed his belief to Bill W. that the addict is a seeker of God:

"His craving for alcohol was the equivalent on a low level of the spiritual thirst of our being for wholeness, expressed in medieval language: the union with God" (ibid.).

Jung considered experiencing the numinous to be the real therapy (Jung 1979); it provides one with new meaning and direction in life. Similarly, spiritual experiences have been seen as therapeutic and conducive to recovery from addiction (Assagioli 1965; Leuner 1996; Farkas 1973; Hein 1974; Grof and Grof 1990; Vaughn 1991; Georgi 1998). In the same vein, Christina Grof found the impulse behind addiction to be "this fervent thirst for wholeness" (1993:17), a craving for experiencing a larger sense of self. When experiences of unity and closeness to the Higher Power or a deeply felt sense of belonging becomes available, the craving for the drug lessens. When made conscious, the underlying search in addiction becomes apparent: the addictive process takes on a numinous quality and can become its own resolution. However, when the attempt at overcoming the ordinary state of mind is acted out instead of completed internally, the consequence may be self-destruction rather than liberation (Grof and Grof 1990). Process Work seeks to facilitate with psychological means the conscious experiencing of the inner potentials the addict searches for by means of drugs, to bring the individual closer to her emotional and spiritual home, to a sense of belonging and inner and outer unity.

5.4. Process Work with addiction

Accordingly, process-oriented psychology understands addictions to substances and compulsive behaviors as attempts at wholeness (1988; 1989c), as a search for neglected aspects of oneself, and an expression of our yearning for a deeper connection with "Dreaming," the mystical core of reality (Mindell 2000):

"...alcohol is a symptom of trying to find dreamtime in cosmopolitan reality; it is a symptom of loss of rootedness in wholeness and dreaming, and of the pain of oppression and disenfranchisement. Drugs are means of getting around personal history and journeying to other realms to find the missing pieces of reality" (Mindell 1993:114).

If we accept the premise that the yearning for altered states is a potentially meaningful and purposeful tendency toward wholeness, important considerations concerning the treatment of addiction arise.

The core belief that addictive experiences are expressions of growth tendencies helps clients and therapists alike to welcome and value even the strangest experience. Within such an atmosphere the details of the deepest yearnings can emerge and become available to the client through other means than drugs.
A crucial tool is awareness or attention. We can train our perception to notice dreamlike events on the edge of awareness, to sense into the mass of non-verbal experiences, and attend to the subtle perceptions arising out of the fuzzy and murky waters of the unknown. Developing our "second attention" helps us perceive and enter the flux of experience, unfold and complete altered states emerging on the fringe of who we think we are. Such perceptual shifts are at the core of peak experiences: they can bring about client movement or change.

Process Work studies experiential patterns according to their distance from awareness and according to the channel or mode of experience in which they are happening. Primary processes (PP) are experiences individuals or systems embrace and identify with. Secondary processes (SP) are further from awareness and happen outside of an individual's or a group's familiar identity. The experiential barrier that separates PP from SP and restricts the world view and its associated feelings and behaviors is called an "edge" (Mindell 1985; Goodbread 1997).

Therapeutic strategies support awareness of experiential patterns, both established ones and newly emerging ones that lie beyond the edge of one's current awareness. They also facilitate exploring the edges of awareness and associated belief systems, to bring closer to home how patterns around edges limit our experiential capacities. All interventions are closely joined to and in accord with experiential patterns and very sensitive to client feedback. Change, in this perspective, happens through awareness, through embracing and unfolding one's experiences - "through appreciating what is already happening" (Mindell 1988:xiii).

From a field perspective, the marginalized parts expressing themselves in addictions do not belong to personal psychology alone but are connected to the environment and to the spirit world. They are all expressions of an inherent tendency toward wholeness.

On a psychological level, addictions can be seen as an effort to relate to inner parts of ourselves that our sober lifestyle excludes, and which we cannot experience and use deliberately (Mindell 1988; Hauser 1994). The addictive tendency is seen as an attempt at wholeness, as a vehicle into a particular altered state that lies beyond the contracted vision of our everyday state.

On a relational level, the altered state represents some essential quality which is not consciously lived in relationship. For example, if love and warmth are marginalized, an impulse sets in toward substances that carry the promise of love or warmth. Relational work makes conscious how these very experiences get marginalized in the moment-to-moment interactions and helps both partners over their edges to expressing their feelings and feeling reactions.

On a social level, the communal family becomes whole by welcoming and listening to the messages of the "city shadow" and reflecting them back to the mainstream to effect social change. Social interventions include community work and town meetings to address the systemic conflicts and abuse issues in the background of addiction (Mindell 1995, 2000b).

From a spiritual viewpoint, the direction of attention is toward the Higher Power one believes to be the mystical source of process. Australian Aboriginal people call the power behind everyday reality, the "Dreaming": it is the energy or life force that moves us. "Indigenous people speak about Dreamtime as the root and essential power from which everything else comes; quantum physicists speak of an invisible mathematical entity called quantum potential from which reality arises" (Mindell 2000b:8). If we attend to our "sentient experience" - which precedes all thoughts, images, or feelings that can be expressed in words - we can sense Dreaming in the form of subtle perceptions. It is an empirical reality, something one senses. With awareness of this

preconceptual level, we can sense, for example, that every movement is preceded by a "tendency" to move in a certain direction. If we dissociate from our "sentient experiences" and ignore them, they tend to reappear in the form of addictive impulses toward the very experiences that have been marginalized on a preconceptual level. “We know today that dreaming and NCR experiences appear in everyday life in the form of body symptoms, relationship signals, and addictions, as well as in disturbances of attention, slips of tongue, and fantasies” (Mindell 2000a:499). The marginalized returns as addictive tendencies and unintentional communication signals, or double signals, in our moment-to-moment interactions. Addiction work, in part, is an effort toward reconnecting to our sentient experience and developing the ability to notice our subtlest tendencies and feelings before they somatize or express as addictive impulses.

We see how addictive impulses carry important information about life. Like body symptoms, addictions can teach us about our physical body and our health, about the longing for particular states of mind or parts of ourselves we have little contact with, about our deepest sentient experiences, from whence the tendencies for altered experiences arise. They teach us about the atmosphere in the social world around us, in our relationships, in our family, our group, and the communities we belong to. Addictions can bring the gift of healing and be their own resolution when we live the sentient experiences consciously, instead of marginalizing them and acting them out externally.

5.5. Process-oriented family work - addictions as messages for change

Families become torn between the need for homeostasis and the need to change and grow. While addictive behaviors have long been seen as protecting the status quo of a family system, theories based in evolutionary epistemology (Dell 1981) consider symptomatic behaviors to be positive feedback, which may push a system in a new direction. Prigogine (1986) demonstrated how amplifying fluctuations in a given system forces the system into a new and more complex structure.

In the view of process work, the altered states the clients are searching for fit into the context: they reflect the dreaming processes which the individual, the family and the culture as a whole tend to disavow. Addictive states, in this view, spring up as reactions to a system that needs more conscious contact to the quality of the states. Herein lies purposefulness and change potential of these troublesome states: as they mirror unconscious aspects of the system, they push the system to develop if other family members take on the role with awareness too.

Let us think of family interactions as a group process. The family field consists of roles which need to be filled. Roles which are not consciously filled can act as disturbing "ghosts" haunting the atmosphere, making people tense, angry, bored, sleepy etc. Incongruities between what any group says it does and what it actually does flood the atmosphere and create an "information float, a sea of signals that have an impact, but their impact is disavowed" (Mindell 1992:14). The disturbance can keep the family stuck when all focus revolves around the problem or serve to propel the family into new behaviors when the qualities reflected by the disturber are picked up. The issue is with the mainstream culture of the family system which cycles in a limited set of roles and needs to open up to its disavowed aspects. It is often the identified patient who becomes the channel for the family's direction of growth. Change and growth take place if the disturber's role is explored and lived consciously by other family members.

I remember seeing a family who thought of themselves as very harmonious except for their 17 year old daughter who was using heroin. The parents felt terrorized by her defiant behavior, her drug use and promiscuous life style. The mother was overwhelmed by the conflicts and resentful had she not sacrificed her career for the family. The father tended to lean back, polite and cooperative, with an occasional outburst of his repressed anger. He admitted having a regular drink or two and complained of feeling isolated in the family. With all their focus on tranquillity and harmony, heroin seemed present in the sessions. Neither of them felt able to confront the daughter nor address the conflicts in their own relationship. Working on the premise that the "disturber" is bringing a new direction of growth for the family, I felt that, in fact, the client was the powerful one ruthlessly doing what she wanted to. The

parents needed to learn from her and pick up their own power and ruthlessness, confront their own inner barriers to a full life, and be more direct in relationship. They courageously started to pick up the challenge. The wife was unhappy with their sex life. She wanted to pursue her own career and take care of her relationship needs more. The husband was turned off sexually because he felt powerless. He needed time to discover his needs and work on his anger and fear of abandonment. As the couple worked through some of their personal issues and relationship conflicts, they became stronger to confront their daughter until she agreed to detoxification and entering a therapeutic community.

PART VI: Theoretical grounding of the study

Human beings from all walks of life, alone and in relationship and groups, wake up and feel alive when supported and seen. When a person's moment-to-moment experience is unfolded (carried forward) until new meanings and a sense of purposefulness emerge, potentially, there is progress toward the positive end of the health ease/dis-ease continuum (Mindell 2000; Gendlin 1996; Greenberg et al 1998; Antonovsky 1979, 1987). Knowing that one's life is meaningful is the central tool to survive even in the worst circumstances. Therefore, reorienting a person toward life tasks and supporting the inherent striving for meaning to be fulfilled is crucial in a salutogenic approach (Frankl 1959). Positive emotions and a sense of meaning play a central role in the developmental process and psychotherapy can use this potential to increase the sense of purpose in life, stimulate motivation, interest, excitement and, ultimately, better performance (Greenberg and Paivio 1997). When our everyday life experiences and difficulties make sense to us, when personal meanings emerge from our symptoms, conflicts and addictions, we often feel closer to our wholeness, healthier and more integrated. It is when we search only for pathology and dysfunction that we miss the chance to tap into hidden potentials for development. Then, instead of using this constructive life force, we may help ameliorate individual symptoms but loose the whole person and her life story as well.

6.1. Foundations of the study

Two theories have been particularly helpful to ground this process-oriented outcome study and providing valid and reliable assessment instruments. The concept of **"salutogenesis"** (Antonovsky 1987), which implies a shift away from pathogenesis to the study of potentials and resources in human situations. Core issues are the final causes of health and accordingly, the development of interventions, which push a person toward health. The **"experiencing"** dimension in psychotherapy process (Gendlin 1962). Experiential theory and process work share common ground in their focus on "experiencing" or "process" as the central tenet of the interactional therapy process. Meaning is experienced when we use a "felt sense" and focus on the vague and not-yet verbalizable experiential process or on "sentient tendencies" (Mindell

2000). The movement of carrying forward the process (following, unfolding) allows for new meanings, emotions and insights to occur.

With the salutogenic orientation, process work shares the concern for health-promoting factors, with experiential therapy, it accords on the importance of moment-to-moment experiencing or process for change. Both one's inner attitude, one's sense of coherence, and the ability to be-in-touch with one's process are crucial factors in maintaining and improving health and thus, necessary ingredients for change.

For reasons of close affinity of these constructs to process work, the "Sense of Coherence" scale or SOC (Antonovsky 1987) and the "experiencing" scale or EXP (Klein et al 1969) have been chosen as quantitative measures of change. The SOC measures a global orientation toward life or a health-promoting inner attitude. The construct assesses the extent to which protective factors are available. While the social context contributes to one's sense of coherence, it refers to an internalized attitude that allows for adequate responses necessary for maintaining well-being or for recovering health. The Experiencing Scale (EXP) measures the extent to which the client is in touch with the inner process, with emotions and feelings. Client involvement in the therapy process is understood as a function of contact with felt referents, and stresses emotions as well as verbal expression of these emotions (Klein et al 1969). Finally, in close analogy to the EXP, the author developed the Process Index as a measure of the extent of contact with "experiencing" independent of modality or form of expression.

6.2. Process Structure Analysis

For the sequencing of human interactions, form and structure of performances as well as content are instrumental in understanding the overall message. Communication theory (Bateson 1973; Watzlawick 1967), transformational grammar (Chomsky 1968) and the language analysis system devised by Bandler and Grinder (1988; 1989) have helped our understanding to discern and differentiate experiential patterns.

Like other experiential relational approaches (Rogers 1961; Gendlin 1978; Greenberg et al 1998), process work techniques are aligned to and supporting the totality of client/therapist experiences. Unlike them, process work embraces an embodied spiritual philosophy[1] which stresses meaning and purposefulness of events. Process work theory uses at core a simple and elegant organizing principle to structure observer perceptions of processes, to configure the variation of communication signals between the partners in the therapeutic dialogue into meaningful bits. The flow of process and the perception of signals depend on the observer's psychology - the experiential process is entirely interactional. Participants / observers are entangled and their perception of experiential patterns depend on their awareness, including awareness of rank, power and privilege, and personal psychology.

As mentioned, process structure analysis (Mindell 1985a, 1985b; Goodbread 1997) provides the theoretical framework and a "rational-empirical strategy" to sort out empirical observations into configurations or patterns of experience (see appendix D for elaboration on process structure analysis). The stream of thoughts, feelings and overt behavioral signals are thought to be emitted from various aspects of the personality in different channels of expression and in various degrees of association to awareness. Accordingly, experiential pattern analysis will group the ongoing flow of signals - verbal statements, paralinguistic and non-verbal signals - into clusters, and attributes them to various internal states and / or state transformation processes such as "edge behavior". A minimal yet sufficient set of formal definitions serves to identify experiential patterns: *primary processes* (PP), *secondary processes* (SP), *edges*, *channels* and *metacommunication*, our ability to communicate about the content and processes of communication. The central tools is using one's *awareness* to attend to *experiencing* and, correspondingly, the practice of focusing attention. The *first attention* focuses on matters of identity and consensus reality, our daily work. The *second attention* is the key to the dream world. It focuses on the edges of awareness

[1] The psychotherapeutic paradigm of process work embraces the final perspective which stresses the causa finalis in events or their movement toward completion. Finality is sometimes used synonymously with teleology which stands for, in process work, the idea that events are organized by the meaning they have for an observer (1989:151).

on tiniest flickers and faintest signals that are in the process of arising from the non-dual realm.

6.2.1. Structures of process

The structure of human experience is characterized by *polarity*, by a tension of opposites, a contrast between various experiential patterns (Jung 1957; Goodbread 1997). Basic polarities include **self** versus **other**, the extent to which one identifies oneself with one's experiences, the sense of agency that accompagnies all experience, behavior and expression. Given this basic polarity, process structure analysis identifies client and therapist experiences and behaviors according to *closeness and distance from awareness* or, according to the *extent to which client and therapist implicitly or explicitly identify with the processes occurring from moment to moment*. And second, the theoretical framework helps differentiating and identifying signals according to the *channels in which these experiences are happening*. In a nutshell, then, process structure analysis aims at identifying avowed and disavowed experiences - instrumental for the therapeutic process to be effective in helping the person noticing, attending to and unfolding the lesser know parts. In the experiencing process, new meanings emerge, messages which call for an integration into everyday life.

Metacommunication

The inner observer is the carrier of awareness about one's identification with processes. Awareness is central in the process work model and so is the attitude of the observer crucial for noticing the different aspects and qualities of experiences. A certain neutrality toward one's processes is prerequisite to being open to whatever is happening. When one's attention is tainted with critical or self-depreciating qualities, then, the critic in the background needs to be addressed and worked with. It is both observation of phenomena from the distance of CR time/space as well as participation in the stream of events that characterize the fluid observer (Mindell 1985).

Primary processes

Intentional messages, experiences and behaviors (verbal and non-verbal signals) which we embrace and with which we identify or would identify if asked, are called *primary processes* (Mindell 1985; Goodbread 1997). These experiential patterns are associated to who we think we are and thus closer to our identity. Active form or I-statements and associated action / states / feelings tend to be primary processes: I am happy person. I feel brave.

Secondary processes

Unintentional messages, experiences or events on the fringe of awareness, which people do not easily embrace and which they do not identify with, which they perceive as foreign and tend to disavow and neglect are called *secondary processes*. (Mindell 1985; Goodbread 1997). Little conscious relationship connects these kinds of experiences to self - they happen to the person, they disturb or attract her. In verbal statements, they take the form of negations, use of future and past tense, qualities of others, third parties, other places and times: these are indications of secondary processes (I am not disappointed right now. Peter is angry with you. On the beach, I was mellow and happy). Secondary processes show up in paralanguage (tone, tempo, rhythm, pauses, sarcasm, irony) and non-verbal signals (body positions, movements, facial expressions, eye movements, breathing).

Edge

A crucial concept in process work, the edge delineates various parts of a system. The edge refers to the limits of primary experiential patterns which we identify with and which we embrace. It separates primary from secondary processes, the known from the unknown, our identification with who we think we are from the disavowed experiential realms. "An edge forms a definition of oneself and comprises the boundaries of consciousness. It is always associated with ideas, deep-seated belief systems, with personal identity, with a life philosophy about who one really is" (Mindell 1987:47). It denotes the limit of what we can do, feel, tell. Dynamically speaking, at the edge, the process splits into primary and secondary processes with rapid and

energetic succession of conflicting signals that mark the border beyond which unexplored experiences lie.

Channels

While each culture, family or individual may use different modalities in which they operate in, in general, processes can be differentiated according to the signals in which they appear to us (Mindell 1985). Processes move in various tracks. Signals reach our awareness in different modalities; in *basic* channels such as auditory, visual, proprioceptive (body experience) and kinesthetic (movement); in *composite* channels such as relationship and environment/world; in *coupled* channels as in simultaneous movement and proprioceptive experience. Some channels are *occupied* by our awareness or are primary processes (I am looking at the picture); in contrast, secondary processes flow in *unoccupied* channels. Unoccupied channels are filled by other people, objects, places etc. (Mindell 1985). In addictions, drug experiences and associated altered states are happening in unoccupied channels (Peter sees me how I really am. Heroin makes me feel calm and relaxed). People usually identify with some channels that are more habitual and dissociate from others which appear more foreign. Knowing the main channels is important in pacing a person's primary process and for integrating experiences, observing unoccupied channels crucial for exploring and entering new experiences "…the main channel can be used to integrate irrational secondary processes. An unoccupied channel will bring the client the most powerful and uncontrolled experience" (Mindell 1985:24). The therapeutic process aims at helping the person identify with the creator of the experience in the background - the appropriate place to begin facilitation is in the precise channel in which the person is experiencing the problem state.

6.2.2. Feedback and process dynamics

Client and therapist are entangled in the therapeutic process and are dreaming together. Since there is no objective observer present, awareness of feedback processes is the most crucial tool in the work. Whatever the therapist observations are at any moment, the client *feedback is the overriding principle to follow*. *Absence or lack of energy characterizes negative feedback*. The client simply does not feel that

therapist observation is right and says so. *Edge feedback* consists in multiple signals that contradict each other as in a rapid succession of yes/no signals; the energy / affect level is high, and although the client is saying no, the statement is incongruent. The client may shake his head and say no, yet at the same time laughing with excitement. In case of edge feedback the therapist may encourage the client to go further, yet willing to drop this particular demand if the client declines. The features of *positive feedback*, finally, are high energy level and congruent yes to the therapist suggestion with body motions that go along with it. If there is much hesitation on the client's side it can be useful to encourage the client to bring out the no more strongly.

Interventions

Process-oriented interventions adapt to what is occurring in the moment to moment interaction. Observing feedback each intervention is a seamless response to the client process. Whatever the therapist does is closely joined to and in accord with the organization of the experiential pattern, that is, primary and secondary processes. Therapeutic change does not arise so much from intervention per se as from the structure of the client's process. Interventions aim at amplification of the patterns emerging on the fringe of both therapist and client awareness - ideally, therapeutic interventions are merely appreciating and supporting what is already occurring. "…interventions required for a given person in a given situation can always be found in the processes occurring" (Mindell 1989:54).

Amplification

The most powerful therapeutic techniques arise from the identification of the structure of processes, primary and secondary patterns, occupied and unoccupied channels. In order for an emerging pattern to come closer to awareness, the therapist facilitates strengthening of signals in the modalities in which they appear. With visual images, the client is encouraged to see the pictures in detail, the colors and shapes etc., project them on a movie screen and letting them unfold etc.; use sensory grounded awareness to explore the pressure and temperature, the "feel" of proprioceptive experiences and make them more global; amplify the sounds of breathing or crying by listening, mirroring or even adding variations; encouraging hand and head movements

by moving without talking or looking, exploring experiences in relationship and in the world more fully, sometimes in role play, sometimes in the relationship to the therapist in the moment.

Unfolding

To unfold secondary processes, the therapist amplifies them in the channels in which they occur. "Following processes means relating to them in the modality in which they are expressed" (Mindell 1989:71). Let's say the person - talking about a heroin experience - closes her eyes for a split second while leaning back ever so slightly. As the therapist encourages her closing her eyes more consciously, feelings come up and, leaning back further, she arches backward with a deep moan. Strong experiences begin to happen in experiential modes of body feeling and movement, in sounding etc.. As she enters experiences in channels not habitually occupied, she leaves ordinary consciousness and enters an altered state. Secondary processes or altered states of consciousness occur in unoccupied channels of experience: “All states of consciousness that are different than the ordinary ones with which we identify ourselves I will call **altered states**” (Mindell 1989:55).

Channel changes

Altering the state of consciousness in one way or another implies channel changes, channel switching or channel blocking to access secondary processes. *Following a process* means that the therapist relates to the client’s experiences in the channel in which the experience is represented. To access altered state or secondary process, signals further away from awareness, in unoccupied channels, are supported and amplified.

Incongruence, double signals and altered states

Patterns of experience are seen as surface manifestations of deeper structures, internalized S/O representations, and complexes or dream figures. Conflicts of interest between these various aspects of self will manifest in communication as *double signals*: “…communication is congruent if all the signals carrying the same meaning, and …incongruent should the various signals carry different meanings” (Goodbread

1997:45). In signals outside the sender's awareness, in unoccupied channels *secondary processes are happening all the time*. The disavowed aspects of self are present in dreams and symptoms as well as in moment-to-moment unintentional communication signals – double signals, conflicting with the primary intent or the content of a message. The double signal contains the missing information in consciousness, and it is precisely by unfolding the disowned aspect of experience in the respective channel that the person's journey into an altered state begins. With awareness, traveling in the unoccupied channels, the person will find a message, a treasure, to be brought back and integrated into the everyday state of mind. Particular to the experimental situation of this study is the set intent to access the altered state the client is seeking through the use of the drug. The therapeutic intention is to carry forward the client's experiencing deeper into the altered state, the dreaming that is happening in the drug state. The therapist helps the client to relive the actual evoked feelings in situation rather than talking about it and both therapist and client enter the scene and co-create its unfolding and deepening (Mindell 2000). Unlike the usual, more open-ended session, for the purpose of this study, the task was to work with the instruction for inner work in which to unfold the altered state enfolded in the yearning for heroin.

6.2.3. In-session Movements

There are several typical in-session movements or tasks which the therapist and the client in a co-creative effort facilitate (Mindell 2000). According to process work, some of the key events which deserve special investigation are a) exploration of the primary process, pacing the client in the problem state; b) facilitating client movement from primary to secondary processes or into an altered state and unfolding that state experientially until the implicit meaning is experienced (Gendlin1962; Mindell 1983); c) working on internal splits, either edge systems or self criticisms (Mindell 1985, 1990, 2000); c) working on transference, countertransference, dreamt-up reactions and interpersonal issues, often in-session with the therapist (Mindell 1985, 1987, 2000); d) Integration of altered state by living the new state in extra-therapy context; in relationship to another person, i.e. the therapist or another person, in role play, imagination and/or, relating from the new state of being to the world, i.e. a group, the

world at large (Mindell 1995; Mahrer 1996). A movement in a process work session is the client transition from a normal, average or ordinary state into an altered state – into a new state of being. Experiential barriers or inner limiting belief systems will come up as the client stretches his/her awareness into the unknown and experientially accesses an altered state.

Figure 2: In-session movement

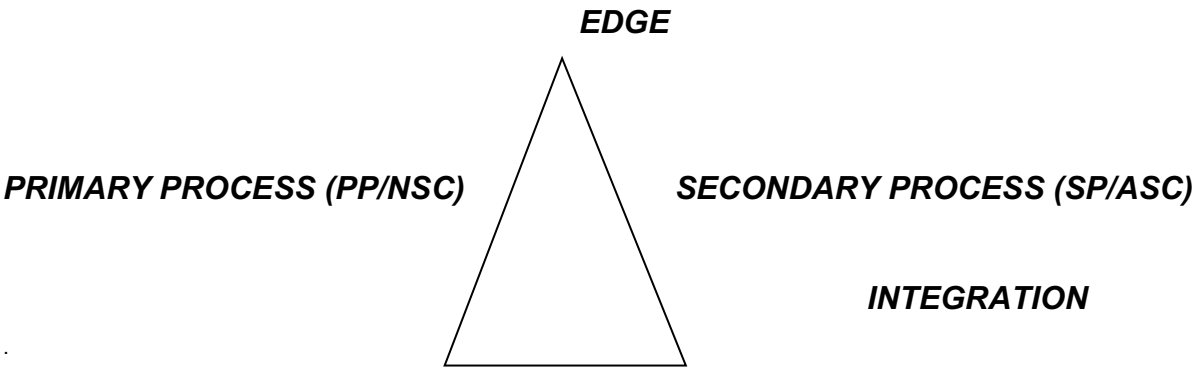


Figure 1. Client in-session states and movements. PP, primary process; NSC, normal state of consciousness; SP, secondary process; ASC, altered state of consciousness

In the baseline or ordinary state, usually associated with problems and life difficulties, the client identifies more or less intensely and consciously with suffering from inner or outer circumstances, restriction, oppression coming from a number of sources.

Process structure analysis identifies primary and secondary processes, occupied and unoccupied channels, and missing parts. A client statement like “I feel trapped” describes a primary process and, implicitly, hints at the “other”, the part or figure that is “doing the trapping”, a secondary process, as a figure or ghost-role. Again, in terms of channels, proprioception is occupied, and the primary state of mind is represented as a feeling. Unfolding of this particular process means shape shifting into the secondary figure and exploring the world and meanings of that aspect of self. The work may move through body work, movement and relationship, depending on the moment to moment appearance of signals.

Process work emphasizes a shape shifting into the part that creates the trap and exploring the feelings, needs or powers of that disavowed part. This gives much clarity to what Greenberg proposes: “The process of working on tasks in therapy thus involves the exploration and creation of new experiential states. Aspects of the self that were previously unclear are brought out into the open and examined. The client tries new experiential avenues in order to arrive at new awareness which, when incorporated into the problem solving process, can be symbolized as new states and then tracked as part of the resolution process” (1984:132).

6.2.4. Working with edges and critics

Likely, while moving toward secondary processes, the client is going to come up against the edge (Mindell 1985) at which point the therapist will try to facilitate the client movement beyond. Possibly, the client does not move beyond the edge but hesitates, retreats, avoids and holds to the known or PP. The therapist will make use of the situation and help client negotiate with whatever stops her/him to moving into experiencing and living lesser known aspects of self. Two-chair techniques, role play, dialoguing, "feel out" various sides. Other client movements to consider are self-criticisms. The client may express self-depreciating thoughts, ideas or paint negative hurtful image of self. At such markers, therapist senses own reaction, the choice may be to interact with the critic. This transformation of inner criticisms toward resolution demands special attention and will be looked at when reviewing the processes occurring in the course of the study with addicts.

Within the one experimental session and in accordance with the defined goal of the study, the focus was on reaccessing the yearned-for state. With some clients, major edges became the focus, however, in practice, establishing the state took precedence and time so that alternative pathway could not be explored sufficiently.

6.3. The Process Index (PI)

Both client-centered and the process work approach stress *manner of process* as the central dimension of change. However, while the EXP emphasizes emotion and its verbalization, the PI accentuates awareness of being-in-contact with inner felt

referents, independent of the types of experiences. The PI is an adaptation of the EXP to account for just this difference (see Appendix D). Klein et al (1986) indicated that adaptations of the EXP scale are admissible when necessary. Raters were systematically trained, first to identify the stages on the EXP scale and second, to differentiate the stages on the PI. Like on the EXP, the rating on the PI observes client processes *in terms of closeness and distance from awareness or from the identity of the speaker and, in addition, in terms of the channel in which experiences occurs. The raters assess the extent to which processes are occupied versus unoccupied by the speaker's awareness in the particular channel referred to directly or indirectly by the speaker.* For further elaboration of these concepts, the reader is referred to the section on process structure analysis.

The original versions of the EXP relied next to the verbal more on observable, non-verbal signals, without, however, there being an elaborated theory of observation/perception which could serve as a bases for the raters to build on. As a consequence, reliability among raters was insufficient (Mathieu and Klein 1984). The changes that led to the present scale (Klein et al 1969) emphasized verbal expression of emotion, particularly emotional shifts that indicate some insight, a sudden release of tension, a stepping into unknown feeling and finally, verbal symbolization. Clearly, this was a change in the service of increased rater reliability, although, at the same time, the authors stress that it is not the content of what client/therapist discuss but the "manner of the process" which correlates to change or progress (Mathieu and Klein 1984).

"Not the verbal *content*, but the *kind of process* occurring, will determine whether we should predict therapeutic changes in later behavior. The extent to and mode in which the individual refers to his experiencing, the mode in which he relates the symbols he speaks to it and brings it into interaction with the other person - these variables will determine whether he is *merely* using words, or whether his words are part of a deeper process. What his words are about will not tell us this" (Gendlin 1962:37).

Likewise, process work focuses on the "manner of process". With a simple yet powerful methodology verbal statements, paralanguage and non-verbal signals indicate just *how* processes are represented internally by the client. With its dual focus on awareness and being-in-experiencing, process work uses precise observation to follow a client's moment-to-moment experience as it unfolds from the preconceptual level into the different channels. Barely noticeable at first, movement tendencies and flirt-like perceptions in various channels unfold into observable visual, auditory, kinesthetic and proprioceptive signals as well as into relational processes with others and the world at large. What may start with a vague felt sense may become a sensation, then an image expressed in a dance or a poem. It may involve relationship and / or the group. Hidden potentials often are communicated in body language, or non-verbal signals, which when unfolded, can lead to shifts in identification. Accordingly, raters need not only training in language structure analysis (Bandler and Grinder 1975, 1976). They also need instruction in the perception of minimal signals and access cues to channels such as facial expressions, eye and body movements, breathing, peculiarities of voice and speech, as well as signals of rank, privilege and power (Mindell 1995). One measure to assess the extent to which the client is in-touch with inner experiencing is the degree of congruence of experience, behavior and awareness, another, assessment of the client's ability to notice upcoming tendencies and attend to the inner process.

The sole focus on the extent of feeling and expressed emotion, as a measure of growth and change is incomplete. Process Work values the *awareness and the experiencing dimension* per se, the extent to which a client is able to participate in and observe any process appearing on the fringe of awareness. The ability to attend with interest and curiosity to one's inner process is valued as a moment-to-moment mindfulness practice, independent of the particular "field" being observed, although emotions and feelings certainly play a major part in it. The therapeutic movement is one of enlarging one's awareness to welcome, identify with and experience from within those aspects of experience which are usually perceived as happening to oneself. This therapeutic process very much relies on "second attention" (Castaneda 1977; Mindell 1993), the focus on the edge of one's awareness, using one's felt sense

(Gendlin 1982) to track sensory and "sentient experiences" (Mindell 2000). Because of the central role of the experiencing dimension in process work, the author adapted the EXP to construct the PI by replacing the concepts of "feeling " and "emotion" with the more neutral term, also broadly used in the EXP, of "experience" and "experiencing".

Biases

Another issue with the EXP is its potential bias. Arguably, the EXP is biased in weighing verbal skill, English as a first language, and education. There is an emphasis on mainstream adult white Anglo-Saxon consciousness. Accordingly, the scale seems to discriminate against people with lower rank in the area of verbal expressiveness and ability or more introverted personal or cultural styles. One could research its bias vis-a-vis children, minorities, non-native speakers, people with hearing and linguistic troubles, as well as people who are other-abled in many creative ways[2].

6.3.1. Stage Characteristics of the Process Index

Not only did Gendlin provide a robust philosophical foundation for "experiencing" as an inner process into which all life taps (1962), he also claimed that "experiencing" is directly observable in overt expression. The central question, therefore, becomes, How can it be known?

Central to process work is a system of experiential pattern analysis, so-called process structure analysis, to sort observer perceptions of the "experiencing" process into logical configurations. For certain, the person in-experiencing will exhibit a large variety of signals on important dimensions which all reflect the experiential process. There are observable signals in various channels of information reaching our awareness of the "experiencing" process. While grammatical, expressive, paralinguistic and content-orientation are important vectors to observe signals in, modern communication or better, signal theory, introduced a model to focus on the change process in terms of signals and channels. Family work and system theory helped understand roles and fields when working with any number of people, and

[2] Thanks to the raters Francie Townes, Kasha Kavanaugh and Joy Brown for addressing these potential biases of the EXP.

shifted the focus from the individual person to interactional processes. Ericksonian hypnotherapy (1981) brought a radical focus on subliminal processes and the potentials present in altered states. In the 70ties, the NLP model explicated the rules that account for the transformations between surface structures (syntax, observable communication) and the deeper, more complete representations of a person's inner world. To understand a person's growing edges and facilitate change processes, NLP stressed the significance of formal characteristics of language, its linguistic structures. It introduced a systematic description of various channels of communication, including incongruence between content and form, and a new therapeutic technology based on the understanding of the relationships between overt behavior and a person's inner model of the world (Bandler and Grinder 1975, 1976).

In short, the PI rates client processes on stages 1-7 just like on the EXP scale - in the form of running ratings, in modal and the peak values for each segment. Two criterion are simultaneously considered for marking the level on the continuum from 1 through 7. One, client processes are assessed *in terms of their closeness and remoteness from the person's awareness* and simultaneously, *in terms of extent to which processes are occupied by the speaker's awareness in the particular channel referred to directly or indirectly by the speaker.* For further elaboration of these concepts, the reader is referred to the section on process structure analysis. Appendices C and D spell out some of the rules raters have to take into account in their decision.

The PI has been developed for this study in close analogy to the EXP. No analysis exist as to the validity or reliability of the scale yet. As non-verbal and verbal processes are rated, rater training is demanding and demands intimate knowledge of process structure analysis. Inter-rater-reliability for both EXP and PI were below expectation; in accordance with expectation, IRR is slightly higher for both the ratings of modal and the peak values on the EXP than on the PI (see section on results).

6.4. Salutogenesis

The "concept of salutogenesis" revolutionized the thinking in the field of psychosomatic medicine by focusing on the promotion of health rather than on pathological signs and symptoms. When, in a study in 1970 on menopause and its effects on health in women, Antonovsky (1987) noticed that of a subgroup of women concentration camp survivors 29% said they felt in good physical and psychological health, he began orienting his research toward the final causes of health. Instead of investigating why people get sick, Antonovsky asked: what makes people healthy?

Refuting the classical health/sickness dichotomy, health and illness are seen as two poles on a multi-dimensional health ease / dis-ease continuum. Antonovsky convincingly argues that illness is not a rare deviation from an ideal state of homeostasis but common in all of us. Heterostasis and entropy are characteristics of life: "We are all terminal cases. And we all are, as long there is a breath of life in us, in some measure healthy" (Antonovsky 1987:3). The salutogenic orientation researches what factors, in the face of innumerable stressors, make a person enjoy well-being and a relative good health. For the clinician, the challenge is how to best contribute to the movement of the client / person toward the health end on the continuum. What intervention in the individual or system promotes this movement?

"The key term becomes *negentropy*, leading one to a search for useful inputs into the social system, the physical environment, the organism and the lower-order systems down to the cellular level to counteract the immanent trend toward entropy" (1987:9).

In this "search for all sources of negative entropy that may facilitate active adaptation of the organism to the environment" (1987:13), the salutogenic orientation enlarges the focus of the clinician beyond pathology to encompass the "total story of a human being". The perspective shifts from researching the causes of illness to coping resources and beyond, to factors strengthening a health-enhancing inner attitude.

In tune with traditional stress and coping research, Antonovsky developed the concept of "General Resistance Resources". GRR's are difficult to conceptualize simply as

composites of internal resources (ego-strength, self esteem or trust etc.) and external resources (money, class, race etc.). Individual variability in these resources is too great and people's responses to stress are so particular that Antonovsky was led to search for the common ground among them. His answer was the development of an overarching concept which he called "Sense of Coherence". In his definition, the "Sense of Coherence" is

“a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic, feeling of confidence that (1) the stimuli deriving from one’s internal and external environments in the course of living are structured, predictable, and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges, worthy of investment and engagement." (1987:19)

The "Sense of Coherence" describes an individual orientation or a "subjective basic attitude" (Lamprecht et al 1997) in the face of challenges; it determines one's response to the world of stressors or the extent of one's adaptation to the environment. A recent study confirms that the SOC is indeed a general measure of a person's world view, independent of pathology (Schnyder et al 2000). The SOC represents one important element for one's exact positioning on the continuum of health ease / dis-ease. People with a strong SOC are more resistant to stress and illness than people with a weak SOC. Accordingly, a strong SOC protects one's health (Lamprecht et al 1997).

3 subscales

The SOC, which describes a stable global orientation or attitude toward life in general, is comprised of three components:

Comprehensibility

Comprehensibility refers to one's cognitive response to the environment. It is the expectation of a person to perceive both internal and external stimuli and changing situations as ordered, structured and predictable. They make sense.

Manageability

Optimism, trust in one's own ability to take on future life tasks and meet challenges. A person with a high SOC can trust her coping strategies and rely on inner and outer resources, someone one can trust, one's friend, even God (Antonovsky 1987:18).

Meaningfulness

The belief that the future holds meaningful tasks for the individual. The person feels emotional involvement and takes action as life tasks and challenges are perceived as meaningful.

In the analysis of these three components, Antonovsky concludes that the sense of meaningfulness is the most important element for the maintenance of health. The sense that life has meaning and purpose is a fundamental motivational force to cope with and transform circumstances and therefore the most significant health-promoting ingredient in the concept of SOC. It is this feeling attitude rather than the cognitive map which offers the most protection. Without that particular feeling that life makes sense, comprehensibility and manageability alone may not exert enough upward pressure toward the health end of the continuum. Antonovsky repeatedly stresses the importance of "meaningfulness" for maintaining health and well being even in the most adverse circumstance and refers to the writing of Frankl to support his thesis. For Frankl, the "will to meaning" is the single most decisive factor for survival in concentration camps (1963).

The "centrality of meaningfulness" (1987:21) refers to the dynamic pressure toward health which a sense of meaning and purpose in life can promote. When studying dynamic interrelations between three components of the SOC, "meaningfulness" turns out to be the most important resource for health. Even when scores on "comprehensibility" and "manageability" are low, the person with a high score on "meaningfulness" experiences pressure to move and may engage in a deep spiritual search and find inner and outer resources to develop.

The “Sense of Coherence” is meant to be a universal concept, influenced by but independent of gender, social class, regions and culture; one's social and psychological rank determines one's "life experiences which in turn engender a strong or weak SOC" (Antonovsky 1987:91). While Antonovsky stresses the contribution of social, cultural and psychological factors toward a strong SOC, the are few references to spiritual resources and their health promoting impact. In one instance, Antonovsky entertains the idea that God can serve as a spiritual resource contributing to a higher SOC (compare 1987). Yet, the SOC scale does not include any items relating to spiritual beliefs, which may be one of its weaker aspects.

What is exciting, on the other hand, is the comprehension that not only social and psychological but also spiritual rank can make for a tremendous resource (Mindell 1995, 2000). A special connection to nature or spirit serves as a powerful motivational force and helps people overcome the most oppressive life situation. It is often precisely people belonging to marginalized or disenfranchised groups that acquire high spiritual rank and become role models in their stand against oppressive forces (Martin-Luther King jr., Mahatma Gandhi, Nelson Mandela and many others).

The potential that opens up from trusting in a higher power or a deep connection to God is a powerful resource and great potential as a health protection resource. Alcoholics Anonymous (AA) demonstrates the tremendous usefulness of spiritual resources in the treatment of alcoholism and other narcotic addictions. Since our goal must be to enhance the negentropic input into a system - interventions must aim at all levels: the social (town meetings, group process), the psychological (individual and relational awareness) and also the spiritual dimension (experiences of oneness, establishing connection to nature or God).

6.4.1. Intentional modification of SOC

In his early writing Antonovsky maintained that the sense of coherence is a stable disposition of the personality formed in early childhood and resistant to change after age 10 (Antonovsky 1987; Sack et al 1997). In 1979, Antonovsky wrote that "it is unlikely …that one's sense of coherence, once formed and set, will change in a radical

way" (1979:188). He later modified that position by saying that changing life situations may bring about changes in SOC. If new patterns of experience are encountered over longer periods of time in one's life, then, in fact, gradual changes in SOC can occur (see Antonovsky 1987:123; Sack 1997:186). He admitted that changes of plus/minus 5 points on the SOC scale as a consequence of an event were plausible and possible (corresponding to a difference of 2.25 on the SOC-13). Temporary as these changes may be, they nevertheless bring relief to the individual case.

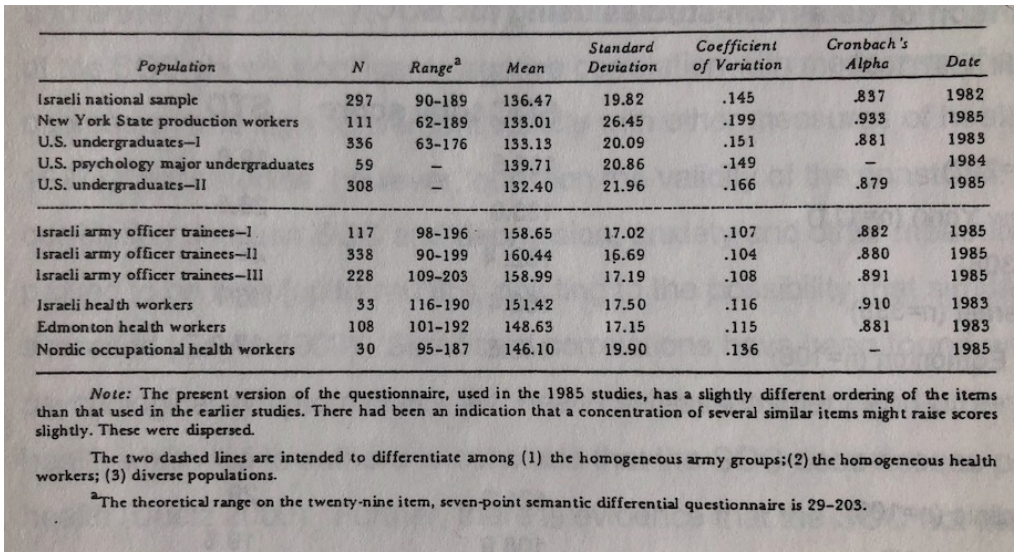
It is common sense that everyday subtle or not so subtle fluctuations in mood make or break the day; these noticeable shifts mean a lot in our subjective experience. Antonovsky would stress the point that therapeutic encounters certainly should be structured in a way as to increase the likelihood of a positive change in SOC (see also Lown 1999).
Intentional modification of the SOC can be achieved in many ways: effecting changes in one's life certainly stand out as important; on the other hand, influencing one's beliefs about life circumstances or re-framing one's experiences can be a powerful tool for coping in the very same circumstances. The labels we attribute to settings, situations or processes may by themselves have a huge effect on one's SOC. A striking example is presented by the burnout of personnel on a hospital ward for terminally ill patients in contrast to the enthusiasm the very same nurses experience after the ward is redefined as rehabilitative (Antonovsky 1987:4). Another example is the terminally ill patient in coronary intensive care after a massive heart attack who everybody had given up on. Interpreting the doctor's comment of the "wholesome gallop", actually his terminal heart condition, as a sign of vital horse power, the patient recovered quickly and was discharged within a week (Lown 1999).

Since Freud pointed to the centrality of positive expectation in successful treatment (see Frank et al 1978:4), positive client and therapist expectation, patient faith and hope have been recognized as among the most powerful common factors central to all healing approaches (Frank 1969). The salutogenic orientation of a positive mind-set is further evinced by Lown, a world-renowned cardiologist, who incorporates the art of using the healing power of words into a scientific practice of medicine.

6.4.2. The Sense of Coherence Scale (SOC-13)

Antonovsky derived 29 items for a scale to measure the sense of coherence (SOC-29) from in-depth interviews with persons with severe trauma whose life turned out remarkably well. The SOC-29 comprises 29 items, 11 items on the sub-scale "meaningfulness", 10 items on "manageability" and 8 items concern "meaningfulness". The questions concern attitudes in life orientation toward meaning and coping strategies in dealing with stressful events. The client responds on a scale from 1 (very seldom or never) - 7 (very often). Several hundred studies exploring SOC of thousands have been completed and the mean values tabulated. The tables below will give a comparison of the mean SOC to the current sample of 13 heroin-addicted persons.

Table 5: Normative data from studies using the SOC



Population	*N*	*Range*[a]	*Mean*	*Standard Deviation*	*Coefficient of Variation*	*Cronbach's Alpha*	*Date*
Israeli national sample	297	90–189	136.47	19.82	.145	.837	1982
New York State production workers	111	62–189	133.01	26.45	.199	.933	1985
U.S. undergraduates–I	336	63–176	133.13	20.09	.151	.881	1983
U.S. psychology major undergraduates	59	–	139.71	20.86	.149	–	1984
U.S. undergraduates–II	308	–	132.40	21.96	.166	.879	1985
Israeli army officer trainees–I	117	98–196	158.65	17.02	.107	.882	1985
Israeli army officer trainees–II	338	90–199	160.44	16.69	.104	.880	1985
Israeli army officer trainees–III	228	109–203	158.99	17.19	.108	.891	1985
Israeli health workers	33	116–190	151.42	17.50	.116	.910	1983
Edmonton health workers	108	101–192	148.63	17.15	.115	.881	1983
Nordic occupational health workers	30	95–187	146.10	19.90	.136	–	1985

Note: The present version of the questionnaire, used in the 1985 studies, has a slightly different ordering of the items than that used in the earlier studies. There had been an indication that a concentration of several similar items might raise scores slightly. These were dispersed.

The two dashed lines are intended to differentiate among (1) the homogeneous army groups;(2) the homogeneous health workers; (3) diverse populations.

[a]The theoretical range on the twenty-nine item, seven-point semantic differential questionnaire is 29–203.

Table 6: SOC - means in comparison (SOC-29)

Lamprecht 1997:27[3]

Sample	SOC	STD	N	Authors
Parents control group Israel	154.4		186	Margalit et al 1992
Population Sweden	152.6	22	148	Cederblad et al 1995

Medical students Israel	150.2	16.4	93	Bernstein u. Carmel 1991
Retirees Israel	148.9	23.3	805	Sagy u Antonovsky 1990
Patients w rheumatoid arthritis	149.9	27,9	572	Hawley et al 1992
Nurses (USA)	143.1	23	238	Lewis et al 1992
Students (Finland)	143	21	99	Salmela-Aro 1992
Psychology students (USA)	142.4	21.9	276	Frenz et al 1993
Students (USA)	141.2		1000	McSherry et al 1994
Persons w relatives in care	138.2	22	126	Gallagher et al 1994
Patients w colitis (BRD)	136.5	24.4	80	Schüffel et al 1995
Population (Poland)	132.8	20.7	60	Parsikowski et al 1994
Youth at risk (Israel)	130.4		137	Magen et al 1992
Students (USA)	129	24.5	307	Radmacher et al 1989
Students in therapy (Finland)	124.9	24.9	28	Salmela-Aro 1992
Psychosom.outpatients(BRD)	121.4	27.1	461	Sack et al 1997
Psychosomatic inpatients (BRD)	121.7	25	60	Broda et al 1996
Psychotherapy patients (USA)	115.9	25	98	Frenz et al 1993
Psychosomatic inpatients (BRD)	112.2	22.8	81	Sack et al 1997

Table 7: Comparison of data from studies using the SOC

Sacks and Lamprecht 1997:188[4]

	SOC total score	**STD**
Israeli population (n=297)	136.5	19.8
Factory workers (New York) (n=111)	133.0	26.5
Students (USA) (n=308)	132. 4	22
Officer candidates Israel (n=338)	160.4	16.7
Hospital employees Edmonton (n=108)	148.6	17.2
Our results:		
Patients outpatient clinic (n=106)	121.2	29
Patients inpatient clinic (n=35)	108.9	19.8

These tables illustrate the correlation between strength of SOC and various populations. Israeli parents do best as does the Swedish population with a SOC of 154.3, or 152.6 (STD 22) respectively. On the low end of the ranking are patients with somatic and psychological problems, with residential psychosomatic clients with 112.2

[3] Abbreviated and translated from German original by author

(STD 22.8) at the bottom. Sacks et al (1997) report an even lower mean score, 108.9 (STD 19.8), for a group of patients in residential treatment at their psychosomatic clinic of (Sacks et al 1997).

Reliability and validity

The measure has been very well received in psychosomatic medicine. Various studies show the SOC to be a reliable and valid instrument (Lamprecht 1997). A number of studies demonstrate good reliability with Cronbach alpha coefficients for internal consistency between 0.82-0.95 for the SOC-29, for the SOC-13 between 0.74-0.91 (Antonovsky 1993). A few test-retest studies were done using the SOC-13. In one study (Coe 1990) with 189 veterans at a VA clinic, the SOC-13 test-retest coefficient is 0.77 (Antonovsky 1993). A recent study (Schnyder et al 2000) using the SOC-13 with severely injured accident victims (n=96) and patients with rheumatoid arthritis (n=60) found a high test-retest reliability ($p>0.70$, $p>0.01$). The same study indicated significant negative correlations between SOC and measures of depression and anxiety ($r=.28$ - $r=.73$; $p>0.01$). A study by Lamprecht on the discriminant validity of the SOC shows significant negative correlation with measures of anxiety and depression and high convergent validity with other measures of health (Lamprecht 1997). Other studies, however, question the validity of the construct: inverse correlation between SOC and depression, anxiety and other measures of health proved to be high (up to $r=0.85$), pointing to the possibility that similar constructs are assessed (Geyer 2000). Significant correlations have been found with the psychological symptom check list, health self-assessment and other related indices of health which led to authors to conclude that the SOC does assess psychological health (Duetz 2000). Further, there is evidence that the SOC not independent of social status, class, education, age and gender, contrary to the claims made by Antonovsky (Sacks et al 1997; Geyer 2000; Duetz et al 2000).

Reproducibility of subscales

The three sub-scales are intertwined and factor analysis cannot reproduce them empirically which is to be expected as questionnaire construction precluded empirically

[4] translated from German by author

separable scales. The best factor analysis solution seems to isolate 1 factor. Although each item clearly belongs to one component, each item also shares facets with other items across scales (Antonovsky 1987). He warns against measuring relations among these components "they are impermissible on technical grounds" (1993:732) - and recommends the scale for measuring the global construct for which it was developed. Although other researchers agree, they nevertheless include subscales in published results (Lamprecht et al 1997; Franz et al 1993, in Lamprecht 1997).

6.4.3. SOC - a measure for therapeutic change processes

This study applies the SOC to measure change after a psychotherapy intervention. To date, there are few studies that use the SOC as an index to measure health changes in individuals and no epidemiological studies of community intervention exist, however, the SOC could be usefully employed to look at such overall outcome. For specific treatment outcome studies, the SOC measure has been employed in only a few studies. Promising results are being reported by Sacks et al (1997) who used the SOC to compare scores of psychosomatic patients at intake and at the end of treatment in an outpatient psychosomatic day clinic and a residential treatment unit. For the residential treatment, the group mean before and after the 8 week treatment indicates a significant change upward of +8, from 107.2 (STD 20.1) to 115.2 (STD 20.5) ($p=0.41$). The total score of the population seems dependent on age, however, as persons above 35 tend to have a higher SOC (+14). This is evidenced for manageability and comprehensibility only (Sacks 1997). In another study, a low SOC score was found to be a risk factor for suicidality (Petrie and Brook 1992, in Lamprecht 1997). Low scores have shown to have predictive power for suicide attempts for up to 6 months.

The SOC in the present study

For the present study, pre- and post-treatment SOC scores will serve to assess each client and serve as a measure of change after the intervention session. The short version of the SOC scale containing 13 items (SOC-13) is used rather than the SOC-29 with 29 items to reduce the demand on the clients. Filling out the questionnaire takes time - using the SOC-13 scale reduced the time for the self rating from 15-20 to

5-10 minutes. The 13 items of the SOC-13 are distributed among the subscales as follows: 5 items on "comprehensibility", 4 items "manageability" and 4 items "meaningfulness". Items 1,2,3 7 and 10 are reversed, meaning that 7 is the lowest value, not 1; these items are to be adjusted for calculation of the scores.
For the results of the pre/post measurements with SOC-13, the reader is referred to part X.

6.5. Experiencing

"Within experiencing lies the mysteries of all that we are" (Gendlin 1962:15)

Awareness and experiencing are basic to living and by analogy, to the therapeutic interaction that seeks to reconnect the client with the deeper flow of life. Therapy aims at positive change by enhancing the person's understanding and self-awareness, by deepening the feeling connection with all aspects of self and by developing fluidity in observing and experiencing at the same time. Moreover, if addiction is the search for powerful experiences which have the potential for self-healing, then one key to addiction treatment may well lie within the experiencing dimension.

6.5.1. The beginnings of process research with Rogers and Gendlin

Most therapists would agree that client involvement in the therapy process is prerequisite for client progress and the quality of self involvement indicative of movement and change. Both Rogers' client-centered theory and Gendlin's phenomenological experiential approach arrived at the concept of "process" as central to awareness, self-understanding and growth. The "experiencing" dimension came to be understood as the crucial factor for successful therapy. In the 1950s Rogers, identifying therapist attitudes of positive regard, empathy and congruence as necessary conditions for "good therapy" (Rogers 1957), defined the process around which all therapy revolves as "the client's experience of exploration" (Rogers 1950). Rogers began researching the dynamics of change in therapy, the movements which take a person from stasis or various degrees of remoteness and distancing, to coming closer to living in the flow of feelings in the present moment to an *optimal level of personality functioning* (Rogers 1958, Rogers 1959). Rogers' characterization of the

therapy process included several aspects, 5 of which refer to the setting of therapy, and the two which concentrate on experiencing (in Klein et al 1986:26):

1) Communication about self: one's willingness to share
2) Personal construct: rigidity of personal identifications and pressure to change
3) Relationship to problems: way of defining and experiencing one's problems
4) Manner of relating: openness to feelings in interpersonal context
5) Incongruence: complete communication, congruence of outer behavior and inner representation
6) Relationship to feeling and personal meanings: quality of awareness of inner life
7) Manner of experiencing: extent to which "feel" is the referent for thought and action.

Rogers original concept of pathology as an "incongruence between awareness and experience" lacked the tools to understand the construct of "experience" in observable terms. With the contributions of Gendlin, increasingly, the experiencing dimension was seen as the central dimension into which all other aspects pertain. The fundamental shift is from looking at content of process to the manner in which a person relates to her experience. In Gendlin's definition, "experiencing" is the basic felt datum of our inwardly directed attention. Accordingly, congruence could be defined as the direct sensing of an implicit felt referent.

6.5.2. Experiencing as a health-promoting dimension

The concept of "experiencing" as the basic felt referent of awareness implies a continuum or various degrees of being-in-touch with one's inner stream of experience. Higher EXP is the critical vehicle which moves a person in the direction of growth toward the healthy pole on the health/disease continuum. Experiencing has been found to be a measure of health as much as it is an index for productive client involvement (Kiesler 1965, 1971; Rogers 1967). People who feel healthy enjoy higher "experiencing" than people who do not (Klein et al 1969). They are in touch with an implicit referent and let their felt sense directly inform action, thoughts and feelings. Thus, experiencing is an important salutogenic factor: the more direct inner referents become felt data of attention, the more the person is able to focus and being in touch

with the experiential process, the more congruent awareness and experience become, and the healthier a person feels.

Implications of the experiencing construct as a major salutogenic factor are far-reaching: the ability to focus on inner experiencing may be a central ingredient in the process of healing. Accordingly, some authors suggest focusing be tested for prevention and coping with illness (Lutgendorf et al 1994). Sachse (1991) reports that 95% of psychosomatic patients do not have access to a felt sense; could they be taught to focus inwardly and attend to the felt sense, illness might decrease (see Hendricks 2000). Similarly, since addicts also have great difficulties in attending inward on a felt sense (McDougall 1989, chapter 4.1.). The author holds that methods that increase EXP could well be health-promoting for addicts and those with additive tendencies.

Just under 100 studies demonstrate that the level of experiencing is related to successful outcome in therapy (Kiesler 1971; Rogers et al 1967; Klein et al 1969, 1986; Hendricks 2000). The client movement in successful therapy will take a person from impersonal remote experiencing to being-in-touch with sensing the inner core process and identifying with processes at the edge of awareness.

"People don't just think about the situation…They attend to what we call a "bodily felt sense of…" a situation or a problem. Words or images arise directly from that sense. What comes is often a surprise. A new aspect of experiencing emerges, s small step of change that brings a body response, like a slight physical easing of tension, or tears, or a deeper breath. We call this a "felt shift". This kind of process is the "motor of change in psychotherapy" (Hendricks 2000:1).

It is only by the experiencing process that change can occur. Insights are based on experiencing since cognition arises from experiencing (Gendlin 1962). Therefore, any methods that sharpen attention and facilitate focusing one's attention inward on an inner felt sense enable change. One such method is "focusing", a technique of inward attention for dealing with problems developed by Gendlin (1982). It makes room for

"mindfulness" in psychotherapy. It teaches bare attention to "that" yet unknown but clearly felt mass of the implicit and by doing so, it reconnects experience and awareness and by doing so, enhances health and well-being. Beside and under the established meanings and concepts, there lie unique experiences which give rise to limitless new creative meanings, thoughts and actions. The approach of Gendlin with its radical phenomenological orientation furthers discovery, exploration and play by focusing attention to one's bodily felt referents, the core of one's self experience.

6.5.3. Gendlin's philosophy of the Implicit

Inspired by the phenomenology of Husserl and Merleau-Ponty, Gendlin's work focused on the "experiencing" dimension. For Gendlin, experiencing is the dynamic process of what we usually call our experience. For all our actions, feelings and thoughts we refer to it. It forms the basic current of life that we sense when we direct our attention inward.

Experiencing refers to what you can sense in your body right now. Klein et al define it as "the basic felt datum of our inwardly directed attention (which) involves preverbal, preconceptual, bodily sense of being in interaction with the environment, a gut-level sense of felt meaning of things. This includes the feeling of having experience and the continuos stream of sensations, somatic events, feelings, reflexive awareness, and cognitive meanings that make up one's phenomenological field" (1969:4).

In his philosophical treatise "Experience and the creation of meaning" (1962) Gendlin outlines the role of experiencing in the creation of meaning. He points to the background to CR as the "flow of feeling, concretely, to which you can in any moment attend inwardly if you wish" (1962:3). His phenomenological philosophy expands the horizon into "a vague no-man's land" of felt experience, into the vast field of the implicit out of which symbols and meanings arise. His interest is the concrete, inner stream of clear or fuzzy feelings and sensations we sense whenever we direct out attention inwardly. His writing is interspersed with …pauses…so that we can refer to felt mass of the implicit which forms the background of all symbolization…*There it is*. CR and NCR are intrinsically linked, the form containing the implicit and vice versa. Forms,

concepts, images which we use to describe and handle reality, rely on preconceptual experiencing, a level which can only be pointed at as it forms:

"It is a concrete mass in the sense that is it "there" for us. It is not at all vague in its being there. It may be vague only in the sense that we do not know what it is. We can put only a few aspects into words. The mass itself is always something there, no matter what we say "it" is. Our definitions, our knowing "what it is", are symbols that specify aspects of it, "parts of it", as we say. Whether we name it, divide it, or not, there it is." (1962:11). His work pertains to linguistics and post-modern philosophy as it posits the fundamental importance of NCR experiences in the symbolization process. The goal of Gendlin's philosophy is to find a new language beyond the rigid boxes language imposes, the stereotypes that usually guide and limit us. The point is that whenever we attend inwardly we notice the non-conceptual experiential background of our everyday life, of ideas, thinking, living. Gendlin's term "experiencing" then is the process of attending to an inward referent, to a concrete bodily felt datum that arises from the totality of the implicit.

"Experiencing is a constant, ever present, underlying phenomenon of inwardly *sentient living*, and therefore there is an experiential side of anything…no matter whether it is a concept, an observed act, an inwardly felt behavior or a sense of a situation" (1962:15).

Experiencing is process. Concepts can only point to the referent, although "it" is concretely "there" in our awareness. We can point to "it", grasp meanings arising from the preconceptual world and differentiate a root feeling sense into many aspects infinitely. Whatever we conceptualize, there is no way around experiencing if we are to make sense and create meaning in our inner lives, our thoughts, feelings and behaviors.

Meaning is experienced

The basic proposition of Gendlin's phenomenological philosophy holds that "meaning is experienced" (1962:44). Meanings arise as we use the "felt sense" to focus on the

vague and not-yet verbalizable implicit whole. There is always more implicitly present in our background "feel" than what we can grasp or even symbolize. There always is an excess to what is already formed, potential meanings, a new sense of something we can grasp. When, in the middle of a sentence we pause…we refer directly to experiencing, and often a new step, a new movement follows naturally. If we let our experiential feedback guide the next thought, feeling, or action, which in turn informs the experiential phenomenological field again we will be in continuous flow. Our process moves in conceptual and experiential steps - in a kind of a "zig-zag" - weaving the strands of our inward sensing and letting new meanings emerge. Gendlin's philosophy includes NCR experiences implicit in concepts and understands that meaningful concepts must have roots in NCR. Abundance, an excess is available. Boundless experiences arise spontaneously from the unknown to create new meanings. Language and communication, feelings and fantasies arise from the flux of the deeper stream of our soul.

Interaction is first

Experiencing is neither inside nor outside but involves body and context just like walking implies body and ground. Experiencing is characterized by feedback loops both on a conscious and an unconscious level between my body and the environment which form, in fact, one interactional process. When you move through a room, you do not think. Instead, an automatic feedback process guides you as your experiencing and objects and events interact. Our bodies are wise; they sense more than what we can grasp with sense perception, i.e. our body senses what is in our back. I have a sense of a situation, your body has a gut feeling for a person, a like or a dislike. If we think of a person … we get a sense of something …which provides us with a rich texture or a feel before we conceptualize the impression the person has on us. "Perception is never first", Gendlin states (1962:32) since "it divides your perception of me from mine of you" when, in fact, the interactional process is one, as between two persons. In short, there is a constant interactional process between the basic data of my experiencing (situations, events, therapy, environment, life) and the process of symbolization. There is a experiential order to sense making as we check inward and

sense of … something implicit …from where we then *carry forward* our experiencing and let new connotations and ideas arise.

Subception, marginalization and sentient perception

As Gendlin explores the process of meaning formation - how experience appears in cognition, he pushes the edge of philosophy and psychology to include the preverbal level on which all conceptualization rests. Since Freud, psychology wrestled with the problem of an awareness below the conscious level which selects with intent some experiences into consciousness while suppressing others. These processes of "subception" (McCleary and Lazarus, Rogers, Sullivan, in Gendlin 1962) delineate a discriminatory function without conscious awareness. "Highly differentiated cognitions on an unaware level seem to select what may then (again) be perceived on an aware level" (Gendlin 1962:53). Similarly, the processes of "marginalization" (Mindell 2000) point to a subtle awareness below the level of what we normally consider conscious awareness. Many levels of automatic "sentient perceptions" (Mindell 2000:49) occur between body / environment before our usual I-awareness notices anything. Indian philosophy and especially, the Buddhist Abidhamma describe various subtle stages of awareness before a conscious observer arises and claim that an intense awareness is possible in dreamless sleep (Mindell 2000). Waking consciousness is one only of four states of mind, which include waking consciousness, dream, dreamless sleep and "pure consciousness or union of Atman/Brahma" (Smith 2000:70). Process work is a practice of attending to this "sentient experience" outside the realm of conscious awareness. It is a training in lucidity to notice flirt-like perceptions and exercise our subliminal awareness (Mindell 2000). These reflections fit seamlessly with Gendlin's studies in "sentient living" which illuminate the processes of meaning formation and show how experiences have meaning apart from and before any conscious symbolization.

Felt meaning is the basis for thought, emotion, observation, action, speech, for art and play, for religion and science. In psychotherapy, in the "zig-zag" movement between conceptualization and felt sense, the process develops. The focus is on the edge of awareness, the felt meanings, some of which are conscious, some of which have a

subliminal status which, when attended to, bring forth new meanings. The therapist focus is on the intended expression and, at the same time, on the implicit "more" in the present experiencing.

Beyond language - awareness and experiencing

Gendlin's work carries forward philosophy beyond postmodern dilemmas into an alternate use of language. In making the realm of the non-conceptual the primary dimension upon which intelligible life rests, his philosophy opens up old forms and categories in relating the process of meaning formation to bodily felt experiencing. The influence of his philosophy of meaning formation and its relationship to language are equaled with the theories of Husserl, Heidegger, Wittgenstein and Derrida (Levin 1997).

Obviously, these are crucial ideas for psychotherapy. Gendlin's philosophy opens up the conceptual to the subjective flow of felt experience underlying psychological concepts such as ego, unconscious, defense mechanisms, etc.. It reintroduces the importance of the experiential process itself and teaches methods of focusing on it, to letting it unfold until new meanings emerge. Where old forms and established meanings have to be shed, suspension of interpretation is crucial for experience itself to become alive, creative and meaningful. In both Gendlin's and Mindell's phenomenological approach the attention to "sentient experiencing" is a central concept. Attending to one's bodily sense in situation carries the process forward into new lands, beyond barriers imposed by convention and custom. While Gendlin focuses on "experiencing" as the basic interactional process of living, Mindell emphasizes lucidity / awareness of … the experiential process. Being human encompasses both the lucidity and the heightened awareness to perceive subtle signals and "flickers" as well as living the experiential process: both the awareness of the river's flow and being-in-the-flow of experiencing are part of life and necessary ingredients for change. The simultaneous realization - at once of our awareness of the flow of life and as living processes, can be a peak experience (Mindell 1993). The ultimate concern of life/therapy is freedom, mindful attention to the present experiencing. In a spiritual perspective, transcendence of subject and object of

experience, is waking up to see both awareness and the phenomenological field as the creative dance of the universe (Bhagavad Gita 2000).

The movement of liberation is from ready made concepts and limiting beliefs to new forms of being in relationship and in community. Implications are far reaching. Social and political change can occur in the carrying forward of our bodily felt sense to create new worlds that exceed custom and socially imposed meanings. Process work has moved the phenomenological focus on dream, body and relationship experience into the social political arena and developed open forum and group process techniques to carry forward the discourse on diversity, rank, power and privilege from a worldwork perspective.

6.5.4.The Experiencing Scale (EXP)[5]

"A good hour is an hour of intense experiencing" (Gendlin 1962:267)

The first attempts to measure the extent of client involvement or extent of immediate experiencing go back to the 1950s. Results on an original 9-point Likert scale confirmed the hypothesis that formal aspects of process were more important in determining successful therapy then the content of what was discussed (Gendlin and Zimring 1955; Gendlin et al 1960). These early findings also demonstrated that "immediate experiencing" was correlated positively with successful outcome.

In 1969 the final version of The Experiencing Scale was established (Klein, Mathieu, Gendlin and Kiesler, 1969) as a method for assessing 7 stages of involvement in the therapeutic process (Appendix C). According to the authors, the 7 stage scale was meant for "evaluating the quality of patient self-involvement in psychotherapy directly from tape recordings and transcripts of the therapy session. Experiencing, the chosen dimension, refers to the quality of an individual's experiencing of himself, the extent to which his ongoing, bodily, felt flow of experiencing is the basic datum of his awareness and communications about himself, and the extent to which this inner datum is integral to action and thought" (Klein et al 1969:1). The experiencing dimension includes the

[5] See Appendix C for scale description.

"continuous stream of sensations, somatic events, feelings, reflexive awareness, and cognitive meanings that make up one's phenomenological field" (ibid.:4). "Whatever the client does, his attention must be on the immediate, concrete, fresh, bodily sense of feel of the issues" (ibid.: 8). While the present scale matches the stage progression of the original scale (Gendlin and Tomlinson, 1962), the most important changes implemented disregarded non-verbal material and focused exclusively on verbal accounts with the objective of improving interrater reliability (Mathieu and Klein 1984).

6.5.4.1. Technical description of the EXP scale

The EXP is a 7-point scale designed to be used with transcripts and audiotapes of sessions (Klein et al 1969). The seven stages define the client involvement in the process and the extent to which felt experience is owned and elaborated upon. The client's involvement moves increasingly toward ownership of experiences and differentiation of feelings.

The EXP scale is multidimensional. The basic dimension is the *degree of ownership with the described phenomena or the gradual increase of inner referents*. From stage 1 to stage 3, as experiences become more personal, the sense of ownership increases in degrees. Stage 4 represents a marked shift of attention from external processes to internal ones. At this level, focusing starts with a definite interest in self-experience, grappling with inner processes and expression of feelings. Stages 5-7 describe various degrees of elaboration and unfolding of one's inner experiencing.

This sense of ownership is reflected in several dimensions included in the rating criteria: grammatical, expressive, paralinguistic and content dimension. Use of first-person pronouns at stage 2 (grammatical), immediate and expressive behavior at stage 4 (expressive), pauses and inward orientation at stage 5 (paralinguistic) are some of the markers for rating. The EXP scale emphasizes feelings and verbal expression, clarity and insight in dealing with inner life.

The rating of the various stages of the EXP relies on verbal expression and there is a definite preference of complete symbolization. The scale is designed to reflect and

measure overt communication from experiencing and one of the prerequisites is that "the patient be able and willing to manifest his or her experiencing in words in the presence of the therapist. Thus the scale is specifically directed at communication about the experiencing since *it assumes that people do not communicate about what they do not experience* …" (Klein et al 1986:28).

The experiencing process is observable since it manifests in expression. While people cannot *not* communicate and inner experiences will be communicated in some form, it is doubtful that verbal communication captures all of it. However, the intention to create a reliable instrument guided the researchers in their exclusive reliance on manifest verbal expression. The EXP scale ratings rely on *verbal expression*. All other observable forms of behavior are excluded - which, though contributing to IRR, creates a handicap. Large parts of experience are not apprehended with EXP while in therapy sessions, the therapist relies on non-verbal behavior as much as on verbal behavior to carry forward the process. Therefore, we must find way to reliably rate all behaviors, verbal, paralinguistic and non-verbal. One such attempt is the development of the PWI scale, an instrument analogous to EXP with one difference, the reliance, in addiction to verbal expression, on non-verbal behavior.

6.5.4.2. Inter-rater-reliability

Several tables of studies in (Klein et al 1986, pages 35-36) demonstrate high-post training inter- rater-reliability (IRR) for psychotherapy sessions and somewhat lower reliability for non therapy studies. In most therapy studies IRR after training is between 0.80 and 0.90, with an occasional lower correlation (r=0.75). Only one study (Joyce 1980, in Klein et al 1986) reported considerably lower IRR. Reliability of ratings of individual therapy segments of 4-5 minutes length (based on transcripts and audio) are reported to vary, on the lower end, between 0.76 (mode) - 0.79 (peak) in a study by Rogers (1967) and from 0.65 (mode) - 0. 61 (peak) (Yalom et al 1977, in Klein 1986) to highs between 0.80 and 0.93. Usually peak ratings have a somewhat higher IRR than modal ratings. For non therapy interviews, IRR of ratings is generally lower. 5 out of 7 studies reported achieved IRR coefficients between 0.60 - 0.80 for the mode, and somewhat higher for the peak ratings.

Studies demonstrate that the scale is independent of speech fluency. The conclusion drawn by the authors suggests that EXP levels are a function of the amount of speech available to raters. One study showed contradictory results: EXP was higher when subjects and therapists talk less (Klein et al 1986). The type of discourse and the EXP level point to strong associations between problem expression and self-disclosure type statements, communication level scales and free association scores. Interestingly, no correlation was found between EXP and measures of affective processes, while positive correlations are consistent with cognitive correlates of experiencing. This points to the importance that the authors of EXP attribute to "differentiation and integration of meaning as a cognitive (as distinct from expressive) component of experiencing" (Klein et al 1986:42). No correlations seem to exist between EXP and client productivity and performance from a psychoanalytic perspective. In brief, positive associations demonstrate relationship between EXP and measures of disclosure, problem expression and internal focus while there are, quite important to the present study, no significant correlations to measures of sensory-grounded concreteness (Pollack 1973, in Klein et al 1986).

6.5.4.3. Validity

Association with measures of health, outcome and personality

According to the construct, significant association of EXP with several different measures are to be expected, above all, with positive outcome and with client expressive and reflective manner. Some research suggested that EXP can serve as a measure of health and good motivation and prognosis in therapy (Rogers et al 1967). Introspective ability is associated with focusing which, in turn, is prerequisite for stage 4 processing (Gendlin et al, 1968). There have been reports that demonstrate EXP correlations with socio-economic and verbal skill level (Fontana et al 1980, in Klein 1986). Note that the PI, the process work measure, explicitly takes into account the bias of EXP toward education/class/verbal IQ in attempting to rate non-verbal behaviors as well.

In terms of correlations with measures of health, findings are somewhat contradictory, as elevated EXP scores are associated with "health" as well as affective distress and help-seeking behavior (Kiesler 1971). High EXP may correlate with depression and anxiety (Fishman 1971, in Klein 1986) and, at the same time, with "intelligence, ego-strength, character and self control, emotional stability, tender mindedness and introspectiveness" (Gendlin et al 1968). In summary, these results point to the fact that higher EXP scorers are open to a wide range of both negative and positive experiences. As they tend to avoid or repress experiences less, persons are able to engage themselves in problems in a way relevant for productive therapy (Hendricks 2000).

Results of training in focusing

Some studies reported clear benefits in experiencing levels from focusing training sessions (Durak et al 1997; Leijssen 1996 in Hendricks 2000). In one study (McMullin 1972, in Klein et al 1986) the subject's experiencing level increased dramatically in response to the presentation of Gendlin's focusing instruction, and dropped when the instructions were not given. Large-scale programs teaching communication skills with focus on experiential process demonstrated that experiencing levels rose significantly from pre- to post-training (Bierman et al 1976). In brief, experiencing skills can be taught even in populations with severe problems. The more precisely the training focuses on the experiential process or experiencing, the more effective the training (Klein et al 1986). When outcome is measured with measures other than EXP, similarly, focusing training correlates with more successful outcome (Leijssen 1996, in Hendricks 2000). Sachse et al (1992) demonstrated that clients who receive focusing instructions during client-centered therapy did better on a number of success measures than those who did not.

Hendricks (2000) reports that therapist interventions in other orientations increased EXP levels from pre- to post measures: good psychoanalytic interpretation (Fretter 1985), guided daydream (Smith 1980), Gestalt (Greenberg 1980) and meditation (King 1979) all increased EXP level significantly. Gestalt two chair resolution of

internal split may even move EXP level into the higher range (>4) (Greenberg 1981, 1983).

Experiencing and therapist conditions/interventions

EXP level with therapist variables a) empathy and b) congruence were strongest (Rogers et al 1967), however, following studies yielded more complex results (Jennen, Lietaer and Rombauts 1978, in Klein 1986). Other findings support the conclusion that client EXP is sensitive to therapist behavior (Elliott et al 1983, in Klein 1986): therapist EXP is an important part of therapist helpfulness; EXP is the result of helpful therapist interventions and, finally, high levels of EXP are an important measure of good outcome. Greenberg's studies of inner conflict situations, comparing two-chair techniques with empathic response alone, yielded higher levels of EXP level for the former, the Gestalt method. At the onset of inner conflict work, the chair representing "self" scores higher than the "other" chair. With the merging of views both positions move to high EXP of 4-6. Resolution yielded significantly higher EXP than non-resolution for both chairs (Greenberg 1980, 1981, 1983).

6.5.4.4. EXP and outcome measures

Since EXP by definition is a measure of productive engagement in the therapy process, one should expect positive correlations between EXP and outcome of therapy. These convergent associations thus serve to underline construct validity. Consistent positive relationships between EXP level and various outcome measures were found (Klein et al 1969; Kiesler 1971; Rogers et al 1967; Klein et al 1986). Kiesler (1971) found that session 1-20 and 1-30 were positively associated to good outcome, but not session 1-5 alone. While some found positive correlation (for primal therapy, Nixon 1982, in Hendricks 2000), others could not find such relationships (Bommert et al 1978, in Hendricks 2000). For psychodynamic therapy, Luborsky (1982, in Klein 1986) failed to find significant correlations between initial EXP and outcome. The most consistent significant correlations between EXP and outcome could be demonstrated with EXP *change scores* over the course of therapy (Klein et al 1986).

Newer reviews of early studies reported by Hendricks (2000), however, point to definite positive association between high EXP and outcome at all levels. Seeman (1996), in a review of 7 early EXP-outcome studies, concludes that initial high levels of experiencing are likely to facilitate positive therapy outcome. Goldman found that higher EXP in the second session related to reduction in depressive symptomatology. Initial high scores, with further increases during therapy strenghten positive outcome (Goldman 1997, in Hendricks 2000). Similarly, Warwar (1996, in Hendricks 2000) found that high EXP scores relate to better session outcome.

Relationships between EXP and outcome at various points in therapy, more often after the first few sessions than in the very beginning, point to the importance of experiencing as a process variable. EXP "change score" over therapy or "rank order" correlations between EXP and well-being are consistently found. Klein et al conclude that these findings suggest that the scale reflects a "mode of productive functioning rather than stable personality trait" confirming with empirical method the centrality of "process". The "original view of experiencing as a process variable and of the scale as a reflection of this essential quality of self involvement and participation in the therapy process still holds" (Klein et al 1986:53).
In summary, "experiencing" operates in many ways: a) successful clients function on a significantly higher experiencing level than unsuccessful ones on a number of client, therapist and outcome measures; b) more successful clients elicit more peak moments (Gendlin et al 1968; Karon and VandenBos 1970; Rogers et al 1967); c) successful short-term therapy clients focus in very session; d) while some clients need focusing training, others focus spontaneously; e) therapist interventions deepen or flatten client EXP (Hendricks 2000).

For results on assessment of mean modal and peak ratings of first and second session on EXP scale, see part X.

Part VII: Methodology

7.1. Quantitative and qualitative methodologies

The design of the present study combines both quantitative and qualitative methodologies - making use of a number of advantages both methodologies contain. Some researchers provide powerful argument not only for a qualitative approach but for a pragmatic combination with quantitative assessment (Patton 1990). The design was partially emerging with the unfolding of the study. Not only did the qualitative design mature over time but the focus on an exclusively discovery-oriented approach evolved to include quantitative measures as well toward integration of both qualitative and quantitative data. The raw data of the study are exact transcripts of session segments, of what subjects actually say, and corresponding videotapes, depicting all the non-verbal behaviors as well.

The study is modeled as an AB design to compare a non-intervention session and an intervention session quantitatively on a process and an outcome measure across the group of 13 opioid dependent subject. This results in a set of findings that have the power to be generalizable to a similar population. Second, the experimental design - applying the therapeutic intervention in the second session - serves to qualitatively study the subjects' experiential responses to the research operation. The discovery-oriented qualitative approach not only involves the researcher as the instrument but also includes objective judges (Mahrer 1986, 1988; Greenberg and Pinsof 1986). The idea is that with an inductive approach, patterns of experiences can be discovered in the subjects' responses - without presupposing what types of states will actually be found. Objective judges, rendering outside viewpoint to the results accomplish this pattern analysis. A process-oriented theory emerging from the pattern analysis will be grounded in the experiences of the subjects.

The following chapter on methodology reflects to some extent the author's evolving grasp on the methodological issues involved in the combination of quantitative and qualitative evaluation. It gives a short description of the quantitative method,

conceptualizes the population as a series of case studies and finally, focuses on process outcome and psychotherapy process research.

7.2. Case studies

The myth goes that appropriate experimental psychotherapy research is nomothetic, and that no valid inferences could be drawn from individual cases. However, clinical psychology has much relied on studies of individual cases, for theory construction and as a source of ideas about behavior (Shaughnessy 1994). Often exploratory in nature and used in the beginning stages of research when there is little known about the field in question, case studies are invaluable for opening the way to new and exciting discoveries and are also considered good opportunities to study new and innovative therapeutic techniques (Kazdin 1998). The issue is less with the lamented inability to draw valid inferences from case studies than that of ruling out alternative hypotheses. To decrease the plausibility of specific rival hypothesis, Kazdin (1998) proposes a model to increase the validity of case studies by

- inclusion of objective rather than anecdotal information and continuous assessments
- understanding the extended history of the problem to draw inferences about treatment changes (as deviation from expected course)
- looking at immediacy and magnitude of effects
- augmenting the number and heterogeneity of subjects included in the study.

The present study addresses several of the limitations usually associated with case studies: inclusion of objective data and measures, choosing a heterogeneous sample from a well-known population and a problem with a reputation for being resistant to therapeutic interventions; and finally, in-session effects are immediate and thus, very plausibly attributable to the therapist intervention. One of the challenges in using both a quantitative and a qualitative approach is the balancing of limitations for each methodology. For the empirical part, the limitations of the study include the low number as well as the heterogeneity of the research subjects. For the qualitative part,

however, the number of subjects is quite large and the heterogeneity of subjects considerable, both which improve the result's validity.

7.3. Outcome research

After tremendous effort in outcome research we know that psychotherapy is overall more effective than not but the reasons remain unclear (Smith and Glass 1977; Kopta et al 1999). There is no convincing evidence that different therapies are differentially effective (Luborsky et al 1975); one reason being methodological, namely, the lack of specificity across psychotherapies and techniques results in a fuzzy notion of what really happens in session (Kazdin 1998). Since Luborsky et all (1975) concluded for psychotherapy outcome research that "all won and all must have prices", new research strategies with an intensive focus on specific in-session processes have been designed. They attempt to identify the kinds of in-session processes that lead to change and thus, to narrowing the gap between research and clinical practice (Goldfried 1980; Kiesler 1985; Gendlin 1986; VandenBos 1986; Kopta et al 1999).

An alternate avenue to comparing or evaluating therapies in across-group designs is to address in-session change events: “What kinds of changes are affected by what kinds of techniques applied to what kinds of patients by what kinds of therapists under what kinds of conditions?” (Parloff 1979:303). Or, as Goldfried (1980) states: “Thus, if new, corrective experiences were seen as a common strategy, one would need to investigate the most effective tactic or technique for providing such experiences (e.g., individually, in groups, in imagination, via role play, face to face), the number and nature of such experiences, the optimal level of emotional arousal needed for change to occur, and the extent to which the particular method of implementing the strategy interacts with other patient/client and therapist variables” (1980:997). Along these lines, Gendlin (1986) proposes that we define microprocesses in psychotherapy and outline strategies for researching these in-session events. The focus is on “identifying, describing, explaining and predicting the effects of the processes” and their immediate, intermediate and long term impact (Greenberg 1986). Any client progress or client movement in-session is small scale outcome (Gendlin 1986) referred to as little o’s in contrast to follow-up outcomes designated as big O’s (Marmar 1990).

For the purpose of the current study a “dismantling strategy” (Kazdin 1995:406) is employed which isolates one particular technique from the large body of process work strategies and researches this particular component for its effectiveness to facilitate therapeutic change. To a baseline session of verbal exploration, a single intervention is added in the second session and assessed for its effect on immediate outcome. If we want to promote new experiences and demonstrate how to facilitate such incremental change events, the research question will be to examine the power of the therapist intervention to elicit precisely those events.

7.4. Psychotherapy Process Research

Important aspects of the present study are based on the new paradigm of psychotherapy process research (Rice and Greenberg 1984; Greenberg and Pinsof 1986; Elliott 1983, 1984; Greenberg 1979, 1983, 1984a, 1984b, 1986; Mahrer 1986a, 1986b,1988, 1996, 1998; Gendlin 1986, Horowitz 1979, Marmar 1984, Hill 1990) which examines in detail in-session “events” in psychotherapy with the goal of discovering mechanisms of client change (Rice and Greenberg 1984, Greenberg and Pinsof 1986). The new paradigm examines episodes or “patterns of change” and researches how in-session transactions become “vehicles of therapeutic change" (Rice and Greenberg 1984:7). These “patterns of change” – key, critical, decisive episodes of client and therapist in-session events – are recognized by psychotherapists on the basis of clinical understanding of in-session processes (Elliott 1983a). An event is identified as a potential moment for client change, and specifically, as a “…therapeutic episode consisting of four components: the patient problem marker, the therapist operation, the client performance, and the immediate in-session outcome” (Greenberg 1986:6). Through identification of typical interactions which take place often enough for the clinician to recognize the beginning and the end of these sequences, we can come closer to understanding how and when clients change. What are the productive client movements and what kinds of therapist interventions facilitate them, precede them and help maintaining them? To observe in-session events will help specify what therapists and clients are doing exactly and how it relates to client change.

This perspective relies on a ***rational-empirical strategy*** (Rice and Greenberg 1984, 1986) for the sequencing of the psychotherapeutic process. In accordance with clinical practice, observations of specific in-situation performances are guided by the "clinicians map or tacit knowledge" (1984:8). In this view, a theoretical framework is necessary to make sense of the indefinite flow of communication processes and to isolate critical episodes from the mass of observations. To perceive the signals of emerging processes, the beginning and end markers of events, a kind of "process diagnosis" is essential (Leijssen 1998:125). In proposing a combination of rational and empirical methodology to study change, Rice and Greenberg suggest the use of a map to sequence sessions and to empirically investigate the episodes for "grounded patterns". Both theory-driven and discovery-oriented strategies complement and inform each other in a kind of system with circular causality. A central role is given to the observer for pattern recognition by emphasizing that the "best instrument for pattern identification is the human integrator" (Rice and Greenberg 1986:vi).

"The complexity of process requires that the phenomena under investigation be approached within a specified theoretical framework to guide the intensive analysis of data. This approach takes both the cognitive map of the investigator, as well as observation of empirical reality, as important sources for science" (Greenberg and Foerster 1996).

The process-oriented approach does exactly that. It provides the researcher/ therapist with a "process structure", a map of in-session processes which inform him/her of various bifurcation points: normal states, altered states and process splits can thus easily be recognized. In this sense, the process work paradigm provides a rational-empirical strategy: it posits a theoretical construct which helps structure empirical observation and identify important experiential patterns, to which interventions then can be aligned to.

"This new paradigm aims to isolate meaningful patterns relying initially on the human integrator as the best screening instrument for pattern identification…Such events or episodes become particularly powerful organizers of the change process because they

permit systematic study of therapist techniques leading to such transitions" (Marmar 1990:266).

Such episodes of change have been investigated for relationship conflict (Luborsky et all 1986), working states (Marmar et all 1984), episodes of internal conflict (Greenberg 1979, 1983, 1984b) and for therapeutic alliance (Foreman and Marmar 1985). However, client altered states of consciousness have not been investigated and this study does accomplish just that. It identifies markers for client altered states and researches their health-promoting potential.

In accord with ***task analysis*** (Greenberg and Saperia 1984; Greenberg 1984), this study proposes a client task that is accessing the altered state of consciousness usually experienced only in the context of a drug experience. Possible sub-steps in the sequence include a) a shift of focus inward; b) a deepening of experiencing; c) dealing with intervening processes (relational processes; internal splits); d) progressing over the threshold of the "edge" (Mindell 1985); e) being in the altered state; f) integrating the experience in the moment in relationship. Greenberg provides a good example of two-chair gestalt techniques to resolve internal split (1979) which is relevant to the present study for methodological and technical reasons; the client edge (E) is characterized by internal split and its resolution bears similarities to the Gestalt therapy approach. Another example demonstrates the task analytic approach for resolving unfinished interpersonal business (1996). However, accessing unusual states of consciousness has not yet been described as an important task in therapy.

In the same vein, Horowitz' (1979) ***configurational analysis*** to identify client states of mind and change of in-session client states is particularly relevant to this study. Configurational analysis describes behavior and subjective experiences of problem states and focuses on transitions into other states. The therapeutic strategy thus can be understood as an attempt at altering "patterning of state prevalence and transition in order to accelerate change" (Marmar et al 1984:195). Similarly, process work describes states of mind operationally so that individual cases can be described and judges can reach consensus. A discrete state of mind is defined as a unit consisting

of sets of verbal and non-verbal behaviors, with alternate states emerging in the form of conflicting signals. The process work model identifies experiential patterns, which lie close to a person's identity as "primary processes" and patterns or states further away from awareness as "secondary processes". The corresponding verbal and non-verbal signals of these states can be identified on the bases of rational process theory. While Marmar et al (1984) mention some specific non-verbal components like “posture, facial expression, tone of voice, gestures, hand and foot positioning, flow of speech, and deployment of attention” (ibid:198), process work uses an elegant and formal system with which to capture the patterns of experience or better, the overt behavior, in respect to the client’s momentary awareness, the degree of identification with any one pattern and their mutual fit (congruence or lack of congruence).

Mahrer's experiential category system

The discovery-oriented methodology proposed by Mahrer to explore important moments in psychotherapy seems particularly intriguing for a number of reasons (Mahrer (1988). First, not unlike process work, his brand of experiential psychotherapy aims at promoting the experience of a new personality state in each session (Mahrer 1996) and second, he offers a category system for in-session events in experiential therapy based on qualitative methodology (Mahrer 1986). According to Mahrer, the experiential category system below goes back to the work of Raskin (1949) and the American Academy of Psychotherapists. It has been derived and refined by Mahrer (1985, 1986) and includes 12 categories of good moments in psychotherapy which are meaningful and relevant to clinical practice. For experiential psychotherapy, 4 categories are especially meaningful. In his research on in-session good moments, the following four categories appear with sufficient frequency to be included here (Mahrer et al 1986:13):

1 *Providing meaningful material about personal self and/or interpersonal relations*. The client is providing (reporting, describing, expressing) material which is meaningful (useful, important, revealing, significant), and which pertains to the personal self and / or interpersonal relations.

2 *Communicating expressively.* The client is communicating in an manner characterized by (a) a voice quality which is alive, energetic, fresh, spontaneous, and vibrant; and /or b) vividness and richness in the spoken words: figures of speech, colorful use of imagery and metaphor, strong sensual quality.

3 *Manifesting a qualitatively different personality state*. The client is manifesting (being, expressing) a qualitatively new and different personality state indicative of a radical shift or transformation in substantive personality.

4 *Expressing strong feelings in extra therapy contexts*. The client is expressing strong feelings within the context of extra-therapy scenes and situations which may be recent or remote, real or fantasized, personal or impersonal, internal or external.

In accordance with grounded theory (Glaser and Strauss 1967; Glaser 1978; Strauss and Corbin 1990), Mahrer proposes to chose instances of target behaviors and, based on grounded theory, have the data examined by objective judges to formulate a category system which fits the data of the particular episode. In the present study, one such category of experience is selected for analysis by judges: in-session altered states of consciousness. This experiential category relates directly to one of the empirical categories devised by Mahrer, namely, "expressing of a qualitatively different personality state". This shift or transformation relative to the person's ordinary state is indicative of an "altered state of consciousness", defined more precisely below. The goal of the qualitative analysis is to find out what kind of experiences addicts are having in response to the therapist intervention. In a first move, judges will flag all segments, in which altered states occur and inter judge consensus will be evaluated. In a second move, these judges describe and name the states they are observing and devise a category system for occurring altered states.

Part VIII: Procedure

8.1. Participants

Subjects were thirteen men and women who volunteered to participate in this clinical trial for alternative treatment of opioid dependency. They either responded on their own to an ad in the local paper or were at the time of the study in a court-mandated residential drug treatment center. For inclusion in the research trial, individuals had to be dependent on heroin or other opiates in accordance with the *Diagnostic and Statistical Manual of Mental Disorder* (DSM-IV, American Psychiatric Association 1994), currently using opiates or in treatment for opioid dependency. Exclusion criteria were unwillingness to focus on self and illicit substance use predominantly other than opiates. A diagnosis of opioid dependency was determined from information collected at the initial interview using the DSM-IV checklist and the drug section of the Addiction Severity Index (ASI: McLellan, Luborsky and Cacciola 1985) as well as based on diagnostic information provided by the residential facility. Eight persons were interviewed while in residential treatment: six from a residential facility for men and two from a treatment facility for men and women. Both six-month treatment programs were comparable and based on behavioral interventions, interpersonal groups, drug education and token economy.

Five persons responded to an advertisement published in the local weekly newspaper. Of these, three persons were in maintenance methadone programs with no additional use of illicit drugs reported. Two people were users at the time of the interview and without treatment. One, a young man, used heroin for just under a year, the other, a woman, had a long history of use and dependency on opioids (opium and prescription medications). She had had three years of private therapy including two trials with "ibogaine", a hallucinogenic plant compound, after which she was abstinent for 2 years before relapsing again.

Drop outs

Four people called in response to the ad without scheduling an appointment. Two persons made an appointment but did not show up to the interview; two persons

dropped out after the first interview; one person turned out to be a crack addict and there was no follow up appointment.

8.2. Study duration

Participation in the study was for 2 sessions, 55-60 minutes each. The time period between the first and the second interview ranged from 2 to 9, in one case 21 days (x=6.7; STD=5).

8.3. Procedures

Two sessions were provided by the therapist/researcher for each client. The first session was conducted as a "placebo" session without active intervention, the second session was designed as the treatment or intervention session. In both sessions the same common factors (Frank 1971, Karasu 1986) are operative. Specific feeling attitudes arising from the world view of process work were imparted equally in both sessions to optimize morale, promote optimism and well-being. Both sessions were recorded with a Hitachi High 8mm video camera for data analysis (see below).

8.3.1. The first session

In the initial meeting, the client was welcomed and introduced to a brief synopsis of the process-oriented perspective on addiction including the goals of the experiential session. Three points were stressed: body grounded focusing was required to access the addictive state; the procedure demanded awareness and a sober attitude in the exploration of the altered state; finally, the idea was to mentally separate the drug from the yearned-for experience. The possibility of craving as a result of the accessing procedure was discussed and the client was offered a follow up session in case he needed help. The client read and signed the statement of informed consent and the video release form. Issues of confidentiality and restrictions on the use of transcripts and video tapes for rating procedures were addressed.

In the first session no active intervention techniques were employed beyond therapist feeling attitudes. The therapist invited the client to explore personal history related to self, family, drugs, health, well being and legal problems. Each client was asked for a

description of the heroin state and a childhood dream or first memory. If the feelings associated to the dialogue invited exploration, the therapist made sure to help deepen, to elaborate and clarify them. While supporting the underlying emotional process, verbal interactions dominated this first session.

Immediately after the session, the patient were handed the SOC-13 and asked to rate the questions. In some instances, the client needed clarification of an item, which was then explained by the interviewer. Finally, in a few words, the client was prepared for the second or experiential session. In essence, the task was to re-feel the state and, following and unfolding sensory-grounded information, access the deeper state the person yearns for in the use of heroin. That altered state which the person was yearning for had some purpose or a teaching in respect to everyday life.

8.3.2. Intervention Session

After welcoming the client and checking in, space was given for client questions and concerns. Then, the therapist asked permission to proceed with inner work instructions to re-access the altered state.

The instructions (see Appendix A for complete set) follow several steps which invite the client to shift attention inward and focus on inner experiences to access the central experience he/she hopes for when taking the drug of choice. Often, this central experience has been experienced only once in the beginning of drug use. This time, the client was invited to go even further into the altered state without using any substance. While the therapist/researcher acted as a guide into the altered state of consciousness, however, he was careful to remind the client to stay focused and attend to inner experiencing with sober awareness. The client is encouraged to feel, experience and sense into vague ... not yet clear and often pre-verbal material.... Accordingly, there are many open spaces ... and pauses … in the provision of these instructions. It is crucial to observe and follow client feedback. Any words or suggestions need exact timing as to join the flow of the client's inner experiencing. Since the aim is to help the client be in touch with his/her inner process much of the

session may unfold non-verbally, in sensing, feeling, moving, only to be symbolized in intervals of outer relatedness.

1. The first steps (1-2) aim at re-accessing, unfolding and completing the altered state until its meaning is experienced and a resolution occurs. While the client is encouraged to relax and recall the central yearning behind the drug use, the therapist supports non-verbal cues of the state described and helps to carry forward the bodily felt experience. At the "high" of inner sensing or feeling, movement is suggested to express the core of the non-verbal process in another channel to unfold the experience even further. Often, movement is the beginning of a symbolizing process after which flashes of insight and meaning follows.

2. The next steps (3-4) facilitate exploring and sensing the root of the addiction, that unknown ... which precedes the impulse... and tries to follow it all the way to the felt sense of the atmosphere or world at the root of that impulse or craving. It makes space for sensing "sentient experience" (Mindell 2000), the subtle tendencies and energies that give rise to the particular addictive tendency. The client is living /experiencing / being in this new state in the present.

3. This next step (5) asks what parts of oneself remain neglected and disavowed in the process of drug use. How are deep sentient experiences being marginalized and, instead, substituted by a substance? Is it possible to open up to these sentient experiences? What tendencies, voices, dream figures or parts are against it?

4. The final steps (6-7) facilitates integration of being / living the altered state into relationship and/or a group situation (real, fantasized, imagined or a combination of these). The therapist encourages the client to being this new personality state in his/her style of relating in the present moment in fantasy, role play or in relationship to the therapist.

The sequencing of steps is nonlinear and depends on client feedback, timing and the co-creative process. While these four steps represent a complete set of interventions,

in the present research trial, re-accessing the altered state (1) was the central focus, with attempts at integrating (4). A few clients felt into the essence behind the impulse (2) and in two sessions, the focus was on belief systems stopping the client from accessing the state (3). The requirement to focus on the altered state was complex and re-accessing time consuming. Often, client and therapist were wandering tangentially and the therapist had to direct attention back to the bodily felt experiencing. These difficulties had to be expected with the population of heroin addicts. Some examples of the meandering process are given in the clinical part of this study.

8.4. Measures

Two primary outcome measures were chosen on the grounds of compatibility of the underlying constructs to the process-oriented paradigm; in addition, the author developed a third, related scale. First, immediately after each session, the **Sense of Coherence Scale (SOC**) developed by Antonovsky (1987) was used to measure the relative location of each person on the health ease / dis-ease continuum. In its short version, the SOC-13, contains 13 questions to which the clients responds on a rank scale from 1 (very seldom, never) to 7 (very often). The scores at t1 and t2 provided a measure for the impact the two kinds of sessions had on the sense of coherence. Second, the **Experiencing Scale (EXP)** developed by Rogers, Gendlin, Klein and Kiesler (1969) assesses the quality of in-session client involvement in the therapy process from a client-centered perspective. Objective raters estimate the depth of client involvement in the process by reviewing transcripts and/or audio tapes. On a scale from 1-7, these raters indicate the stage at which the client operates during the session, both the average (modal) and the peak level. To make sure reliability among raters is sufficient, rating procedures rely exclusively on the client's verbal statements. Third, designed in close analogy to the EXP scale, the author developed the **Process Index (PI)**. Trained raters assess the in-session client process along the seven stages the EXP proposes, however, from the perspective of process-oriented psychology. The modified rating procedures, based on transcripts and corresponding video tapes, demand that the raters include non-verbal as well as verbal material in their assessment of levels. For the purpose of this study, 4 segments per clients were

assessed and the differences in EXP and PI levels between the first and the second session computed.

EXP and PI interpret the "experiencing" construct differently, however, reflecting a more fundamental difference in what client-centered therapy and process work consider to be the central health-promoting ingredients in successful therapy. In short, the **EXP** construct rates *ownership and verbal expression of feelings, emotions and insights,* while the **PI** assesses *ownership and extent of involvement with an in inner felt referent, irrespective of the channel the experience is represented in and without necessarily relying on verbal expression.* The raters are trained to notice non-verbal signals and verbal messages in various channels of experience and compare transcripts and audio-visual impressions for the rating.

The client self-assessment with the SOC was measured immediately after the initial session and again, immediately after the intervention session on the SOC-13. To assess the in-session involvement in the therapy process, EXP and PI were employed. Three raters, trained for an objective assessment, rated 4 segment per client with the help of transcripts and corresponding video clips, following the "running rating" method (Klein et al 1969). The 4 segments per client were arranged in random order to insure that each segment was independent of the previous or following segments.

In addition, two objective judges, process work therapists with clinical experience, rated the occurrence or absence of altered states in the 4 randomly ordered segments per client and named the state they observed. Their categories and state descriptions served for qualitative analysis of the material.

8.5. Selection of segments (for EXP and PI)

In accordance with the recommendation by Klein et al. (1969) several samples per client were transcribed. Two 5-minute segments from session one and two equally long segments from session two were selected and transcribed. Transcripts and a video tape segments, in random order, were prepared for the rating procedure.

The final sampling was done along a story-line, a gestalt in dialogue or experiencing in both session and, at the same time, oriented to include those segments with most emotional content in both the initial and the intervention session. Segments of re-accessing the heroin state revolve around the task and attempt to capture the yearned-for state of consciousness.

8.6. Rater selection

Raters were volunteer psychology students who responded to a call on a local email string of students affiliated with the process work institute. They were blind as to the design of the study and had genuine interest in learning to study a process through the lens of the Experiencing Scale. There were no financial incentives involved and the students participated out of interest, using the training as a learning opportunity. They had very cooperative attitudes, good verbal skills as well as trained non-verbal awareness and a high level of mutual interest in establishing reliability across the stages (see Klein et al 1986).

8.7. Rater training

Instructions in the training manual (Klein et al. 1969) recommend 8 x 2 hours of rater training to reach a sufficiently high IRR (Cronbach alpha of 0.80). A goal was set to match this IRR after training of 0.80. Three 4-hour sessions or a total of 12 hours of training were completed. During these highly structured training sessions, raters familiarized themselves with the experiencing concept and learnt to differentiate the 7 stages according to the manual. They worked through large parts of the training segments, discussing stage characteristics and analyzing divergent ratings. After each training session, the between rater accord was statistically evaluated (SPSS). After completion of the 3rd training session, IRR reached 0.79 (Cronbach Alpha) for the three raters on the EXP scale. A decision was made that sufficient IRR was reached and at that point training was stopped.

For the EXP, assessments were made for overt verbal expression of the client only. Sometimes, the client would attend to an inner process in silence and words or images

would come later. Raters would then rate retrospectively on the process the client came to symbolize (Klein et al 1986).

There are obvious and serious ***limitations*** to the format of the rater training. For one, training included only 12 hours and IRR was slightly below expectation after the training was completed. Another limitation is the fact that PI training was included in the training with the EXP manual. However, on a positive note, two rating sessions were enhanced by including training transcripts and video tapes to rate both EXP and PWI. Also, the raters, students with a minimum of 2 year participation in the process work training program - were quite familiar with rating of non-verbal signals - and therefore, PI rating did not seem to present much additional difficulty after the EXP assessment was mastered.

8.8. Rating procedures

Running ratings

Procedure of "running ratings" was employed in the study. Running rating mark shifts in levels after each speech turn or topics in speech. The rater calibrates the sample and stays on the level until changes up or down occur (compare Klein et al 1986, page 31).

Modal and peak ratings

The running ratings of each segment include so-called modal and peak values. Modal ratings characterize average or overall level of experiencing during the segment while the peak is given to any higher point reached in the segment, if only momentarily.

8.9. Judges (for qualitative study)

While the researcher hoped to be able to find a team of three judges, only two would be available at the time of the evaluation of the study. Two sophisticated judges, psychologists and process–oriented therapists were reviewing the 52 segments with transcripts and corresponding videotapes. In a first step the judges had to flag and mark occurrences of altered states as defined by process work (see section on

process work). In a second step, altered state episodes were reviewed and the judges described what altered states happened and named them to construct a category system of altered states. Finally, the judges tried to describe what therapist and client did to promote and maintain these unusual states of consciousness.

8.10. Selection of judges

The researcher sent out a call for participation in the study on a local email string for trainers in process work. In order to be included in the study, each judge had to hold a diploma in process work (minimum of 5 years of training) and have a minimum of 3 years of post-graduate clinical practice. The judges had to spend approximately 8 hours without financial incentives. Instead of three judges, only two could be found for the time period of the final evaluations.

8.11. Number of judges

A greater number of judges would have been preferable (Mahrer 1986) to increase the confidence in the identification of important events as well as to provide for a richer description of occurring states of consciousness. Due to constraints in time and finances, only two judges could be found to participate. Thus, two judges were chosen for pragmatic reasons as a sufficient number of observers both to guarantee valid IRR and meaningful descriptions of occurring states of consciousness. The clinical sophistication of the judges and their intimate knowledge with the concepts used in this study will make for less variation, i.e. a higher IRR, more plausible the findings.

PART IX: Goals of Research and Hypotheses

9.1. Goals

The present research investigates a set of process-oriented interventions with opiate dependent persons, which promote important in-session client movement – defined as altered states of consciousness. The author holds that facilitating experiences of altered states of consciousness has huge potential in the treatment of addicted persons as these states are indicative of change in the right direction. If clients self-medicate with opiates in the search of a high and/or against unwanted affects, then it should be possible to teach them alternate, benevolent procedures to reach the same goals.

There are two main goals of the study: first, a quantitative assessment of the immediate effect of the intervention on a measure of health (SOC-13) and on client involvement in the therapy process (EXP; PI; similarity-factor, see below); and second, a qualitative description of the types of altered states occurring.

While the goal of the intervention is to promote client experiences of altered states of consciousness, this research study seeks to determine the effectiveness of the intervention by quantitatively comparing the first or baseline session to a second or intervention session on these process / outcome measures.

A second goal of this research is to discover qualitative categories of the altered states, which clients experience in re-accessing the drug of choice state. Nowhere in the literature are there explorations of methods that elicit strong positive in-session feelings and changes of consciousness even though clients and psychotherapists alike value such significant moments. This present study fills a gap and researches the qualitative nature of the client's responses to the intervention and answers the question as to "What are the altered states of consciousness following the therapist intervention?

In short, while the main purpose of the proposed set of therapist interventions is to promote in-session altered states or “very good moments”, the task will be a) to measure changes in client states; and b) for independent objective judges to identify the occurrence of such states and to research, with an approach leaning on grounded theory (Glaser and Strauss 1967; Glaser 1978; Strauss and Corbin 1990), what kinds of altered states people experience as a result of the intervention.

In order to assess these events accurately, the sessions are videotaped and transcribed so that complete data on the sessions are available to the researcher and to outside observers.

9.2. Hypotheses

The hypothesis of this research study is that for some subjects who have an interest at self-exploration and the ability to focus their attention on the stream of inner experiences, especially on their body sense, the therapist interventions will have the potential to elicit altered states of consciousness. The hypothesis is that these altered states can be quantified and recognized with reliability by a set of judges who, in addition, will describe and name the different types of altered states that occur.

It is expected that occurrence of altered states as flagged by the judges will correlate positively with scores on the Experiencing scale (EXP) and on the Process-Index (PI) as well as with the posttest scores of the sense of coherence questionnaire (SOC).

The effectiveness of the therapist intervention will be assessed by comparing the SOC scores at t1 (after "placebo" session) and t2 (after intervention session) and by measuring and contrasting in-session extent of client "experiencing" in both session – using a therapy process variable for determining short-term outcome (Marmar 1990). There is evidence that these significant in-session experiences have transformative power and are connected to positive in-session outcome (Orlinsky and Howard 1978; Mahrer 1985; Rice and Greenberg 1984).

9.2. Hypotheses

1) Hypothesis #1: The "Sense of Coherence" (SOC) will significantly increase between initial and intervention session, in the total SOC score as well as in the 3 subscales (C, M, Me).

2) Hypothesis #2: The experiencing level (EXP) will significantly increase between the first and the second session, both in the modal and peak value (in the mean rating of three raters).

3) Hypothesis #3: The experiencing level (Process-Index) will significantly increase between the first and the second session, both in the modal and the peak value (in the mean rating of three raters).

4) Hypothesis #4: The research subjects' subjective evaluation of the "Similarity of in-session altered state with heroin state" correlates significantly with the SOC, EXP and PI measures.

5) Hypothesis #5: There will be a high inter-rater-reliability (IRR) among the three trained raters on both modal and peak values of the EXP and the PI for the first and the second session.

6) Hypothesis #6: The intensity of the experience, measured by subjective and objective evaluation (SOC, EXP, PI, and similarity-factor) is independent of current treatment program, age, gender, race, education, and criminal history.

7) Hypothesis #7: The intensity of the experience as measured by SOC, EXP, PWI, similarity-factor, is directly dependent on the length of opiate addiction.

8) Hypothesis #8: There will be a high correlation between the "altered state" ratings of the judges and increased levels of experiencing measured with EXP, PWI and similarity-factor.

9) Hypothesis #9: The time difference between the sessions does not contribute to the increase in experiencing level from the first to the second session (SOC, EXP, PWI, and similarity-factor).

Part X: Results

10. Table 8: Participant Characteristics

Variable	Persons	%	Min	Max	Mean	SD
Age (years)			21	51	36.85	9.21
Gender						
Female	4	30.8				
Male	9	69.2				
Race						
White	9	69.2				
Other	4	30.8				
Relationship status						
Single	10	76.9				
Married	1	7.7				
Divorced	2	15.4				
Education						
HS not completed	2	15.4				
HS/GED completed	7	53.8				
>two years college	2	15.4				
BA completed	2	15.4				
Work						
Full time	3	23.1				
Part time	3	23.1				
Day work	1	7.7				
Unemployed	6	46.1				
Drug dependency						
Opiates (years)			0.75	32.00	11.13	9.15
Alcohol			.00	35.00	11.54	11.69
Cocaine			.00	32.00	8.15	11.19
Amphetamine			.00	15.00	2.46	4.20
Cannabis			.00	15.00	4.54	5.27
Diagnosis other than drugs						
None	8	61.5				
300.4 Dysthymia	4	30.8				
296.23 Major depression	1	7.7				
Medication						
None	8	61.5				
Paxil/Zoloft	5	39.5				
Incarceration (months)			.00	120.0	30.31	43.57
Number of treatment attempts			.00	6	2.54	1.71
Current treatment situation						
Residential	8	61.5				
Methadone	3	23.1				
None	2	15.4				
Treatment duration						
Residential (weeks)	(n=8)		2.00	16.00	7.00	5.32
Methadone (years)	(n=3)		1.50	2.50	2.00	0.50
Time between t1 and t2 (days)	(n=13)		2.00	21.00	6.69	5.02

Results[1]

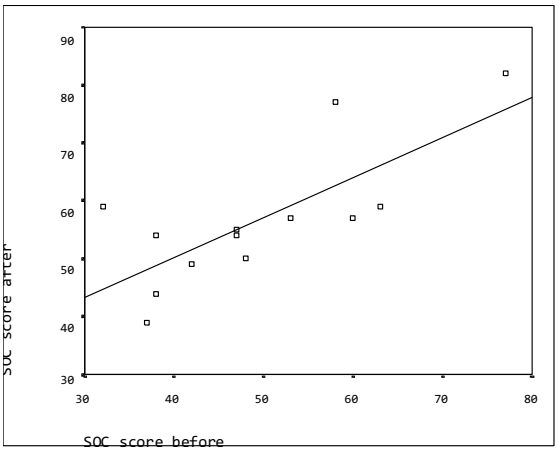
10.1. Hypothesis #1: The "Sense of Coherence" (SOC) will significantly increase between initial and intervention session

Description:

M_b = 49.23	**M_a = 56.62**
SD_b = 12.68	**SD_a = 11.76**
SE b = 3.52	**SE a = 3.26**

Inference (Paired Samples Test):
t(12) = -3.059, p = 0.010

95% Confidence Interval of the Difference:
(2.12,12.64)
Effect Size: d = 0.85



Correlation: r = 0.749, p=0.003

Discussion of results

The hypothesis that the "Sense of Coherence" (SOC) would increase significantly from t1 (after initial session) to t2 (after the intervention session) is confirmed. The mean value for the population on the SOC-13 is 49.23 (SD 12.68) after the first session and 56.62 (SD 11.76) after the second or intervention session. The t-test for paired samples indicates the increase of +7.4 (SD 8.7) to be highly significant ($p<0.01$). The effect size d=0.85 (Cohen) is very large and is evidence for the very significant

[1] I am indebted to Dr. Alojz Ritomsky for statistical data analysis

improvement in SOC scores of the population after session 2 as compared to after session 1.

Further, the matched pairs scores after session 1 and after session 2 correlate highly ($r=0.749$; $p<0.003$). This very good test-retest reliability gives evidence of the usefulness of the SOC for follow-up measurements. This further represents an important finding in the light of the theoretical model of the SOC. While the construct initially considered the SOC score a stable trait with only minor fluctuations after adolescence, the results demonstrate that intentional modification are possible and can effect high increases.

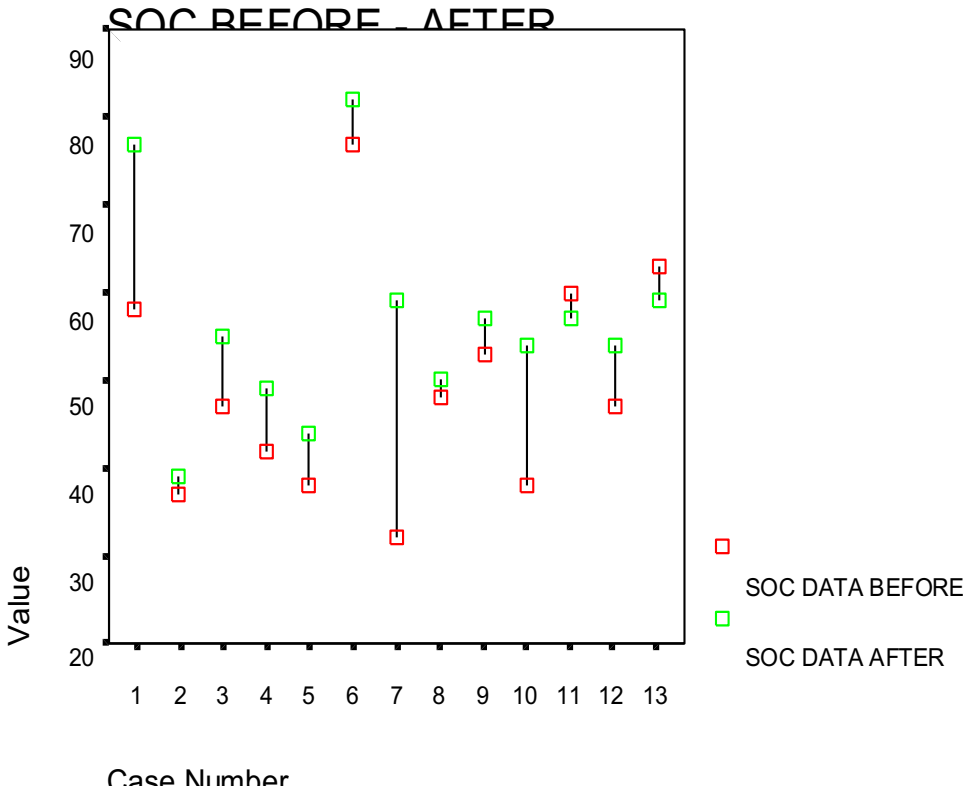
In a report, the mean SOC scores obtained by the SOC-13 demonstrates scores in the range from 68.7 (STD 10) down to 55 (STD 0.7) (Antonovsky 1993:731). The mean group score of the population of heroin addicts (49.23) in this study is slightly lower than the mean SOC of a population of minority women, many who use also drugs, whose average score is 55.0 (Antonovsky 1993). It makes sense that the population of heroin addicts in this study scores even lower; they comprise many periodically homeless, long-term users of illicit drugs, as a whole a disenfranchised group with many social, medical and psychological problems. A report by Antonovsky on alcoholics gives further evidence that addicts tend toward the low end of the continuum (Antonovsky 1987:85).

The main results clearly confirm the hypothesis. The increase in the mean score after the intervention session is impressive ($x=49.23$ at t1 to $x=56.62$ at t2, increase $x=+7.38$). The difference of +7.4 points is highly significant ($p<0.01$). Extrapolated for the SOC-29, the increase becomes even more impressive ($x=109.82$ at t1 to $x=126.31$ at t2; increase $x=16.49$). For the SOC-29, the total increase is +16.5 points or double the therapy effect Sack at al demonstrate in their evaluation of 8 week treatment for psychosomatic patients (1997).

10.1.1. SOC of individual subjects

Table 9: Treatment effects on SOC of individual subjects

The individual scores (n=13) at t1 and t2 are plotted and analyzed in more detail.



10.1.2. Comments on the individual courses

Individual SOC increases are impressive. More than half of the subjects, or 7 of the 13 subjects, ranging between 37-52 at t1, increased by +2 to +8 points at t2 (an even more impressive +4.5 to +18 points on the SOC-29). This cohort represents the most homogenous group and comprises the typical case: starting with a low or mid range score, this group demonstrates a strong increase in SOC after session 2. The remaining 6 subjects fall in three categories discussed separately.

Extraordinary increases

Three subjects demonstrated extraordinary increases in SOC. One client, increasing in score by 27 points to 59, started the lowest at t1 (32). This middle aged African-American male client responded very well to the re-accessing session and carried his process forward into body feeling, movement and relationship to the therapist. There was a definite sense of completion and, by the end of the session, the client was in a relaxed and good mood which he also expressed verbally. Similarly, a middle aged white female client who demonstrated an increase of +16 points to 54, started low at t1 (38). Initially in a hypomanic state, she experienced the re-accessing session as profoundly calming and centering and resulting in insights. She referred to practicing the inner work between the sessions and expressed her trust in the therapeutic relationship. Both these clients were in residential treatment and long-term hard core heroin users. The third high riser, a middle aged white woman in a methadone treatment program, started relatively high with a score of 58 at t1 and increased the SOC by +19 points to 77. The high initial SOC could be explained as a consequence of the subject's stable situation in a long-term methadone program. The increase in the second session is attributable to the work she accomplished. She followed her inner experiences during the "high" and unfolded it into body feeling, movement and an image of the center, or the Self, rising from her solar plexus. However, since the client is on long lasting methadone, it is unlikely, although possible, that different plasma levels during the sessions influenced the results.

Fake SOC

One person was considerably beyond the average initial score with 77 points at t1. The increase after the second session was strong, with +5 points (or +11 points on the SOC-29) to 82. This white male in his early 30ties is in a methadone maintenance program and it is possible that the initial high score may be an artifact, an effect of the onset of the prescription opiate antagonist. However, the client's self- presentation seemed to fit the description of the person with a fake score. Antonovsky has pointed to the problem of the unusually high score and argues that a person with a weak SOC may assume a pseudo identity and compensate with a fake score. In the methadone program for 3 years, the impression was of a protracted puberty phase in a person

with narcissistic personality features. The increase in score after the intervention, however, may well be the reflection of his complete re-accessing experience. This client went into experiencing of the altered state, feeling the state and moving his whole body to reflect inner experiencing. At the end, he expressed that at the core of the state was an awareness of self that is both fluid and definite in form. As he formulated the insight, he appeared touched and grateful.

SOC declines

Two persons ended at t2 with a decrease in SOC score by 3 and 4 points respectively (client 11 and 13). Their initial scores at t1 were clearly elevated above the average score with 60 and 63 points. One interpretation of the declining scores therefore could be statistical regression to the mean. Both were in residential treatment only a very short time at t1 (2 weeks). They had to deal with adapting to abstinence and the treatment groups, which may have contributed to fluctuations. Clinical observations seemed congruent with the decline in one case. This client, the youngest man in the study, a 21 years old college dropout, appeared restless and not motivated for treatment. His father had died of an overdose a year prior and he was hopeless about improving his situation, helplessly blaming outer circumstances or himself with bitter self-criticisms. In the re-accessing session, this young man went so far into the drug-state as to disappear in it. He had a dream-like experience, however, without much metacommunication. Coming out of the state, he said that he loved the altered state, however, that drugs were even better. A few weeks later, he dropped out of treatment and was back at home with his mother.

The other client, a middle aged-man white male had used heroin for many years on a maintenance schedule, cautiously and never overdosed. He had lived his life in the drug manufacturing business and had spent many years in prison. Like many other addicts he had no relationships outside the drug scene, however, he was missing emotional closeness and expressed the desire to get to know him and relate from his core self. He accessed a subtle state of self-confidence, which he could ground in his body, in his voice and his posture. Heroin removed him from external orientation and allowed him to make contact with himself. This client's decrease in SOC surprises and

rises the question as to the fluctuations due to extraneous influences or uncontrolled variables.

Although it is clear that the study does not control for the many factors that threaten reliability, i.e. influences of maturation, history, life events etc., the short time between first and second interview and the timing of the second measurement, lend support to the conclusion that the second session was the major contributor to the increase in a significant manner.

10.1.3. SOC subscales

The theoretical construct of the "Sense of Coherence" measures a "global orientation" which includes comprehensibility, manageability and meaningfulness as components. From the total of 13 items 5 items relate to comprehensibility, 4 items each relate to manageability and meaningfulness. Some authors have calculated the sum scores for each individual component of the scale in spite of the warning they themselves give (Lamprecht et al 1997; Sacks et al 1997) since they scales are empirically not reproducible. Nevertheless, interesting insights into the weighting of different items in the overall concept

On the three components increases are significant for subscale 1 "comprehensibility" and for subscale 2 "manageability", not significant for subscale 3 "meaningfulness".

SOC subscales

	t1	t2	<	T-Test	correlation	effect size
comprehensibility	18.08	21.15	3.07	p<0.015	r=.706/p<0.007	d=.79
manageability	15.46	17.69	2.23	p<0.001	r=.924//p<0.000	d=1.25
meaningfulness	15.69	17.77	2.07	p<0.187 n.s.	r=.337/p<0.262	d=.39

In his 1993 paper, Antonovsky states, however, that the SOC was developed to measure the sense of coherence as a global construct. Empirical evidence does not permit calculating individual subscales (Antonovsky (1993). In a factor analysis the

three subscales cannot be reproduced. However, one empirical factor explains 41% of the variance and contains 11 items, meaningfulness (7) and manageability (4). The above results show a significant increase on the components of C and Ma and a nonsignificant, however, still considerable increase is detectable (+2).

10.1.4. Discussion

In confirmation of the initial hypothesis, we find a significant increase in SOC in the mean of the 13 heroin clients after the intervention session. A difference of +7.4 points is highly significant ($p<0.01$). Extrapolated for the SOC-29, the increase from 109.8 to 126.3 is even more impressive (+16.5). For 8 clients, the increase was +2 to +8 for the SOC-13, extrapolated to the SOC-29, the increases in SOC range from +4.5 to +18. 3 clients moved up very high (+16, +19, +27, corresponding to +35, +42 and +60 on the SOC-29. 2 clients moved downward (-3, -4; or -7, -9 respectively). The changes involve the three components (+3, +2.2, and +2) almost evenly, significant increases however are found on the comprehensibility and manageability scales only.

The results above indicate that the SOC can be used as an outcome measure, confirming the finding of Sack and Lamprecht (1997). Antonovsky (1987) already had pointed to the possibility of influencing the SOC by intervention; by a supportive health-oriented perspective of the professional and, even more desirable, plan "SOC-enhancing experiences" that have a long lasting effect on the person (1987). This study affirms that is it possible to structure therapeutic encounters in such a way as to provide a strengthening of the SOC. Only a follow-up study could determine how long the increases last. However, every movement upward is welcome and brings relief. As health professionals, we are called to structure therapeutic encounters in a health-oriented manner (Antonovsky 1987).

The therapeutic setting is of paramount importance in creating a growth-enhancing atmosphere where trust, curiosity, compassion and exploration are at play. The belief in the purposefulness of the addiction process co-creates a supportive environment and contributes to the therapeutic process by enhancing the therapeutic alliance. It is the first "negentropic input" into the system. In a co-creative dance a beginning

relationship is built, themes explored and the task for the inner imaginative tour into the altered state land is discussed.

"Meaningfulness" may well be the most central factor to our sense of coherence and may be of an another order altogether (Sack et al 1992). In line with what Antonovsky had noted (1987:22) that "the motivational component of meaningfulness seems most crucial" the author proposes that a teleological perspective contributes best to enhancing of meaning. If we regard addiction like a dream we can start to explore the states with dream work. With body-oriented process work we follow inner and outer experiences and amplify them in many channels until the client realizes their meaning. Hopefully, a session contains a series of such "good moments" in the session, in the resolution of inner split, working on an edge, dialoguing with the critic or re-accessing a state.

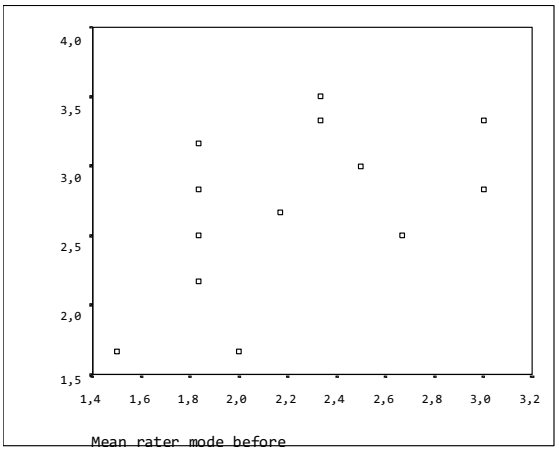
10.2.1. Hypothesis #2a: The experiencing level (EXP) will significantly increase between the first and the second session in the average or modal value (mean rating of three raters).

Description:

M_b = 2.22	**M_a = 2.71**
SD_b = 0.47	**SD_a = 0.60**
SE b =0.13	**SE a = 0.17**

Inference (Paired Samples Test):
t(12) = -3.293, p = 0.006

95% Confidence Interval of the Difference:
(0.16, 0.81)
Effect Size: d = 0.91



Correlation: r = 0.524, p=0.066 nonsignificant! TREND!

Discussion of results: The EXP modal ratings

The modal ratings indicate the average or common level of experiencing within each session or segment. As expected, the average mode or experiencing level rose significantly from the first (m=2.22; SD 0.60) to the second session (m=2.71; SD=0.47). The increase of +0.49 is highly significant (p<0.006) on the paired samples test. Furthermore, the effect size (Cohen Index) is very large (d=0.91). Although the pre-posttest correlation is not significant (r=0.524; p<0.066) by a slight margin, the value of p=0.066 still represents a clear trend.

Thus, the second hypothesis is statistically confirmed for the modal ratings on the Experiencing scale. In the mode, the subjects average between stage 2 and 3. Although the increase between sessions amounts to half a stage only, the results are clinically meaningful, given this population of heroin addicts with no prior training in focusing.

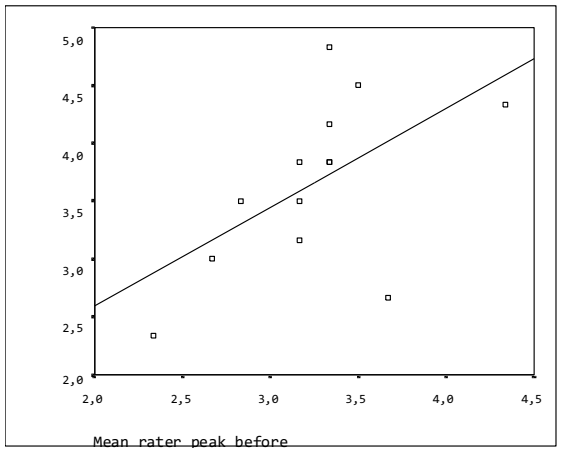
10.2.2. Hypothesis #2b: The experiencing level (EXP) will significantly increase between the first and the second session in the peak value (in the mean rating of three raters).

Description:

M_b = 3.24	**M_a = 3.65**
SD_b = 0.48	**SD_a = 0.73**
SE b = 0.13	**SE a =0.20**

Inference (Paired Samples Test):
t(12) = -2.452, p = 0.030

95% Confidence Interval of the Difference:
(0.04, 0.77) /Effect Size: d = 0.68



Correlation: r = 0.568, p = 0.043

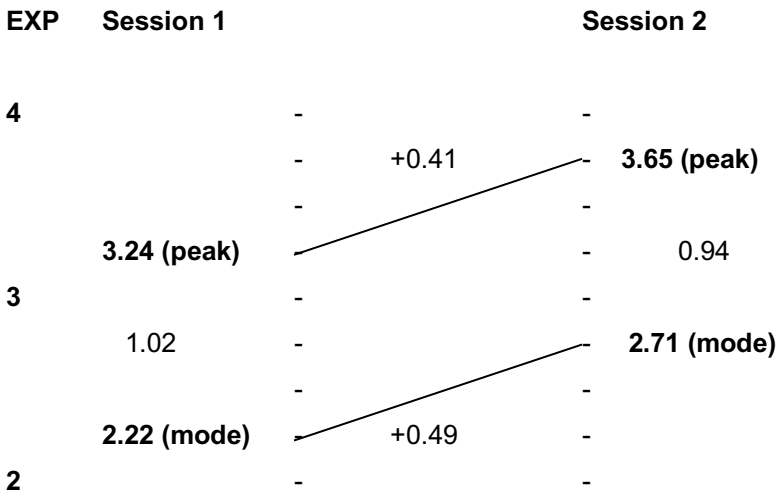
Discussion of results: The EXP peak ratings

The hypothesis for the peak ratings on the Experiencing scale is statistically confirmed as well. The peak level of experiencing, the highest stage of experiencing reached within the session or segment increased significantly. From the first session (m=3.24; SD 0.48) to the second session (m=3.65; SD=0.73), the increase of +0.41 is significant ($p<0.03$) and the effect size well above average (d=0.68). In the mean peak ratings, pre- and posttest correlate significantly ($r=0.568$; $p<0.043$). The highest level of experiencing reached by the population fluctuates between stage 3 and stage 4.

In the peak ratings many clients have reached moments of stage 4 and beyond, up to stage 5 and even some on stage 6. Stage 4 and beyond represents the level where the shift occurs from focusing on external events to an interest in following and observing one's own inner process. Again, with an increase of half a stage on the Experiencing scale, the results are modest, however, clinically useful with the given population.

10.2.3. EXP modal and peak ratings

The diagram below demonstrates the relationships between modal and peak ratings in the first and the second session. The differences between mode and peak between sessions remain stable: they amount to approximately one full stage on the Experiencing scale (1.02 in the first, 0.94 in the second session). Increases between sessions in the modal and peak ratings are about the same too: they amount to half a stage (+0.49 in the modal and +0.41 increase in the peak values) from session one to two.



In short, the population of heroin addicts in this study functions on a mode EXP level between 2 and 3, and on a peak EXP level between 3 and 4. The variation in EXP stages is small (half a stage), the resulting depth of experiencing modest. However, given the population of chronic heroin users, with no prior training in focusing, these levels are not surprising and are to be expected.

10.2.4. Discussion

Overall, in the mode and in the peak ratings, the level of experiencing or extent of client involvement in process is modest and rather low. The client operates mostly between stage 2 and 3 in the mode and, between stage 3 and 4 in the peak ratings. However, it comes as no surprise that heroin addicts, particularly in the beginning stages of the therapy process, score low on the EXP. This population seems to be particularly cut off from body feeling and emotion; self-medication against overwhelming and unmanageable affect and yearnings for a high to make whole the

addict's fragile self are underlying issues (see chapter 4.1. for the discussion of psychodynamics). Clearly, heroin addicts represent a particularly challenging population - difficult to work with and hard to motivate toward changing the habit. The chronicity of addiction in this study's population is illustrated by the average number of years of heroin use (m=11 years, range 1 - 32 years), concomitant cocaine use (m=8 years, range 0-32 years) as well as alcohol abuse (m= 11 years, range 0-35 years). At the same time, an average of only 2.5 attempts at treatment was made.

In short, while these clients represent one of the most difficult populations to work with and one of the least motivated to change, the process-oriented approach facilitated very clear positive results. In comparison to the first session, the EXP in the mode was significantly higher in the second session (+0.49; p=0.006). This increase in the mode between stage 2 and 3 represents a gain of more than 22%. The peak value increased significantly as well (+0.41; p=0.03) - between stage 3 and 4 - amounting to a gain of 13 % from the first to the second session.

Although the clients in this study were volunteers and as such motivated to participate in the research trial, they had no practice in focusing. Specific practice sessions in focusing - is suggested to help augment client involvement, heighten body sensory awareness and contribute to refining differentiation of emotion. For a follow-up study, such practice session could help deepen the process and thus increase the score on the Experiencing scale (see Sachse et al 1992; Hendricks 2000). In a personal communication (2001), the developer of the EXP Scale, Prof. Dr. Marje Klein, interpreted the present results as clinically meaningful: even modest increases between level 2 and 3 are clinically valuable with populations with severe psychosocial problems, specifically, with axis I diagnoses (DSM-IV) and / or with severe addictions.

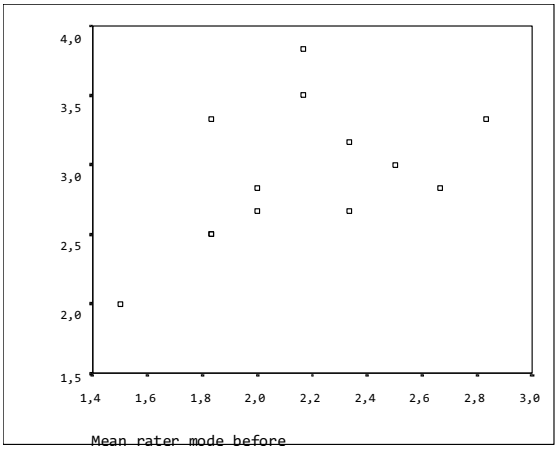
10.3.1. Hypothesis #3a: The Experiencing Level (Process-Index) will significantly increase between the first and the second session in the mean ratings of the three raters)

Description:

M_b = 2.15 **M_a = 2.94**
SD_b = 0.38 **SD_a = 0.49**
SE b = 0.10 **SE a = 0.14**

Inference (Paired Samples Test):
t(12) = -6.220, p < 0.000

95% Confidence Interval of the Difference: (0.51, 1.06)
Effect Size: d = 1.73



Correlation: r = 0.483, p=0.095 (nonsignificant) TREND!

Discussion of results: The PI modal ratings

On the PI, the group of 13 clients averages a first session mode of 2.15 (SD 0.38). In the second session, the modal ratings average 2.94 (SD 0.49), reflecting a highly significant increase of +0.79 on the PI ($p<0.000$; t-test for paired samples). The Cohen effect size is very large ($d=1.73$) which underlines the highly significant increase in client involvement in the therapy process from the first to the second session.

For the PI modal ratings, matched pairs correlations are not significant ($r=0.49$; $p<0.095$), however, a trend exists toward a linear relationship between pre- and post-measurements. The variation of +0.79 in depth of processing between the first and the second session represents an impressive 37% increase in the modal ratings from session one to session two.

Comparing the results achieved on the PI with the ones on the EXP for the mode, the difference is striking. The PI appears to be more sensitive than the EXP for measuring the concept of "experiencing" or "processing" - reflected in the greater range of means between session one and session two. In comparison to the EXP, the PI renders lower values in the initial, verbally oriented and exploratory session and higher scores in the experience-oriented second session.

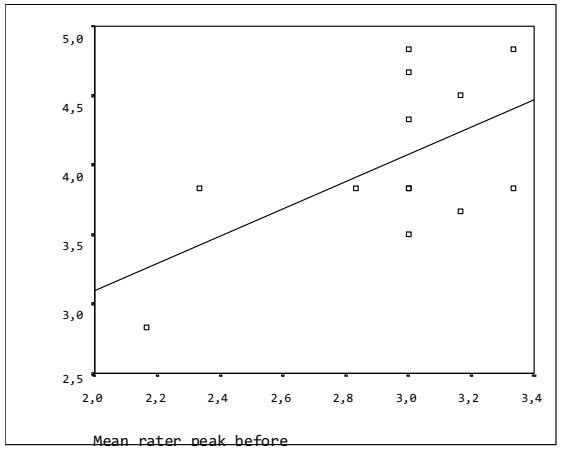
10.3.2. Hypothesis #3b: The experience level (Process-Index) will significantly increase between the 1. and 2. session in the peak value (in the mean rating of three raters)

Description:

M_b = 2.95	**M_a = 4.03**
SD_b = 0.34	**SD_a = 0.58**
SE b = 0.13	**SE a =0.16**

Inference (Paired Samples Test):
t(12) = -8.185, p < 0.000

95% Confidence Interval of the Difference:
(0.79, 1.36)
Effect Size: d = 2.27



Correlation: r = 0.577, p=0.039

Discussion of results: PI peak ratings

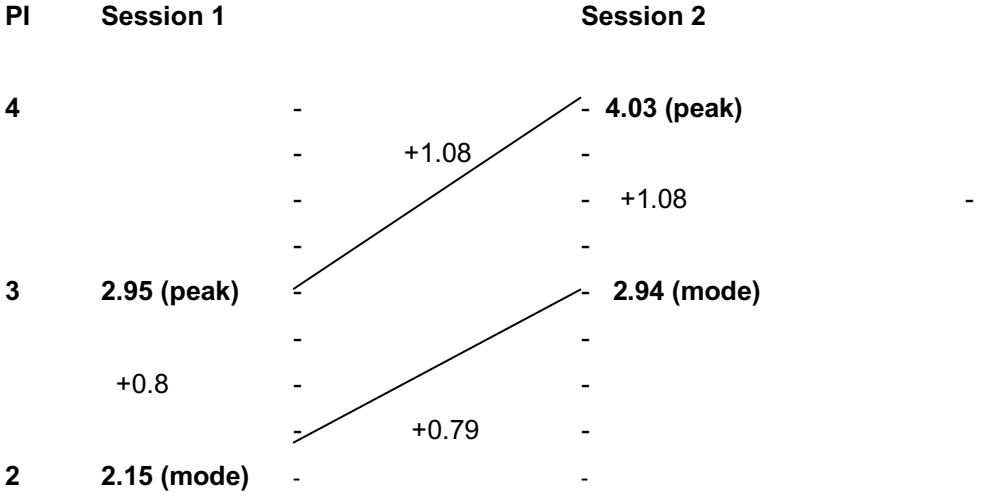
The mean value in the peak ratings for the first session across the three raters is 2.95 (SD=0.34); in the second session, the PI experiencing score rose significantly to 4.03

(SD=0.58) with p<0.000 (t-test for independent samples). The Cohen Index for effect size (d=2.27) represents the largest effect on all measures of experiencing in this study. This *one stage increase* represent a highly significant and clinically meaningful expansion of the extent of involvement or depth of experiencing between the first and the second session (+1.08; SD=. 47) on the PI scale. The paired samples correlations for the mean peak ratings in the first and the second session are significant (r=0.577; p<0.039).

On the PI, clients are now reaching the cut-off point or stage 4, which is strong clinical evidence of positive outcome. Reaching stage 4, clients actually have learnt to focus internally and to follow their stream of inner experiences and to elaborate on it to some extent.

10.3.3. Process Index modal and peak ratings

Relationships between modal and peak ratings in the first and the second session for the PI are plotted below (for comparisons with EXP see below). Again, differences between mode and peak remain relatively stable between sessions. Therapy effects in the PI mode are somewhat lower (+0.8) than in the PI peak (+1.1), however, overall, therapy effects are approximately twice the size from those on the EXP (+0.8 increases and 1.1 increases in peak scores). These results point once more to the PI as a very sensitive instrument to measure in-session processing levels. Intervention effects are distinct on the PI than on the EXP.



10.3.4. Experiencing Scale and Process-Index in comparison

In comparison to the EXP scale the PI shows greater sensitivity to changes in client behavior. The PI discriminates better between mode and peak than the EXP. Compared to the EXP, the PI ratings demonstrate a broader range with lower scores in the first session and higher scores in the second session. These results point to the PI as an instrument well suited to measure the experiencing construct as understood by Process Work where changes in "experiencing" or "processing" rather than in emotional expression are at the center of the therapy effort (see chapter 6.3.).

EXP and PI in comparison

BEFORE	AFTER	STATISTICS
EXP		
Mode before 2.22	mode after 2.71	+0.49 or 22% (p=0.006;r=0.5, p=trend; d=0.91)
Peak before 3.24	peak after 3.65	+0.41 or 13% (p=0.03; r=0.6, p=0.043; d=0.68)
PI		
Mode before 2.15	mode after 2.94	+0.79 or 37% (p=0.000;r=0.5, p=trend; d=1.73)
Peak before 2.95	peak after 4.03	+1.08 or 37% (p=0.000;r=0.6, p=0.039; d=2.27)

Mode and peak scores on EXP and PI have significantly increased from t1 to t2. Modal ratings show a clear trend, peak ratings have significant paired samples correlations. The sensitivity of the PI to assess the effect of the intervention is demonstrated for this study since the PI discriminates better between levels of client involvement in the initial exploratory session and the intervention session. Further research, however, is necessary to study validity and reliability of the PI.

10.4.1. Hypothesis #4a: The research subjects' subjective evaluation of "similarity of in-session altered state with heroin state" correlates significantly with SOC and subscales.

Correlations

		Self rating: similarity to H state/depth
SOC score after	Pearson Correlation	,701
	Sig. (2-tailed)	,008
	N	13
Subscale 1: comprehensibility after	Pearson Correlation	,488
	Sig. (2-tailed)	,090
	N	13
Subscale 2: manageability after	Pearson Correlation	,701
	Sig. (2-tailed)	,008
	N	13
Subscale 3: meaningfulness after	Pearson Correlation	,597
	Sig. (2-tailed)	,031
	N	13

10.4.2. Hypothesis #4b: The research subjects' subjective evaluation of "similarity of in-session altered state with heroin state" correlates significantly with modal and peak values on the EXP scale in the intervention session.

Correlations

		Self rating: similarity to H state/depth
Mean rater mode after	Pearson Correlation	,131
	Sig. (2-tailed)	,669
	N	13
Mean rater peak after	Pearson Correlation	,080
	Sig. (2-tailed)	,795
	N	13

10.4.3. Hypothesis #4c: The research subjects' subjective evaluation of "similarity of in-session altered state with heroin state" correlates significantly with modal and peak values on the PI scale in the intervention session.

Correlations

		Self rating: similarity to H state/depth
Mean rater mode after	Pearson Correlation	,191
	Sig. (2-tailed)	,531
	N	13
Mean rater peak after	Pearson Correlation	,205
	Sig. (2-tailed)	,502
	N	13

10.4.4. Discussion of results: Correlations of similarity factor and SOC (4a), EXP modal and peak (4b), PI modal and peak (4c) in the intervention session.

The in-session altered state of consciousness achieved in the second session was assessed immediately after the session. A self-rating measure was given to the client to estimate, on a scale from 1-7, a) closeness of in-session experience to the heroin-state and b) the depth of altered state in comparison to baseline waking state. The hypothesis stated that depth of altered state achieved in-session would correlate positively with the objective scores on the SOC, the EXP, and the PI.

The results show that the hypothesis is confirmed for the scores on the SOC. The self-rating values measuring the subjective state correlate with the increase in SOC scores positively and highly significantly (Pearson $r=0.7$; $p<0.008$). The positive correlation is duplicated on each of the three *SOC subscales*, which correlate most significantly on manageability (Pearson $r=0.7$, $p=0.008$) and meaningfulness (Pearson $r=0.6$, $p=0.031$); on comprehensibility, the significance level still indicates a trend (Pearson $r=0.5$, $p=0.09$ trend).

An interesting tentative conclusion to draw is that the client's subjective self-assessment of his or her in-session altered state serves as an indicator for progress on SOC. The subjective feel of the depth of the altered state achieved is an important gauge for one's place on the health continuum.

For both the EXP and PI, however, there are no significant correlations between the subjective estimate of the in-session state achieved by the client and the assessment of client involvement by independent raters. These results come as a surprise. The subjective evaluation of the achieved in-session state correlates significantly with an outcome measure, the SOC, which reflects progress on a measure of health (comprehension, manageability and meaningfulness). However, the "similarity-factor" does *not* correlate with the extent of client involvement or depth of experiencing as assessed by the three objective raters on the EXP nor on the PI.

This rather puzzling result demands explanation. Both the EXP and, particularly the PI, are conceived as measures of client in-session state alterations. One possible source of inconsistency may lie in the fact that the self-rating questionnaire yielded two different estimates of client state, which had been averaged for calculation. (1) Similarity to the heroin state, and (2) an estimate of depth of in-session altered state - the extent to which the client everyday waking state changed. Both ratings distribute on a scale from 1 - 7. Separate calculations of each factor may have given different results. In particular, separate calculations might have demonstrated whether the two factors differ as to their correlations with "experiencing".

Since Process Work does not aim at reproducing the heroin state but at deepening the state which arises from the yearning, one could expect the extent of PI in the second session to correlate with self-ratings of the in-session altered state rather than with similarity with the heroin state. A follow-up study will have to calculate correlations of effect with the two separate factors the similarity factor comprises.

10.5. Hypothesis #5: There will be a significant inter-rater-reliability (IRR) among the three trained raters on both modal and peak values on the EXP and the PI for the first and the second session.

Several statistical methods were employed to calculate and test the degree of consensus among the three raters (Cronbach's Alpha, paired samples t-test for each pair of raters, factor analysis (principle component analysis) and intraclass correlations. The results below summarize the statistical output on IRR.

IRR were examined for both modal and the peak values of the EXP and the PI, for initial and intervention sessions. Overall, from different statistical angles, consensus or IRR among the three raters is good.

10.5.1. Cronbach's Alpha and Principal Component Analysis (PCA)

EXPERIENCING SCALE		**IRR (Cronbach Alpha)**	**Total variance explained (%) (PCA)**
MODE	Before	0.684 (0.7)	63.13
	After	0.754 (0.8)	69.63
PEAK	Before	0.584 (0.6)	60.27
	After	0.751 (0.8)	74.37
PROCESS INDEX			
MODE	Before	0.610 (0.6)	56.33
	After	0.660 (0.7)	66.21
PEAK	Before	0.518 (0.5)	52.04
	After	0.705 (0.7)	65.86

Interrater reliabilities on modal and peak ratings in both sessions differ between EXP and PI and, according to the statistical method used. Clearly, overall results are consistent and demonstrate that the three raters reach an acceptable (first session) and a good (second session) level of consensus on most ratings.

Measured with Cronbach's Alpha, the consensus among the raters is somewhat below IRR reached in training sessions (0.79), however, mostly satisfactory. IRR is good for ratings in the second session the EXP scale (0.754 and 0.751), acceptable for the PI (0.660 and 0.705). IRR is higher on the EXP than on the PI where particularly modal ratings fall below expectation.

The difference in IRR between EXP and PI is not surprising and may reflect the fact that ratings on the EXP rely on verbal expression while ratings on the PI include non-verbal signs and signals. As statistical analysis indicates, the reliance on rating of non-verbal material makes the PI somewhat more vulnerable to rater disagreement. However, improved rater training may minimize this difference.

Rater consensus for the experience-oriented intervention session is consistently higher than for the first exploratory first session. This difference may reflect greater variability of the material in the first session resulting in increased rater disagreement. This consistent difference needs to be addressed in rater training with additional focus on rating verbal exploration.

The results obtained with factor analysis confirm the overall good IRR: EXP ratings of the three raters explain 60% -75% and the PI ratings 52%-66% of the total variance on the general factor extracted (PCA). This may be seen as the level of rater agreement, reaching 70-74% on the EXP and 66% on the PI for the intervention session. Clearly, IRR is best for the intervention session and slightly lower on the PI.

10.5.2. Component Matrices (PCA, one general factor extracted)

The strength of involvement of each rater in the general factor extracted (PCA method) was calculated. The high loadings are representative of equal involvement or high rater consensus of the three raters. Of a total of eight ratings on the EXP and the PI, only three ratings deviate from consensus: rater A once, and rater B twice (underlined):

Raters	A	B	C
EXP mode before	.785	.768	.829
EXP mode after	.735	.859	.900
EXP peak before	.920	.518	.832
EXP peak after	.830	.811	.940
PI mode before	.443	.844	.885
PI mode after	.853	.708	.870
PI peak before	.721	.427	.927
PI peak after	.846	.778	.809

The component matrices emphasize good inter-rater-reliabilities. For most cases, deviations of the ratings of the three raters from maximum consensus are well in an acceptable range. Rater A and C do best and their IRR is analyzed below in more detail.

10.5.3. T-Test results for Rater A and C

The paired samples test to compare raters pair-wise yielded the results below. As reflected in the PCA component matrices, t-test results show that performance of rater A and rater C was most consistent and significant in most comparisons:

		Paired samples correlations	**Paired samples test (2-tailed)**
EXPERIENCING SCALE			
MODE	Before	r=.490, p>0.089 trend	p>.240 n.s.
	After	r=.709, p>0.007	p>.120 n.s
PEAK	Before	r=.671, p>0.012	p>.472 n.s.
	After	r=.721, p>0.005	p>.584 n.s.
PROCESS INDEX			
MODE	Before	r=.235, p>0.440 n.s.	p>.392 n.s.
	After	r=.654, p>0.015	p>.549 n.s.
PEAK	Before	0.502, p>.0.080 trend	p>.613 n.s.
	After	0.545, p>.0.054 trend	p>.636 n.s.

The result of paired samples correlations confirm significant inter-rater correlations or definite statistical trends between rater A and rater C in their pre-and post ratings on both the EXP and the PI, on 7 out of the total 8 paired sample measurements. The paired samples t-test demonstrates that raters do not diverge significantly (n.s.) in their ratings, i.e. they use the same level or stage on both the EXP and the PI.

10.5.4. Average measure intraclass correlations

To provide another view on IRR, intraclass correlations were calculated. The SPSS 8.0 computes several different intraclass coefficients (McGraw et al 1996); the one-way average measure model was employed for our purpose.

	Before	After
EXP mode	,5803	,6949
EXP peak	,5897	,7581

The assessment of IRR on the EXP scale by average measure intraclass coefficient confirms results obtained with other statistical methods above. IRR is very high on modal and peak ratings of the intervention session (0.69 and 0.76) and, slightly below expectation but still acceptable on the mode and peak ratings in the first session (0.58 and 0.59).

PI mode	,3636	,6662
PI peak	,5455	,7022

The average measure intraclass coefficient confirms that for the PI, IRR is slightly lower than for the EXP. As discussed elsewhere, non-verbal ratings are more demanding for raters than ratings of verbal expression and therefore, raters may require extra training on the PI. However, except for the modal ratings in the first session, IRR for the PI is acceptable (0.54) and high for mode and peak ratings during intervention (0.67 and 0.7)

10.5.5. Discussion of IRR

Overall results on IRR are good among all raters although rater consensus is below training results (0.79 Cronbach's Alpha). In comparing raters pair wise with the t-test, B was found to deviate most. A separate t-test calculation for rater A and C detected no significant rating differences and confirmed significant pre-posttest correlation in 7 out of 8 comparisons for rater A and B. In addition, factor analysis emphasizes consistent agreement among rater whose ratings are congruent in approximately 2/3 of the total cases. High factor loading on the general factor (PCA) underline the strength of congruent ratings.

The statistics show higher IRR for intervention segments. These segments may in some way be easier to assess than first session segments, which mainly consist of exploration of a person's life story. This higher IRR in the intervention session may be an effect of the distinctive characteristics of this very session. Much of the therapeutic process emphasizes non-verbal channels in which much of the altered states occur: sensing inward, expression of feeling, movement and relationship processes are the materials for raters to focus on in the intervention session. The initial session, in contrast, comprises more variation of topic, elaborates themes and explores life events, present and in childhood, drug history etc. - much of it in verbal dialogue.

In summary, while IRR is good, with high agreement on some assessments, the consistency of lower agreement for the first session demands further exploration. Further research is necessary to find those factors, which influence rater agreement, and make the first session episodes more difficult to agree on in terms of levels of involvement in experiencing than intervention segments. Consistent rater training (exceeding 16 hours) on both scales is prerequisite.

10.6. Hypothesis #6: The intensity of the experience, measured by subjective and objective evaluation (SOC, EXP, PI, and similarity-factor) is independent of therapeutic program, age, gender, education, race, and criminal history.

10.6.1. Treatment group affiliation and treatment effect

For a closer look on differential effects of treatment group affiliation and SOC, EXP and PI scores, the one-way analysis of variance (ANOVA) was calculated. The treatment groups are (1) residential treatment (n=8=61%), (2) methadone program (n=3=23.1%) and (3) untreated users (n=2=15.4%). The three different treatment groups (1) residential, (2) methadone and (3) untreated users differ significantly in treatment benefits. Caution in interpretation of results is warranted due to the small size of treatment groups.

In the ***first session***, affiliation with treatment group significantly effects ***EXP peak*** scores (F=5.4; p=0.026). Untreated users (3) differ significantly from persons in residential treatment (1) (p=0.017) and from the methadone (2) group (p=0.010) on EXP peak scores. Interestingly enough, untreated users score highest with a mean score difference of +0.83 EXP scores in comparison to the residential group, and again, with a mean score difference of +1.06 scores as compared to the methadone group.

Treatment group and EXP peak before (ANOVA)

		Sum of Squares	df	Mean square	F	Sig.
Mean rater peak before EXP	Between groups	1,460	2	,730	5,400	0,026
	Within groups	1,352	10	,135		
	Total	2,812	12			

Multiple Comparisons (post hoc test): EXP peak before

Dependent variable	(I)X9	(J)X)	Mean Diff (I-J)	Std.Error	Sig	95% Confidence Intervall lower	upper
Mean rater peak before EXP	1,00	1,00					
		2,00	,2222	,2489	,393	-,3324	,7768
		3,00	-,8333*	,2907	,017	-1,4810	-,1857
	2,00	1,00	-,2222	,2489	,393	-,7768	,3324
		2,00					
		3,00	-1,0556*	,3356	,010	-1,8034	-,3077
	3,00	1,00	,8333*	,2907	,017	,1857	1,4810
		2,00	1,0556*	,3356	,010	,3077	1,8034
		3,00					

Residential treatment group (1), methadone treatment group (2) and group of untreated users (3)

In the ***intervention session***, on the ***SOC***, affiliation with treatment group yields a significant differential effect (F=5.29; p=0.027). Multiple comparisons point out significant differences between residential group (1) and the methadone treatment (2) group (p=0.016) as well as between methadone treatment group (2) and the group of untreated users (3) (p=0.019). Numeric comparison finds a mean difference of +17.6 scores for methadone group (2) to the residential treatment group (1), and +23 scores to untreated users (3); between group (1) and (3), the mean difference is +5.4 scores in favor of the residential group (n.s.).

Treatment group and SOC score in the intervention session (ANOVA)

		Sum of Squares	df	Mean square	F	Sig.
SOC score after	Between groups	853,202	2	426,601	5,294	0,027
	Within groups	805,875	10	80,588		
	Total	1659,077	12			

Multiple Comparisons (post hoc test): SOC in intervention session

Dependent variable	(I)X9	(J)X)	Mean Diff (I-J)	Std.Error	Sig	95% Confidence Intervall lower	upper
SOC score after	1,00	1,00					
		2,00	-17,6250*	6,0775	,016	-31,1665	-4,0835
		3,00	5,375	7,0970	,466	-10,4381	21,1881

Dependent variable	(I)X9	(J)X)	Mean Diff (I-J)	Std.Error	Sig	95% Confidence Intervall lower	upper
SOC score after	2,00	1,00	17,6250*	6,0775	,016	4,0835	31,1665
		2,00					
		3,00	23,000*	8,1949	,019	4,706	41,2594
	3,00	1,00	-5,3750	7,0970	,466	-21,1881	10,4381
		2,00	-23,000*	8,1949	,019	-41,2594	-4,7406
		3,00					

Residential treatment group (1), methadone treatment group (2) and group of untreated users (3)

Most importantly however, pertinent to treatment, is the influence of ***group affiliation and overall therapy effects***. Calculation for treatment effects, i.e. differential scores (t2-t1), yields a significant treatment group effect on ***EXP peak scores*** (F=4,641; p=0.038). Multiple comparison matrix (post hoc test) identifies significant EXP peak mean advantages of the residential group (1) versus the untreated users (3) of +1.14 (p=0.012). Further, as a trend, the mean peak score of the methadone group (2) exceeds the one of the untreated users (3) by +0.89 (p=0.068).

Treatment group and treatment effects (ANOVA): EXP peak scores

		Sum of Squares	df	Mean square	F	Sig.
DX3	Between groups	2,102	2	1,051	4,641	0,038
EXP peak	Within groups	2,265	10	,227		
difference	Total	4367	12			

Multiple Comparisons (post hoc test): EXP peak

Dependent variable	(I)X9	(J)X)	Mean Diff (I-J)	Sdt.Error	Sig	95% Confidence Intervall lower	upper
DX3	1,00	1,00					
(EXP peak differences)		2,00	,2569	,3222	,444	-,4610	,9749
		3,00	1,1458*	,3763	,012	,3075	1,9842
	2,00	1,00	-2569	,3222	,444	-,9749	,4610
		2,00					
		3,00	,8889	,4345	,068	-7,91E-02	1,8569
	3,00	1,00	-1,1458*	,3763	,012	-1,9842	-,3075
		2,00	-,8889	,4345	,068	-1,8569	7,91E-02
		3,00					

Residential treatment group (1), methadone treatment group (2) and group of untreated users (3)

Conclusions

The finding that treatment group affiliation does have significant effects on our measures does not surprise. However, the result on EXP scores in the first session, in which the group of untreated users in particular exceed the scores of both residential and methadone treatment groups significantly does actually surprise. Besides obvious statistical uncertainties due to small sample size (2 untreated users only), one possible clinical interpretation may relate these elevated scores for untreated users to illicit drug

use prior to the first session. However, an alternate interpretation is proposed. The two high scores may relate to the fact that both people had extraordinary verbal skills and therefore received higher ratings, in particular, since both the EXP ratings in general *and* the first session in particular depend most on verbal expression.

Clinical judgment would expect residential and the methadone treatment group doing best on our measures, with untreated users scoring generally lower. These expectations are confirmed on the SOC of the intervention session, where active users (3) score 23 points lower than methadone clients (2) and 17.6 points lower than the residential group (1). Methadone clients are, very possibly, more stable and overall healthier than persons in residential treatment, solely because treatment duration is much longer for the former group (x=2 years; STD 0.5) in comparison to the latter (x=7 weeks; STD 5.32).

Obviously, treatment group effects on results are reflected best when compared with net intervention effects. The only significant influence of group affiliation is found on the EXP peak scores, where treated users score one full stage lower than the residential group, and almost one stage lower than the methadone group.

The latter results are impressive. The population in residential treatment does better in the therapeutic process toward recovery then the active street user. It is reasonable to expect that the treatment situation bears influence on involvement in process, on expression of emotion and on one's sense of coherence or well being. The difference makes clinical sense and speaks for the need to reach out to active users and motivate them for entering a treatment program, be it methadone maintenance or residential treatment.

10.6.2. Age and treatment effect

To look at the question whether age determines treatment effects in some ways, the independent samples t-test was employed to compare two age groups in terms of their pre- and post-treatment scores. Cut-off point was set at age 35; 8 persons are older, and 5 persons younger.

Frequency table: Age

		Frequencies	Percent	Cumulative Percent
Valid	21.00	1	7.7	7.7
	25.00	1	7.7	15.4
	27.00	1	7.7	23.1
	29.00	1	7.7	30.8
	32.00	1	7.7	38.5
	37.00	1	7.7	46.2
	39.00	1	7.7	53.8
	42.00	2	15.4	69.2
	44.00	2	15.4	84.6
	46.00	1	7.7	92.3
	51.00	1	7.7	100.0
	Total	13	100.0	

Group statistics: Age

	Age	N	Mean	STD	STD Error
SOC before	**>=35.00**	8	46.00	10.2120	3.6105
	< 35.00	5	54.40	15.6780	7.0114
SOC after		8	56.50	9.6214	3.4017
		5	56.80	15.8965	7.1091
EXP mode before		8	2.2917	.5327	.1883
		5	2.1000	.3837	.1716
EXP mode after		8	2.8333	.4272	.1511
		5	2.5000	.8165	.3651
EXP peak before		8	3.2917	.5020	.1775
		5	3.1667	.5000	.2236
EXP peak after		8	3.8333	.4960	.1754
		5	3.3667	.9958	.4453
PI mode before		8	2.1667	.3673	.1299
		5	2.1333	.4314	.1929
PI mode after		8	2.9583	.3959	.1400
		5	2.9000	.6729	.3009
PI peak before		8	3.0208	.3142	.1111
		5	2.8333	.3909	.1748
Pi peak after		8	4.1667	.4797	.1696
		5	3.8000	.7110	.3180

The independent samples t-test does not detect any significant differences or trends on any measures determined by age. There is, however, a substantially elevated SOC for those younger than age 35 compared to those age 35 and older (+8 points, n.s.), a difference, by the way, which disappears after the intervention. These results are in contrast to findings reported by Sacks et al (1997) for the SOC. He found that those

older than 35 had significantly higher scores on the SOC than those younger, which hints at the possibility that SOC is age-dependent and strengthened in middle age.

For the EXP and the PI, no statistically significant differences or trends could be found, which would point to age as a determinant of treatment effect.

10.6.3. Gender and treatment effect

Women score consistently higher on average then men on all measures, though, most numerical differences do not reach statistical significance. However, the numerical gains of women in the study are remarkable and demand further clarification with larger samples. In the *intervention session*, on the SOC after, the four female clients score +5.6 points higher than the male's counterparts; on the EXP and PI, consistently, higher ratings are found for females as well. On the EXP mode after, the difference is +0.43, on the EXP peak after, +0.44 for females compared to males. On the PI, +0.15 for mode after, and +0.3 for peak after ratings are in favor of the females.

In the *first session* ratings, on the SOC before, no gender differences are found to effect the SOC, however, on EXP and PI ratings, females scores are higher again. For the EXP mode +0.49 and for the peak +0.43; for the PI mode +0.38, and for the peak, females are ahead by +0.38. The independent samples t-test found a significant consistent influence of gender on first *session* PI peak ratings (p=0.021), with a trend for first session PI mode ratings (p=0.065).

Most important and pertinent to the goal of the study, however, are *treatment effects* and their relationship to gender. Numerical differences demonstrate yet again a clinically relevant therapy effect of +6 on SOC scores for females versus males, however, no statistical significance could be detected on any measure.

T-Test Group statistics: Influence of gender on treatment effects

	Sex	N	Mean	STD	STD Error
DX1	m	9	5,5556	9,0707	3,0236
SOC effect	f	4	11,500	7,1414	3,5707

Conclusion

In short, gender does influences ratings. Overall, women do better than men on all the measures in a clinically meaningful way. However, except for the PI in the first session, no statistical confirmation for these numerical differences was found.

For the SOC, a dependency of results on gender has been suggested elsewhere (Sacks et al 1997; Geyer 2000; Duetz et al 2000). In particular for therapy effect, the present findings of a clinically meaningful difference of +6 SOC scores for women over men lend support to this possibility. Again, statistical significant results are difficult to obtain with small samples. Only a follow-up on a larger sample could clarify the relationship with statistical means.

10.6.4. Education and treatment effect

Correlations with Spearman's rho for non-parametric data do not yield any significant results. Education is independent of SOC, EXP and PI scores before and after. Similarly, no significant correlations could be found between education and treatment effects on the various measures.

10.6.5. Race and treatment effect

The data on race was dichotomized into white and non-white (African-American, Hispanic-White, White-native American) and the t-test employed to compare means. The independent samples test brings up unexpected results. It demonstrates highly *significant correlations on EXP and PI for the intervention session*. These are precisely those measures, which require independent rater assessments. No statistically significant correlation could be found with either pre or post test data on the SOC, although the numerical difference on the SOC for both intervention session and first session is considerable with scores of non-whites exceeding those of whites by +4.9 and +4.25 scores, respectively.

T-Test: SOC, EXP and PI for the intervention session

Group Statistics

				Std.	Std. Error
SOC score after	1,00	9	55,1111	12,0773	4,0258
	2,00	4	60,0000	11,9164	5,9582
Subscale 1: comprehensibility after	1,00	9	20,8889	5,5327	1,8442
	2,00	4	21,7500	5,1881	2,5941
Subscale 2: manageability after	1,00	9	17,5556	5,1988	1,7329
	2,00	4	18,0000	3,7417	1,8708
Subscale 3: meaningfulness after	1,00	9	16,6667	3,2404	1,0801
	2,00	4	20,2500	5,1881	2,5941
Mean rater mode after EXP	1,00	9	2,4630	,5514	,1838
	2,00	4	3,2500	,2152	,1076
Mean rater peak after EXP	1,00	9	3,3889	,6667	,2222
	2,00	4	4,2500	,5000	,2500
Mean rater mode after POP	1,00	9	2,7407	,4006	,1335
	2,00	4	3,3750	,4167	,2083
Mean rater peak after POP	1,00	9	3,8333	,5465	,1822
	2,00	4	4,4583	,4383	,2192

Independent Samples Test

		Levene's Test for				Sig.
SOC score after	Equal variances assumed	,027	,874	-,676	11	,513
	Equal variances not assumed			-,680	5,903	,522
Subscale 1: comprehensibility after	Equal variances assumed	,001	,975	-,263	11	,797
	Equal variances not assumed			-,271	6,205	,796
Subscale 2: manageability after	Equal variances assumed	,558	,471	-,153	11	,881
	Equal variances not assumed			-,174	8,116	,866
Subscale 3: meaningfulness after	Equal variances assumed	2,581	,136	-1,541	11	,152
	Equal variances not assumed			-1,275	4,084	,270
Mean rater mode after EXP	Equal variances assumed	2,232	,163	-2,709	11	,020
	Equal variances not assumed			-3,696	10,983	,004
Mean rater peak after EXP	Equal variances assumed	,370	,556	-2,290	11	,043
	Equal variances not assumed			-2,574	7,790	,034
Mean rater mode after POP	Equal variances assumed	,008	,930	-2,606	11	,024
	Equal variances not assumed			-2,563	5,616	,045
Mean rater peak after POP	Equal variances assumed	,008	,929	-2,003	11	,070
	Equal variances not assumed			-2,193	7,274	,063

Consistently higher values with statistical significance are found for non-whites on the *EXP mode after* (+0.79) (p=0.02) and peak after (+0.86) (p=0.043), on the *PI mode after* (+0.63) (p=0.024) and peak after (+0.63) (p=0.070 trend).

Not only do non-white levels of experiencing far exceed the level of whites, but non-whites each scores on both the EXP (4.25) and the PI (4.46) well beyond critical stage 4, and in excess of the peak scores for whites (3.39 on the EXP and 3.83 on the PI) in the intervention session.

In the first session, differences between racial groups are minimal on EXP and PI mode and peak mean scores (+0.05, +0.13, +0.08, +0.13), however, the consistent numerical differences between whites and non-whites is reflected too on EXP and PI scores, and namely, on the SOC. Although these differences are statistically not

significant, they support the impression as they fit into the overall picture of race as a contributing factor to the results.

Therapy Effect X Race

Group Statistics

				Std.	Std. Error
DX1	1,00	9	4,5556	6,0023	2,0008
	2,00	4	13,7500	11,3541	5,6771
DX1A	1,00	9	2,4444	4,0346	1,3449
	2,00	4	4,5000	3,6968	1,8484
DX1B	1,00	9	2,0000	1,6583	,5528
	2,00	4	2,7500	2,2174	1,1087
DX1C	1,00	9	,1111	3,3333	1,1111
	2,00	4	6,5000	6,6583	3,3292
DX2	1,00	9	,2593	,4339	,1446
	2,00	4	1,0000	,3600	,1800
DX3	1,00	9	,1852	,5365	,1788
	2,00	4	,9167	,4410	,2205
DX20	1,00	9	,6111	,1667	5,556E-02
	2,00	4	1,1667	,6804	,3402
DX21	1,00	9	,9259	,4258	,1419
	2,00	4	1,4167	,4410	,2205

Independent Samples Test

		Levene's Test for				Sig.
DX1	Equal variances assumed	4,480	,058	-1,953	11	,077
	Equal variances not assumed			-1,527	3,770	,206
DX1A	Equal variances assumed	,016	,901	-,867	11	,404
	Equal variances not assumed			-,899	6,350	,401
DX1B	Equal variances assumed	,622	,447	-,683	11	,509
	Equal variances not assumed			-,605	4,571	,574
DX1C	Equal variances assumed	2,006	,184	-2,367	11	,037
	Equal variances not assumed			-1,820	3,688	,149
DX2	Equal variances assumed	,429	,526	-2,970	11	,013
	Equal variances not assumed			-3,208	7,025	,015
DX3	Equal variances assumed	,080	,783	-2,377	11	,037
	Equal variances not assumed			-2,577	7,094	,036
DX20	Equal variances assumed	9,077	,012	-2,416	11	,034
	Equal variances not assumed			-1,612	3,161	,201
DX21	Equal variances assumed	,062	,808	-1,899	11	,084
	Equal variances not assumed			-1,871	5,639	,114

When calculating race for *therapy effect*, again, t-test for independent samples produces statistical significant results on mode *and* peak scores of EXP and PI. Gains for non-whites exceed therapy effect for whites significantly. For the mode, the differential gain of +0.74 by non-whites is significant (p=0.13), for the peak as well with +0.73 (p=0.037). For the PI, the effects are significant on the mode +0.56 (p=0.034) and as a trend on the peak ratings +0.49 (p=0.084). These results could suggest a hidden factor, which influences results on measures where objective raters assess behavior.

Race also seems to effect therapy outcome on the rater-independent SOC (p=0.077 trend). On the SOC, the average gain for non-whites is +13.75, for whites +4.55. This numerical difference of +9.2 is clinically astounding, reflected by a statistical trend.

This trend on the SOC calls for caution in the conclusion that some rater-dependent factor bears on the results for non-whites. Certainly, these results deserve further clarification, particularly the question as to whether race bears on therapy effect with "objective" raters when persons of color are the research subjects.

Conclusion

On all measures therapy gain is more pronounced for non-whites than for whites, statistically significant on the EXP and one the PI, with a trend on the SOC. The results on PI and EXP suggest the possibility of a hidden factor in the ratings of the three raters favoring non-whites. Some unknown factor cannot be ruled out which influences the results. Since race is significant for the second session only which relies more on experiencing and expression of process than on verbal dialogue, one could speculate that non-whites are more expressive than whites with emotion and movement resulting in higher scores for the second session. This conclusion, however, reflects racial stereotype, which cannot be ruled out as a contributing factor in the ratings. However, since the self-ratings on the SOC indicate the same trend, the findings need clarification on larger samples.

10.6.6. Incarceration and treatment effect

Frequency Table: Months in prison

Eight clients in the study have been incarcerated for drug-related offenses, five have never been in prison. Below, the frequency table for incarceration time (in months) is given:

		Frequency	Percent	Cumulative Percent
Valid	.00	5	38.5	38.5
	1.00	1	7.7	46.2
	5.00	1	7.7	53.8
	6.00	1	7.7	61.5
	24.00	1	7.7	69.2

60.00	1	7.7	76.9
78.00	1	7.7	84.6
100.00	1	7.7	92.3
120.00	1	7.7	100.0
Total	**13**	**100.0**	

Group Statistics

				Std.	Std. Error
SOC DATA BEFORE	>= 7.00	5	42.0000	10.6771	4.7749
	< 7.00	8	53.7500	12.2445	4.3291
SOC DATA AFTER	>= 7.00	5	52.6000	6.1074	2.7313
	< 7.00	8	59.1250	14.0350	4.9621
X4ALL_BE	>= 7.00	5	2.3333	.5137	.2297
	< 7.00	8	2.1458	.4666	.1650
X4ALL_AF	>= 7.00	5	2.8000	.3416	.1528
	< 7.00	8	2.6458	.7316	.2587
X5ALL_BE	>= 7.00	5	3.2333	.2528	.1130
	< 7.00	8	3.2500	.6042	.2136
X5ALL_AF	>= 7.00	5	3.9000	.4346	.1944
	< 7.00	8	3.5000	.8545	.3021
X6ALL_BE	>= 7.00	5	2.1667	.2635	.1179
	< 7.00	8	2.1458	.4493	.1589
X6ALL_AF	>= 7.00	5	2.9000	.3837	.1716
	< 7.00	8	2.9583	.5756	.2035
X7ALL_BE	>= 7.00	5	3.0667	.1491	6.667E-02
	< 7.00	8	2.8750	.4155	.1469
X7ALL_AF	>= 7.00	5	4.0333	.4625	.2068
	< 7.00	8	4.0208	.6752	.2387

x4= EXP mode; x5=EXP peak; x6=PI mode; x7 PI peak

The cut off point was set at < 7 weeks lifetime prison time. Eight persons have been incarcerated a total of 6 weeks or less, and five persons from between 24 - 120 weeks. Comparison of means brings up some interesting results on the SOC: people with 6 weeks or less of prison time score +11.75 scores higher than those who spent 24 -120 weeks in prison (p=0.106 trend). After the intervention, on the SOC, this difference is reduced to +6.5 points (n.s.). On the EXP and the PI scales, differences are minimal and not statistically significant.

Time spent in prison may be seen as an indicator of severity of lifetime drug use. The severity is reflected well on the first assessment on the SOC before the intervention. The high severity drug users have a significantly lower score than those with no or few weeks incarcerated.

10.7. Hypothesis #7: The intensity of the experience as measured by SOC, EXP, PWI, similarity-factor, is directly dependent on the length of opiate addiction.

This hypothesis was to rule out the dependency of the results on the length of the heroin addiction or, by implication, the life style and personality connected to chronic condition. The Pearson's correlation coefficient for interval data demonstrates no significant relationships between the SOC, the EXP nor the PI scores in the intervention session and the length of the heroin addiction.

Correlations

		Years of opiate dependen
SOC score after	Pearson Correlation	-,132
	Sig. (2-tailed)	,668
	N	13
Subscale 1: comprehensibility after	Pearson Correlation	-,180
	Sig. (2-tailed)	,556
	N	13
Subscale 2: manageability after	Pearson Correlation	-,196
	Sig. (2-tailed)	,521
	N	13
Subscale 3: meaningfulness after	Pearson Correlation	,074
	Sig. (2-tailed)	,809
	N	13
Mean rater mode after EXP	Pearson Correlation	,229
	Sig. (2-tailed)	,452
	N	13
Mean rater peak after EXP	Pearson Correlation	,214
	Sig. (2-tailed)	,483
	N	13
Mean rater mode after POP	Pearson Correlation	-,030
	Sig. (2-tailed)	,922
	N	13
Mean rater peak after POP	Pearson Correlation	,058
	Sig. (2-tailed)	,850
	N	13

10.8. Hypothesis #8: There will be a high correlation between the "altered state" ratings of the judges and increased scores on SOC and levels of experiencing measured with EXP and PI.

10.8.1. Inter judge agreement on altered states

First, inter judge reliability in differentiating normal and altered state segments is very high. The cross tabulation demonstrates that the two judges agree almost 100% as to whether a segment depicts an altered state or a normal state of mind. Bot judges

identify correctly so-called normal state segments in 96% of the cases, so-called altered state segments in 81% of the cases (per chance agreement rate 50%).

Content-oriented and/or formal characteristics of sessions could serve as markers for identification of segments and consequently, states of mind. Both sessions had quite distinct qualities: in the intervention session an inward-oriented exploration took place in channels of experience usually less occupied, i.e. movement, body awareness and feeling. Markers for normal state segments were exploration of life events, drug history, and relationship and family life as well as accounts of the childhood dream and descriptions of the heroin-state. The first session proceeded mostly in verbal dialogue, prominent were talking and listening and remembering or "looking" at events in the past. Altered states of mind, by definition, were unfolding mostly in lesser-known channels of experience like proprioception (feeling) and kinesthesia (movement). Markers for altered states, thus, were more likely to be channels changes or, changing of focus from external to internal, using one's felt sense to sensing the mass of the implicit, grasping for disavowed experiences and symbolizing or representing them in other channels.

The results show that normal state segments were somewhat easier to identify than altered state segments or, normal state markers more readily recognized than markers for altered states. In addition, the main criteria to judge an altered state were its closeness to the person's awareness and the extent to which the state is rooted in one's felt sense, the extent to which the client is in touch with inner felt referents. Obviously, the requirements for identification of altered states are more complex than for normal states.

10.8.2. Correlation of altered state segments and high scores on measures

To analyze the hypothesis whether agreed-upon altered state segments correlate significantly with higher scores on the different measures compared to segments identified as normal states segments, the t-test for independent samples was employed. On first impression, the numerical mean values indicate that mean scores of eleven identified altered state segments achieve higher scores on EXP and PI than

the mean scores for two segments associated with normal states. The t-test group statistics demonstrate that the difference in mean scores are, for altered state segments versus normal state segments, on the EXP mode after (+0.56), on the EXP peak after (+0.68), on the PI mode after (+0.61) and on the PI peak after (+0.82). The independent samples test calculated the table below for EXP and PI scores. Calculations were done separately for both segments 1 and 2 of the intervention session. Below, results of the inter judge agreement on ***segment 2*** are presented:

Group statistics (t-test): EXP and PI after

		N	Mean	STD	STD Error
EXP mode	1*	2	2,3333	,9428	,6667
	2*	11	2,7727	,5541	,1671
EXP peak	1	2	3,0833	1,0607	,7500
	2	11	3,7576	,6682	,2015
PI mode	1	2	2,4167	,5893	,4167
	2	11	3,0303	,4398	,1326
PI peak	1	2	3,3333	,7071	,5000
	2	11	4,1515	,4913	,1481

*1=normal state; 2=altered state

Altered states versus normal states (as identified by judges) on EXP and PI after(independent samples test)

		Levene's Test for Equality of means		t-test for Equality of means		
		F	Sig.	F	df	Sig (2-tailed)
EXP mode after	Equal variance assumed	1,005	,338	-,953	11	,240
	Not assumed			-,639	1,129	,628
EXP peak after	Equal variance assumed	,653	,436	-1,230	11	,244
	Not assumed			-,868	1,149	,529
PI mode after	Equal variance assumed	,103	,754	-,1,753	11	,107
	Not assumed			-1,403	1,212	,363
PI peak after	Equal variance assumed	,235	,637	-2,068	11	,063
	Not assumed			-1,569	1,182	,333

Because of the small numbers in the two groups, in particular in the "normal state" group, significant statistical differences are hard to detect. However, the t-test for independent samples confirms the numerical impression statistically for the PI mode and PI peak in the intervention session: statistical trends are detectable between

altered state versus normal state segments (identified by judges) and PI mode after (p=0.063 trend) and PI peak after (p=0.107 trend). If one considers the real numerical differences, however, there are trends for altered state segments to have elevated scores on both PI and EXP as compared to normal state segments.

Altered state and normal state (as identified by judges) numerical therapy effects on SOC, EXP and PI

The numerical net effects (means) of altered state and normal states on the various measures are, for segment 2:

Therapy Effects	Normal state (n=2)	Altered state (n=11)
SOC	6.00	7.63
EXP mode	0.33	0.52
EXP peak	0.250	0.44
PI mode	0.33	0.86
PI peak	0.75	1.14

Clearly, altered state segments correlate with higher mean numerical scores on all measures. However, a single significant correlation is found with the therapy effect on PI peak scores (p=0.051), a trend in PI mode (p=0.103).

Altered states and normal states (as identified by judges): therapy effects on SOC, EXP and PI (independent samples test)

Therapy effect on the PI		Levene's Test for		t-test for		
Segment 2		Equality of means		Equality of means		
		F	Sig.	F	df	Sig (2-tailed)
Effect on PI mode	Equal variance assumed	,995	,340	-1,622	11	,133
	Not assumed			-2,490	2,564	,103
Effect on PI peak	Equal variance assumed	5,128	,045	-1,065	11	,310
	Not assumed			-2,266	8,697	,051

Finally, for ***segment 1*** of the intervention session, the judges agreed in 10 cases on an altered state segment, in three cases on a normal state segment. For segment 1 in

the intervention session, only rater agreement and higher therapy effect in the PI peak scores associate as a trend.

Therapy effect on the PI		Levene's Test for		t-test for		
Segment 1		Equality of means		Equality of means		
		F	Sig.	F	df	Sig (2-tailed)
Effect on PI mode	Equal variance assumed	1,578	,235	1,555	11	,148
	Not assumed			-2,126	6,432	,075

In segment 1 of the intervention session, the altered state episodes the judges agreed upon correlate as a trend with the therapy effect in the PI mode (p=0.075). In comparing the scores on the different measures for identified normal versus altered states, however, demonstrate large numerical differences in favor of the latter. Notably, SOC scores are elevated by approximately +5 points in altered state segments.

Therapy Effects	**Normal state (n=3)**	**Altered state (n=10)**
SOC	3.67	8.5
EXP mode	0.33	0.53
EXP peak	0.33	0.67
PI mode	0.44	0.88
PI peak	0.89	1.13

Discussion

Inter judge reliability as to identification of altered state segments is high. Markers like channel changes into unoccupied experience, sensation, movement and, overall, expression of felt tendencies from a deeper strata of experiential process - indicate to judges state transitions and serve to identify characteristic altered states.

The Ho hypothesis states that there are no positive correlations between identified altered state segments and high scores on SOC, EXP and PI. In contrast, the results demonstrate a positive association of altered state segments as identified by the judges and high scores in the intervention session. This is true as statistical trends for PI mode and peak scores, and more important, for PI mode and peak therapy effects.

Being an important indicator, the PI peak therapy effect scores, approximates statistical significance (p=0.051) with altered state segment identified by judges.

The confirmation is important as it allows drawing conclusions between the qualitative judgment and the quantitative assessment. The results call for optimism. First, the PI as an instrument is sensitive enough to correlate with qualitatively identified altered states. Second, the trends indicate that indeed positive associations exist between high scores on the PI and altered state segments identified by qualitative agreement. Not only can altered states be accessed in therapy, and reliably identified as such by objective judges, altered states correlate with deeper experiencing or processing material. For the current population, on the PI, processing level reached stage 4. These findings are important to the study.

In contrast to our expectation that altered states episodes would correlate with the qualitative assessment of the judges on all measures, this is true only for therapy effect on PI. Numerically, in a clinically meaningful manner, however, means are consistently higher on all measures for altered state episodes. With a look at the clinical relevance of the effects on SOC, EXP and PI, given the small numbers, the conclusion is safe that higher therapy effect associates with altered states. Defined in greater detail elsewhere (6.2.2.), altered states are characterized by channel changes into more secondary material, and a process of sensing into the deeper strata of experiencing, into the mass of the implicit, one's sentient tendencies. These findings represent some evidence in support of process-oriented altered state therapy, which elicits alternate states and heightens the processing level. Follow-up studies with larger population are needed to confirm the reported trends.

10.9 Hypothesis #9: The time difference between the sessions does not contribute to the increase in experiencing level from the first to the second session (SOC, EXP, PWI, similarity-factor).

Correlations

		Time (days) between 1st and 2nd
DX1	Pearson Correlation	-,146
	Sig. (2-tailed)	,635
	N	13
DX1A	Pearson Correlation	-,249
	Sig. (2-tailed)	,411
	N	13
DX1B	Pearson Correlation	-,186
	Sig. (2-tailed)	,542
	N	13
DX1C	Pearson Correlation	,007
	Sig. (2-tailed)	,981
	N	13
DX2	Pearson Correlation	-,287
	Sig. (2-tailed)	,342
	N	13
DX3	Pearson Correlation	-,665*
	Sig. (2-tailed)	,013
	N	13
DX20	Pearson Correlation	,121
	Sig. (2-tailed)	,695
	N	13
DX21	Pearson Correlation	-,193
	Sig. (2-tailed)	,527
	N	13

*.

Time difference between initial session and intervention session was between 2 and 21 days (mean=6.7; SD 5); mostly, both interviews were completed within a week. The Pearson's correlation shows a significant, albeit negative correlation, for duration of research trial (t1-t2) and therapy effects on peak levels on the EXP (r= -, 665; p=0.013). The negative correlation indicates that the longer the time differences

between the first and second session, the smaller the net effect on the EXP scale. This is an interesting finding as it tentatively points to the long-term course of EXP scores after intervention. Considering the probability that scores are already elevated after the first session (from an assumed baseline state) due to first therapy session effect, this negative correlation possibly points to a decline in EXP scores, which takes place after the first session over the approximately 7 days of the study. One could speculate that the more time passes from the first to the second session, the more of the initial gain in EXP scores is lost, therefore, the smaller the net effect on EXP scores after the intervention session. Naturally, the same decline might be observed after the intervention session and, the same would hold true for SOC or PI scores. Indeed, negative correlation can be found between time t1-t2 and therapy effects on SOC and PI. However, because these relationships between time and therapy effect, albeit negatively correlated, do not reach statistical significance, one is lead to conclude that the effects (in this case, of the first therapy session) do hold over the course of several days.

Two issues are important to consider. First, one can quite safely assume that the first therapy session (plus the novelty of participation in research) had a considerable effect on the SOC, the EXP and the PI scores. The longer the time period between session, though, the more of the original gain gets lost. A follow-up study should include focus on therapy effect of the first session by utilizing a suitable design to do so. Second, a follow-up study should give attention to the stability of therapy effects by measuring the long-term course of the intervention.

10.10. An alternative hypothesis: does illicit drug use confound the results?

To rule out a possible alternative hypothesis which could explain the effect of the intervention magnified by potential use of illicit drugs before the session (ingestion of methadone or using), the group of residential clients was examined separately.

T-test for paired samples

Results on the SOC-13 demonstrate that increases are identical for persons in the residential treatment group (n=8) as for the overall sample - an increase of +7.4

matches the overall sample (n=13) exactly (+7.4). This numerically identical increase is not significant for the subsample due to the small size of this group, though, a clear trend is demonstrated (p=0.080). The paired samples correlations (not significant) point out that changes from t1 - t2 are not in the expected direction in a linear manner. A closer look confirms that the two persons who increased their score most also started lowest. In addition, the only two persons in the study whose scores declined at t2 stem from this residential group. Statistically, in such a small sample, significant results are hard to come by. A larger sample size would improve effect size and bear on statistical results. Still, the clinical significance is strong to rule out the one major potential alternative hypothesis, namely, that drug use contributed to the increase of SOC scores from t1 to t2. The question deserves further analysis in a larger follow-up study.

For the EXP scale as well, increases in the residential treatment group are similar to the overall sample on the mode and the peak ratings and statistically overall significant as well (mode +0.54, p=0.021, r=0.3, p=0.48 n.s., and peak +0.64, p=0.006; r=0.76, p=0.027). The PI, again, is more sensitive and yields a stronger differentiation between mode and peak values: lower on the mode and higher in the peak measurements (mode +0.85, p=0.001; r=0.41, p=0.31 n.s. and peak +1.2, p= 0.000; r=0.135, p=0.75 n.s.). Though, paired samples correlations are non-significant, the small sample size makes a statistical effect unlikely.

Conclusions

Increases on SOC, EXP and PI scores are in the same magnitude for the residential group of n=8 persons as for the overall sample n=13. Increases on the SOC are statistically confirmed as a trend. Increases on the EXP and PI show statistical significance, though, most paired sample correlations remain non-significant. The small sample size of the residential treatment group makes statistical significance and linear pre- /post correlation unlikely. The results suggest that there are no differences in terms of treatment effect between the residential group and the overall sample. For differential effects of each treatment group on SOC, EXP and PI, compare the results of one-way analysis of variance (ANOVA) above (hypothesis #7).

PART XI: Limitations and Conclusion

11.1. Limitations

There are several limitations to the study which bear on the results reported here. Though the experimental intervention demonstrated a large effect on SOC, EXP and PI - with reasonable to good inter-rater-reliabilities - there are several factors limiting the extent to which valid inferences can safely be drawn. Further evaluation is needed for a follow-up study with a larger and more homogenous sample, which can address some of the issues discussed below.

Internal, external, construct and statistical validity are especially pertinent to the interpretation of results (Kazdin 1996). Life events and maturation between sessions cannot be excluded as possible sources of client improvement, although the two interview sessions were usually within a week. However, this short duration of the study as well as immediacy and magnitude of effects are in support of internal validity. Possibly the single most serious confounding variable was found in the uncontrolled potential opiate use of some five clients in the study; three persons in a methadone program and two untreated opiate users. Potential effects of drug intake on pre-and postmeasures could compromise the quantitative results - thus, representing an alternative hypothesis, which could not be ruled out. However, careful calculation of the sub-sample of clients in the residential treatment group (n=8) showed that the increases for the n=8 clients in residential treatment matched the overall increase on SOC, EXP and PI precisely.

Additional support for internal validity comes from the AB design. The baseline session served as control of the therapy effect. The significant increases demonstrated come on top of first therapy session gains. Thus, they are evidence of the strength of the intervention on all measures. The intervention was well standardized and uniformly given - the inner work instructions a routine application for the experienced therapist, although each process unfolded in a unique manner in-session.

Though, repeated testing on the SOC with pre-/posttreatment assessments may confound validity. A threat to statistical validity arises from the small sample size. In small groups, significant effects are difficult to come by. A larger sample could provide answers to race and gender influences with greater authority, and look at differential effects of different treatment groups more effectively. The heterogeneity of the sample, while an advantage for the qualitative part of the study, is a weakness from the statistical quantitative point of view. For future empirical work, a larger and more homogenous sample will be essential.

A question concerns external validity: are the results of the study are generalizable to other situations, subjects and places? The clients were volunteers and motivated to participate in a nontraditional experimental form of therapy. This subject self-selection procedure led to a sample of active users, methadone patients and residents in treatment with, probably, higher motivation than the average population. Since the 13 clients do not represent a random sample, inferences to the general population of heroin addicts are tentative.

IRR, although acceptable to good, could be improved by longer training sessions so that a level of Alpha = .80 can be maintained. In addition to the SOC, EXP and PI, other measures could be employed to achieve a more differentiated view on progress. For instance, therapeutic alliance (Belding et al 1997; Gaston 1990; Horvath and Symonds 1991; Luborsky et al 1985), life purpose (Crumbaugh 1968) and depression and anxiety (Hamilton 1959, 1960) could be assessed. In a follow-up study, such measures should be utilized for refining the therapy effectiveness claims presented here. Moreover, measures involving the perspectives of self, observer and possibly, of significant others, could broaden the validity of the assessments.

A shortcoming of the AB design was the lack of adequate follow-up. Although evidence of dramatic intervention effects on top of the assumed first session effect is clearly demonstrated, the design makes it impossible to answer the question as to the stability of the increase. Again, an AB design with follow-up assessments would have provided insights as to the maintenance of positive change over time. Also to consider

is a more sophisticated ABAB design, which would make it possible to study fluctuations and stability of scores over time.

In terms of the qualitative analysis, this heterogeneous sample provides richer material than a homogenous one. For objectivity of obtained data to be strengthened as well as meaningfulness of categories preserved, many judges would be better than just a couple (Mahrer 1986). However, the clinical sophistication of judges contributed to the relevance of the category system of altered states. While the consensus among both judges was almost 100% in differentiating altered states segments from normal state segments, qualitative process pattern analysis is more complex. Reviewing the processes of the13 clients, discussing and sorting out core structures and finally, condense and name them, was much more time consuming than planned. The discussion of the process structures remains tentative. The qualitative analysis represents a first and imperfect attempt to qualify the many experiential patterns by a number of judges. Nevertheless, the results yielded surprising and meaningful results, (see section XI and XII).

11.2. Conclusions

The process-oriented intervention of re-accessing and unfolding the "drug-state" proved effective on all measures employed. On the Sense of Coherence Scale (Antonovsky 1979, 1987), results demonstrate a significant intervention effect with increases from 49.2 (STD 12.7) to 56.6 (STD 11.8). The increases on the ***SOC-13 (+7.4 scores, p=0.01*; r=0.75, p=0.003, d=0.85)*** underline empirically the potential of this process-oriented method to promote movement toward the health end of the ease/disease continuum in opioid dependent persons. An increased SOC stands for an improved attitude in the faces of challenges, an outlook on a life, which is perceived as more meaningful, manageable and comprehensible. It indicates augmented resistance to stress and more protection of one's health (Lamprecht 1997). A higher SOC strengthens the person's sense of resourcefulness and positively influences an attitude on life now infused with a bit more optimism as well as renewed trust in one's ability to meet challenges. The sense that life is meaningful is the most crucial ingredient in health promotion. The "centrality of meaningfulness" (Antonovsky 1987)

holds that purpose and meaning in life push a person toward health, and observes that meaning is the most important resource for health.

Re-accessing the altered state the person yearns for with somatic focusing allows establishing an experience needed in a person's life. A striking example is client (10) for whom the practice of recalling the state provides an immediate calming, slowing effect, which improves her subjective cognitive functioning, and well being (+16 on the SOC-13). Just like increases in well being are possible, maintenance of the state with repeated practice of this form of intervention is likely to occur.

Antonovsky (1979, 1987) did not believe intentional modifications could be so dramatic, but admitted that changes of 5 scores be possible. He recommended the therapeutic encounter be arranged in a useful manner to push the client in the direction of the health end of the continuum. Sack et al (1997) have used the SOC for follow-up on treatment of psychosomatic inpatients and reported significant gains (+8) over some weeks.

The present intervention study with a small sample of 13 opioid dependent persons, in recovery, in the methadone program and users, demonstrates that substantial therapy effects on the SOC can be achieved in session. The increases of +7.4 are double of what Sacks et al (1997) reported for residential treatment outcome with psychosomatic patients. Transposed on the SOC-29, the current population starts at 109.7 and augments to 126.3, with a dramatic increase of +16.5. This therapy effect is all the more astounding as it comes on top of gains in the initial therapy session.

The SOC score of the population in this study starts at 49.2 (STD 12.7) to increase to 56.6 (STD 11.8). The initial low levels of SOC are to be expected in a population of heroin addicts whose conscious focus is narrowed by the addictive process with little expression of feeling and emotion. Likely, little or no attention is given to inner experiencing lest under the influence of the drug, then only unconsciously. The score levels of the population of heroin addicts in this study makes sense when compared to

psychosomatic inpatients in the study by Sacks (108.9) and outpatients (121.2) on the SOC.

As an instrument used in psychosomatic medicine (Lamprecht 1997; Sack et al 1997), the SOC is an excellent measure with the population of opioid dependent persons because of diagnostic overlap: severe addictions can be seen as a "psychosomatic attempt to deal with distressful conflict " (McDougall 1989). The health-promoting factor of the therapeutic intervention enlivens what is experienced as empty, dead and which can not be felt in a differentiated manner. Focusing fills body sensory awareness and, following the yearning for a particular state, deepens awareness of self and of an inner "high" state.

The self -medication hypothesis (Khantzian 1974, 1995) provides a useful framework and rationale to unfold and deepen the altered state the client is pursuing. For example, one client is finding relaxation and focus on cocaine; another, calmness, improved feeling about self, feeling active and energized on heroin (see chapter 4.1.). Process-oriented interventions go further by supporting
and unfolding the yearned-for state, until a momentary resolution occurs. As an adjunct in addiction work, "re-accessing a state" helps to experientially establish the state the addict yearns for and to create meaning grounded in subtle body experiences. The needed state is established and unfolded until its subjective meaning can be experienced.

In addition to the effects on the SOC, increases from session 1 to session 2 are significant on the Experiencing Scale (Klein et al 1969) as well. On the ***EXP, the modal scores increase from 2.22 (STD 0.47) to 2.71 (STD 0.6) or +0.49 (p=006; r=0.524, p=0.066 trend; d=0.91),*** in the ***peak from 3.24 (STD 0.48) to 3.65 (0.73) or +0.41 (p=0.03; r=.568, p=0.043; d=0.68).*** The increases are modest but can be interpreted as clinically meaningful. In a study, Hill (in Russell 1993) reports similar levels of experiencing. For Klein, co-developer of the EXP scale, these "EXP findings suggest a shift from externalizing to some minimal internal referent which is clinically meaningful" (Klein, personal communication 2001). Moreover, on the PI, participants

reach critical stage 4 in the mean on the PI and well beyond in individual ratings. On this level, clients are beginning to follow their process and attend to the stream of inner experience.

What has been found for the SOC holds for the increases in EXP scores too: they have health promoting impact. Clients with higher experiencing feel overall healthier than those who do not (Klein et al 1969; Rogers 1967). Congruence of awareness and experience on higher experiencing levels reflect the person's ability to be in touch with inner felt referents as basic data from one's life process, thus, the salutogenic benefit. On these higher levels of experiencing the client is more involved in the therapeutic process and - in touch with an inner felt sense and attending to moment-to-moment experience - stage 4 is achieved. The correlation of higher level of functioning and therapy benefit is confirmed by research. Many studies point to the positive association of experiencing level and successful outcome in therapy (Hendricks 2000). Focusing has been suggested in prevention and therapy for psychosomatic patients to increase access to an inward felt sense (Sachse 1991).

The intervention has show to be effective in eliciting higher levels of experiencing with a large effect in the intervention session. This increase is particularly astounding as it comes on top of a first session profit, which can be assumed as a consequence of first therapist contact, novelty of situation and therapeutic exploration of the client situation (Stohler, personal communication 2001. Thus, the effect size of the presented intervention on EXP levels is accentuated.

In the same vein, impressive increases are also found on the ***PI in the mode from 2.15 (STD 0.38) to 2.94 (STD 0.49) or +79 scores (p=0.000; r=.483, p=0.095 trend; d=1.73), in the peak an outstanding effect from 2.95 (STD =0.34) to 4.03 (STD (0.58) or +1.08 scores (p=0.000; r=.577, p=0.039; d=2.27) to stage 4.*** On the PI, participants reach stage 4 and well beyond in individual ratings. This is a crucial cut off point where inward attending begins. On this level, clients learn to listen and follow their inner process with interest.

The PI has been shown to be sensitive in assessing altered states in particular. The range of mean scores on the pre / posttests is larger than for the EXP in both mode and peak and renders an impressive full stage increase for peak values. This result is clinically meaningful, demonstrating that clients reached a focusing level where previously there was none. In the PI, the *manner of process* is rated as central change dimension. Raters study non-verbal feedback and estimate the extent to which the client is in contact with inner felt referents. They assess the speaker's identification with experience, including emotion, body sensory awareness, movement, inner splits and outer relationship processes, while estimating the extent to which the client is in touch with her inner life stream, her "felt sense" and her ability to direct attention to "sentient experience". The PI processing dimension includes ratings of non-verbal sensory awareness and its expression or symbolization in some other form, while the EXP bases ratings of experiencing solely on emotion and its expression.

The PI may be more sensitive than the EXP because it also assesses non-verbal behavior. It represents the "processing" construct closest, however, the price is a slightly lower IRR compared to the EXP. As the PI scale is derived from the EXP scale, the concepts are intrinsically linked. Ratings based on the seven stages, with minimal adaptations, which reflect the focus on felt process rather than on expressed emotion (see appendices C and F). EXP and PI results on both scales are in agreement, only, on the PI, peaks are higher, modes lower than on the EXP. This points to the usefulness of the PI to assess processing levels and measure intervention or therapy effects. Further studies are needed to assess IRR, reliability and validity of the scale on a larger sample. Since the PI is based on the experiencing construct and the seven stages in a close manner, similar outcomes could be expected. As indicator of change, both scales are congruent in the effects reflected in mode and peak ratings.

In the **intervention peak segments, IRR is good on all reliability measures** (Cronbach Alpha 0.66-0.75; on the general factor (PCA) 65-75% of total variance explained; average measure intraclass correlations r=0.67 to r=0.76). Rater A and C agree best and their ratings correlate significantly in 7 out of 8 paired samples

comparisons, without significant disagreements on the level of client experience (t-test). For the first session ratings on EXP and PI, is acceptable; longer rater training could ameliorate consensus in the first session. However, inter-rater-reliabilities in this study are compatible with numbers reported by Klein et al 1969. Studies by Rogers (1967) and Yalom et al (1977) reached similar reliabilities on the EXP. of the EXP. Similarly, the findings that peak ratings are somewhat more reliable than mode ratings are confirmed.

The ***similarity measure*** is a self-rating scale to estimate a) similarity of in-session state to heroin-state, and b) the depth of the altered state relative to the normal waking state, both on a Likert scale from 1-7. Results demonstrate a ***significant correlation between the similarity factor and SOC scores (Pearson Correlation Coefficient 0.701; p=0.008).*** No significant correlations could be detected between EXP and PI scores and the similarity measures. This may be a consequence of the statistical procedure: the two values were averaged for calculation, not studied as two distinct measures. The correlation of similarity self-rating and SOC scores, however, tentatively points to the usefulness of in-session altered state self-assessment as an indicator for one's place on the health continuum.

One-way analysis of variance (ANOVA) demonstrates that ***affiliation to treatment group*** significantly affects therapy results with the residential treatment group and methadone clients significantly ahead of active users. In the intervention session on SOC scores (p=0.027), the methadone (2) scores +23, the residential group +17 SOC scores ahead of untreated users (3). And, in overall therapy effects on EXP peak scores (p=0.038*), similar significant inter-group differences between residential group (1) and untreated users (3) of +1.14 (p=0.012*), and as a trend, between methadone group (2) and untreated users (3) of +0.89 (p=0.068) have been detected. Not in line with these results are first session peak ratings, where untreated users score ahead of the other two treatment groups (p=0.026). The reasons may lie in the fact that the two untreated users excelled in verbal expression, which led to higher scores in the initial exploratory session in particular, on the EXP (both type of session and measure favor

verbal skills). These results, though, are tentative with such small group sizes, and need to be replicated with a larger sample.

Also, with ***one-way analysis of variance (ANOVA) and t-test***, variables such as age, gender, race, education, duration of addiction and criminal history were studied as possibly ***confounding variables on treatment results***. While both ***education*** and ***duration of addiction*** do not bear statistically on the results, gender and race do. For ***gender***, the numerical scores are consistently higher for women than for men on all measures, though, except for ***first session PI peak ratings (p=0.021) and a trend in the PI mode (p=0.065)***, results are below the accepted level of statistical significance (confidence p=0.05). The overall numerical evidence, however, points to the possibility of gender as a potential confounding influence.

Women may be more introspective and able to relate to and express inner experiences easier than men which confirms a common stereotype. Or, conversely, there might have been a hidden gender factor influencing the ratings of the three raters who happened to be women. The interpretation is tentative as these interpretations are derived mostly from numerical values. No statistical evidence has been found except for first session peak ratings on the PI where higher levels of experiencing for women are significant. It is possible that women have been more expressive, in particular in the initial exploration session and more in touch with their inner experience than men. These findings are in contrast to reported data by Duetz et all (2000) who found that woman may estimate their health subjectively slightly lower than men. Since SOC scores depend significantly on subjective estimates of one's health, women may, in general, have a lower SOC than men (Duetz 2000; Bengel et al 1998). In the present study, however, the SOC of women in the initial session is equal, in the intervention session higher to the ones of men (n.s.).

The author is unaware of previous research on the dependence of SOC score on ***race.*** The present study looked at race as a potential confounding variable and found that non-whites score significantly higher on EXP and PI and as a trend on the SOC. On both ***EXP mode (p=0.02*) and peak (p=0.043*) in the intervention session***, as

well as on the ***PI mode (p=0.024*) and peak (0.070 trend)***, differences for race are significant. Similarly, for ***therapy effect***, non-white score significantly higher than whites on ***the EXP mode (p=0.013*) and peak (p=0.037*)***. For the ***PI, therapy effects are significant for the mode (p=0.034*) and on the peak (p=0.084 trend)***. ***Therapy effects on the SOC are dependent on race***, with non-whites scores exceeding the ones for whites by +9.2 points. Although not statistically significant (p=0.077 trend), this difference in effect on the SOC is clinically meaningful and confirms the general result of a race-related factor which augments scores. Interpretation can focus on intrinsic attributes of people of color - an expressive style of being, more feeling and in closer contact with self. Both mode and peak intervention effects on EXP and PI (which rely on ratings) depend on race significantly. This suggests that ratings may have been subjectively affected by racial stereotypes. However, since the SOC, a self-rating measure, points to a similar trend, the treatment effects are not attributable to raters alone. Rather, persons of color also subjectively rate themselves higher than their white counterparts do. It is possible that non-whites do better with the presented intervention, and that these effect result in larger self-attributed effects, which in turn may be mirrored in the higher ratings of the raters.

Sociological aspects of the SOC may have been neglected in research so far. Some evidence points to the possibility that one's financial situation, social class and education does, in part, influence the SOC (Lundberg 1997; Geyer 2000). Results, however, are conflicting. Knesebeck (1997) and Schmidt-Rathjens (1997) could not detect SOC differences based on status or education. Similarly, in the present study, no correlations of SOC with education have been found. Gender and age have been implicated in other studies (Geyer 2000; Duetz et al 2000). The present study could substantiate the findings as a tendency for gender. Most interestingly, SOC scores were found to be dependent on race with non-whites scoring higher than whites, particularly on the EXP and PI during the intervention.

With many questions still open on the sociological components of the SOC, construct validity of the SOC also is in doubt. For one, there is mounting evidence the SOC may be an inverse measure of depression, anxiety and psychological problems and, a

measure of mostly psychological rather than physical health (Lamprecht et al 1997; Geyer 2000; Duetz et al 2000). Further studies are necessary to clarify the construct the SOC measures.

A possible threat to internal validity, the uncontrolled-for use of heroin or other drugs during the research trial, had to be examined to rule out the ***alternative hypothesis*** that treatment effect was confounded by drug use. The t-test for the n=8 residential treatment group who were abstinent for 7 weeks (STD 5.02) found identical numeric increases in SOC, EXP and PI to the total sample. On these measures, the ***SOC increase for the total sample and the residential group is +7.4***, significant for n=13 (p=0.01*), a trend for the subsample of n=8 (p=0.080). Similarly, **EXP and PI increases are equivalent to the increases in the overall sample** and highly significant for both the total and the sub-sample. Consequently, this particular alternative hypothesis can quite safely be ruled out or, independence of results from illicit drug use is affirmed.

No significant effects or trends on any measures seem to be determined by **age**. Numerically, the SOC is 8 points higher for those younger than age 35 compared to those ages 35 and older. Sacks et al (1997) reported opposite findings for the SOC of psychosomatic patients. In his sample, those older than 35 had significantly higher scores on the SOC than those younger (+14.7; p=0.012). Possibly, it is characteristic for the course of severe addiction that the longer the addictive process, the lower the Sense of coherence. Follow-up studies should consider this hypothesis with a larger sample.

Criminal history was studied for effects on treatment outcome. As lifetime incarceration for drug-related crimes can be understood as an indicator for the severity of a person's drug history, its relationship to outcome is important. Eight persons are in the low (6 months or less), five persons in the high severity group (24-120 months). The results demonstrate that the low severity group scores +11.75 points higher than the high severity one, this confirming expectations (p=0.106 trend). Surprisingly, the high severity group seems to benefit more from the intervention (+10.6) than the low

severity group (+5.4): after the intervention, their SOC score difference is reduced to +6.5 points (n.s.). Whether this result is a statistical artifact or not, the hypothesis is worthwhile pursuing in a follow-up study. On the EXP and the PI scales, differences are minimal and not statistically significant.

Qualitative judgment on states of consciousness and quantitative therapy effects have been investigated**.** The ***qualitative assessment*** of the material by the two judges yielded 81% agreement on whether a segment was depicting an altered client state and 96% whether it represented a normal state segment. Markers indicating altered states of consciousness are several: (1) channel changes into previously less occupied modes of experiencing like feeling, sensing, moving, relating. The client follows the experience and carries it forward though various modes of expression. (2) change of focus from external to internal, with distinct shifts in attention to inwardly focusing and on self-experience. The client makes a deliberate attempt to feel into the not-yet verbalizable mass of the implicit and senses the "sentient tendencies". In various degrees, she is in touch with inner felt referents. (3) Expressing feeling, body sensation, relationship needs, all what previously been guessed at, felt, sensed, is now verbally symbolized and / or expressed in various expressive modes.

A comparison of the mean scores of those n=11 altered state segments which the judges identified as such with normal state segments (n=2) yielded impressive numerical effects on all measures for altered state segments (segments 2 of intervention session). Most important for the study, the qualitative identification of altered states is confirmed quantitatively. Judges can easily recognize intervention or altered state segments. Altered state segments upon which judges agreed in 77-85% of cases, score higher on different measures. ***On all measures, the mean therapy effects are numerically larger for altered state than for normal state segments***, even though below statistical significance. For statistics to detect significant correlations, numbers in each cell need to be larger.

For segment 2, ***on the PI, qualitative analysis and quantitative assessment correlate* as trends.** T-test results show ***statistical trends for altered state***

segments identified by judges to correlate with PI mode (p=0.107) and PI peak (p=0.063) in the intervention session as well as for the therapy effects in the PI mode (p=0.103) and PI peak (p=0.051). These segments associate positively with effect scores on the PI (trend) and, numerically, with mean effect scores on all the other measures as well. For segments 1, there is a ***trend for altered state segments to correlate with therapy effect scores of the PI mode***.

These are exciting results. They lend support to the hypothesis that altered state segments can be reliably identified, for one, and that these states correlate with higher scores on outcome measures. Not only are the scores in the second session significantly higher than scores in the first session on all measures, raters agree on segments which are associated with positive outcome. It is precisely these altered states which receive the highest scores on SOC, EXP and PI.

11.3 Final Remarks

These results are ***evidence for the usefulness of altered state therapy in addiction work.*** The effectiveness of the intervention on the SOC, EXP and PI has been demonstrated on this sample of 13 opioid dependent persons. There is empirical evidence for the process-oriented technique of re-accessing a state to have a place as adjunct in different phases of drug treatment. Follow-up studies with a larger sample to replicate the results and measure the stability of the therapy effect over time are a necessary future project.

The study demonstrated that observers could reliably identify altered states of consciousness. Moreover, it is possible eliciting the altered state the addict yearns for. The intervention results in higher levels of experiencing and progress on a measure of health. Higher experiencing levels, i.e. deeper contact with one's inner life, have been implicated as indicator for good therapy outcome and, in general, as a salutogenic or health-protecting factor. As the client learns to access and establish the state without the drug, a sense of self-efficacy returns, a sense of manageability and comprehension as one's inner experiences become more meaningful.

For the addict, large parts of her experience are represented outside of normal awareness, in a particular altered state, which usually seems inaccessible to reach outside of drug use. These "state-specificity" of the addiction process calls for state specific intervention. There is evidence from altered state research (Tart 1983) and from psychobiology (Rossi 1993) that intense emotional experiences, which have occurred in particular states of mind, create state-bound systems, which can only be influenced when in that specific state. Change occurs when we re-access that particular state and in that state restructure old programs or imprint new patterns.

Altered states therapies are a growing field in the treatment of addiction with room for improvement and use of alternatives experimental, adjunctive interventions. Although not by itself a sufficient ingredient in the prevention or treatment of substance addiction, the Process Work intervention investigated in his study is not alone in the attempt to working with state-specific conditions. The deliberate use of altered states of consciousness in psychotherapy (Leuner 1993) and, specifically, in addiction treatment has a long tradition (Hoffer and Osmond 1960) and is currently entering a new phase with renewed interest in various altered-states therapies (Heggenhougen 1997). Indigenous rituals and folk medicine (Blum et al. 1981), outbound programs (Houston et al. 1990), meditation (Gelderloos et al. 1991; Glaser 1994), relaxation (Klajner et al. 1984), biofeedback (Denney et al. 1991), psychedelic therapy (Kruptitsky 1997), altered-states therapy (McPeake et al. 1991), and creative art therapies (Johnson 1990) recognize an innate need for altered experiences and provide means to achieve a "high" with nondestructive means.

Effectiveness of alternative treatment has been demonstrated in studies. There is a growing body of evidence that speaks for alternative therapies in drug treatment. Acupuncture is used to support detoxification, probably by stimulating the release of endogenous endorphins. Positive outcome has been reported on treatment retention, drug use reduction and relief from withdrawal symptoms from opiates, cocaine, alcohol and nicotine (Dodgen et al 2000). Studies on transcendental meditation (TM), practiced twice a day for 20 minutes, demonstrated effective reduction of negative affects, improvement of self-esteem, sense of self-empowerment and well being

(Gelderloos et al 1991, Glaser 1994). These effects make meditation a helpful complement in the treatment and prevention of addiction.

Alternative therapies often integrate spiritual or religious components in the approach. Some faith-based programs are based on religious beliefs, like Teen Challenge, others, like AA or NA, rely on spiritual beliefs by recommending recognition of powerlessness over drug use and acknowledgment of a Higher Power. There is strong evidence that spiritual treatment for alcohol and drug use is effective in some well-defined circumstances. Further research in this area is necessary (NIHR 1996-97). Next to involvement in 12-step groups, meditation-based interventions are associated with "significantly reduced levels of drug and alcohol use" (United States General Accounting Office GAO/HEHS-98-72, 1998).

Process work interventions rely on meditation, relaxation, imagery, relationship and movement in interaction between therapist and client to create the best conditions for focusing on one's "sentient experience". Body sensory awareness is intrinsic part of the therapeutic practice, especially when psychosomatic symptoms and addictions prevail. Subtle body awareness is a requisite for developing a felt sense and attending to subtle experiences and tendencies. Psychological and somatic changes can happen below the level of conscious awareness. The processes of "subception" or "marginalization" point to a more subtle level of awareness, which is at the bases of the living process. Much before our conscious observer wakes up, our bodies regulate feedback loops between self and environment on an automatic level. These levels are important to consider in the therapeutic process. Practicing sensory feedback to deepen experiential possibilities can open new potentials with clients. Sensory awareness reaches into the deeper strata of the life process and be useful to access disavowed experiences. Like ancient Yoga, body awareness has been part of the established practice of healing for millennia. Like it is said that Yoga teaches Yoga, it is in our subtle body awareness that new experiences arise and become conscious. It is the basic data of the experiential process, from which change and progress arise. Movements toward change are prepared before the level of conscious symbolization

and to dwell on that sensory level is prerequisite for processes to unfold to symbolization and new meanings.

A hypothesis to consider in the future includes "treatment alliance" and process work. It is suggested that the process-oriented approach enhances treatment effectiveness because a final perspective on life issues tends to improve the "therapeutic alliance" (McLellan 1998). The therapist's attitude is the single most important factor for treatment success. Positive therapeutic alliance, therapist empathy and genuineness, have been identified as the most important factors in successful drug treatment, especially because motivation for treatment and treatment retention are problematic with addicts (Miller 1992, Petry et al 1999; Dodgen et al 2000).

Treatment compliance is one of the challenges in the treatment of addiction. Therapeutic alliance is thought to be of major importance in successful treatment of addiction. Process work offers a shift in paradigm from which both health professionals and the population of addicts can benefit from. With a focus on the message in the addictive process, the meaning in individual processes is highlighted which helps the working alliance and in a co-creative process purpose and spiritual values in life can be restored. According to Frankl, the creation of meaning or purpose in the life of an addict is positively associated with the recovery process (Frankl 1963).

Process Work complements the medical discourse in addiction treatment by emphasizing the final perspective. While harm reduction measures and medical intervention are and always will be an integral and necessary part of addiction treatment, they are not sufficient. The new framework within which to discuss addiction is oriented toward salutogenesis. This health-oriented perspective is looking for the pivotal ingredients in well being rather than exclusively for causes of illness. The belief that addictive processes are meaningful attempts at development is a powerful salutogenic intervention, one that also enhances motivation for self-exploration. The belief in a "telos" embedded in the disturbance leads to specific feeling attitudes of the therapist which facilitate a very helpful relationship to the addict and serves to improve the therapeutic alliance.

If we look for factors that enhance life quality and move us toward the health end of a continuum, then a final approach seems most suitable. The reconnection with meaning and purpose, the use of positive emotions, love, humor, excitement, compassion, "joie de vivre" to further hope are basic ingredients in good therapy. These and other feeling attitudes of the therapist who embodies a final or salutogenic orientation become interventions that support growth. Rumi captures the central feeling attitude in a beautiful poem. The "Guest House Keeper" welcomes all experiences, even adverse ones, into the house as they all are messages from God (Rumi 1995). In that, a sense of the spiritual core of our existence is nourished and with it, a movement toward health promoted. With the appropriate tools to facilitate direct experience of meaning in addiction, the Process Work approach strengthens a person's involvement in the recovery process, provides a renewed sense of meaning and purpose, and teaches to hold on to a feeling of ease even in the midst of stress and tension.

The Guest House

This being human is a guest house.
Every morning a new arrival.

A joy, a depression, a meanness,
Some momentary awareness comes
As an unexpected visitor.

Welcome and entertain them all!
Even if they're a crowd of sorrows,
Who violently sweep your house
Empty of its furniture,
Still, treat them honorably.
He may be clearing you out
For some new delight.

The dark thought, the shame, the malice,
Meet them at the door laughing,
And invite them in.

Be grateful for whoever comes,
Because each has been sent
As a guide from beyond.

Rumi

Part XII: Case Vignettes and Process Observations

This chapter will give the reader an impression of the actual therapy sessions by presenting excerpts of segments from the initial and the intervention session. Two typical clients, a man in residential treatment and a woman in a methadone maintenance program, have been selected for this detailed analysis. Each segment is followed by a short discussion of the client process, his or her in-session movements and the therapist interventions and techniques to access and maintain the altered state. Theoretical aspects pertaining to process work are explained. Further, the author will analyze the function of the altered state in respect to the primary process or, the "fit" of normal and altered state. In his conclusions, the author aims at understanding the meaning of the process in the overall life situation of the client.

12.1. Rex: Doors to the Process

I met this 37-year-old, single, white, heterosexual man in a residential treatment center for men in PDX, Oregon. He appeared grounded, focused and clear in his presentation of self and his recovery process.

His father left when he was a two-year-old. He grew up with his mother who remarried into an abusive relationship, to a stepfather who verbally abused him. At age 21, he started to experience "grand mal" seizures. At that time, he also got diagnosed with spinal meningitis, was hospitalized and slipped into a coma. In his recovery process, he had to relearn talking and walking. After a suicide attempt with epilepsy medication a few months ago, he is diagnosed with depression (DSM-IV 300.4) and taking anti-depressants. According to the police report, he was found in the basement, screaming for life.

He used heroin for the past 7 years, barbiturates and alcohol for almost 20. He had been incarcerated for drug-related crimes a total of 6 months and was court mandated for residential treatment after several relapses. He appeared motivated to work on his recovery. He returned to this particular center four times since 1997 to continue and

complete treatment but dropped out after short treatment periods. A year ago he graduated the full 6 months treatment but relapsed soon after completion. He is currently in his 4th months of his 4th residential treatment attempt.

Not much is known about his relationship life. He indicated to have a close relationship to his mother. He was never married but had several significant relationships with women in his life. In the last few years, however, he has been single.

He did not complete high school, however, got a certificate later on and did two years of art college. For the last few years, while in and out of treatment, he has been leading groups doing community work in schools and churches with adolescents.

12.1.1. Reaching the ceiling

(Previously, the client had mentioned a "tingling" sensation and the feeling of a "rush through my body"

Th Let's go back to feeling the tingling and the feeling of that first rush through your body. Use your imagination…to increase and strengthen the feeling.

Cl (closes eyes, inward sensing for 40 seconds). Hmm…ahh…umm…

TH Yes, you made some nice noises. Hmm… That rush state, right…?

Cl (looks at therapist, giggles, holds hands in front of face, blushing)

Th Now, sometimes it helps to just make a movement that goes along with feeling. Is it a rush like … slowly … or, rather like … zsss! If you could make a movement that mirrors the rush….

Cl (eyes closed, sitting, slowly moving his arms above the head)

Th Just like that… lets get up.

Cl (follows suggestion immediately, gets up and stretches arms toward ceiling).

Th Yes. As you feel the rush…whatever is happening now model it through movement (therapist models client movement). Is it such a slow rush?

Cl It is very slow, yeah! (starts to move his arms slowly upward. Two minutes of movement process follow). Ah… It rises up, it keeps coming on up …and it's hot and it

is usually …but so high and that's the ceiling (both arms stretched all the way toward the ceiling).

Th Aha. That is the ceiling of the heroin. Right… Let it go even higher now…Without drugs you can go even higher.

Cl (Standing straight, arms up, eyes closed, feeling inward) And then, ah…that feeling, it stays for a little bit and it goes up a bit more…further up…it feels hot…

Th It is very hot; "it", that special feeling….

Cl …and (in breath) then ah … (out breath) usually … very gradually …it comes down to an even level where it is just comfortable ..ahh …and then …(arms come slowly down, focused) …then…that's that (relaxes arms and giggles, relaxed). Yeah! That's it! (smiles).

Th Just right there.

Discussion

The therapist operation aims at the re-accessing the state, starting with the client perception in the moment - and follows the signals in their respective channels into the lesser known aspects of the experience. The goal is to help the client access the "flow mode" where the discrete bits of observation melt into the flow of experiencing while tracking the experience with acute awareness. In accessing the altered state the client yearns for, the exploration and unfolding of the process sets in. The therapist interventions facilitate entering this stream of experience and helping the client to feel and sense the core of her desire or attachment.

How does the therapist intervention work?

At the beginning of the segment, the therapist intervention aims at amplifying the client's proprioceptive experience (feeling / sensation) which lies at the core of his heroin state. The client makes sounds, which match his experiences, but seems to reach an edge - when the process of inner self-exploration stops and an embarrassed and shy part emerges. This is a bifurcation point: it would have been interesting to stay with the sounds longer, explore the shy part, find out what its experiences and feelings are and what beliefs hold him back. Rather than staying with sensation / feeling or explore the emerging shy part, the therapist chooses to propose a channel

change from proprioception to movement as a method to help the client unfold the "high" further, yet in a different expressive mode.

Process edges

The edge to sound and feeling is not explored at this point in favor of finding another route for the process to unfold. Thus, we do not know what inner belief system limits the client's ability to feel and what it is that embarrasses him. As a result of the process at the edge, what we do see is a child-like figure appear who seems self-conscious about the many deep feelings he is having (implicitly). As the therapist's focus was on establishing the "high" state, a choice was made to not pick up the intervening process but instead, to gently focusing the client toward the altered state by allowing the process to express itself through a different channel. This can be seen as a form of edge work where the process is taken from one channel to another to move it further along its path.

In this sequence the client's experience unfolds from feeling to movement coupled with the sensation of *inner heat*. As the client stretched his arms up to the ceiling, he seems to have reached another edge, this time in movement. Reaching all the way upward, he does not only feel hot but a *ceiling* restricts the high. Again, this could be a good moment to negotiate between the desire to go "high" and the restricting part, the ceiling. The client pushes a little higher, then his arms move slowly downward as he lets go and the feeling eases gradually into relaxation. There is a sense of completion as the client smiles: That's it! Although there was a felt sense of an implicit more … the therapist follows the clients feedback and let it be: that where we got right now.

Channel changes and amplification

The therapist intervention of a "channel change" (to movement) is an attempt at amplifying feeling sensation by coupling sensation/feeling with movement. With most movement processes, amplification involves full body motion, getting up from the chair or the floor and standing, walking, swinging, pushing, rolling or dancing etc. Getting up in the therapy room, with dependent users as with other clients, is a welcome change in setting with oftentimes allows for dramatic transformation. In process work,

unfolding of a process involves carrying it forward through different modes of expression as to get a complete experiential "feel" of the core of the experience.

What has been completed?
When the client starts shifting paradigm and participates with awareness in his or her inner process, much is achieved: the in-session movement from the primary process to the edge and beyond to an open exploration of the further reaches of experience is a crucial step in experiential therapy. Increased interest and curiosity in one's own process facilitates the transition from a narrow conscious attitude, limited by criticisms and inner beliefs, to an awareness of the moment-to-moment changes and the flow of experience on the way toward a larger definition of oneself.

This sequence has the client enter the stream of experience and practice moment-to-moment awareness of his inner process. The next steps, at this point, could involve edge work. In the process of unfolding the inner heat the client reaches a ceiling, literally, in movement. Whatever inner figure limits his sounds, his feelings and sensations, and embarrasses him, may well be core in fueling the addictive process. The client, in reaction to this stopper, may use drugs again and again to break out and experience moments of freedom. The edge figure is drugged for moments but not dealt with and therefore it will remain unchanged.

The edges explored and negotiated, the process can be unfolded further until its meaning is directly experienced and symbolized and integrated into everyday life. In this segment, the core of the process achieved was just that: immediate experiencing of inner heat as an aspect of the client's yearning as well as the ceiling that limits further expression and integration. This sets the stage for the next steps, edge work, and beyond into sensing the essence of that heat and carries "that" further.

12.1.2. The children catcher with the giant syringe

Th Do you remember your first dream as a child?

Cl Yes! I was alone with my mother because my father left when I was very young, and I would wake up almost on a nightly base with this terrible scream to the point where she would have to comfort me. I would usually have to sleep on a cod in her room … because she did not want to baby me and let me sleep with her.

So, in the dream, I am going down the slide and at the end of the slide there is this Mad Hatter type character with the top hat and the tails… in black. He is very sinister looking - I have drawn him before - and he has, at the end of the slide as I am going down, a giant syringe, believe it or not.

Th Um, um…

Cl …and ah, I had this dream from probably two to about five years old on a weekly bases … I would always go down the slide and he was at the bottom…

Th …waiting with a giant syringe.

Cl I am not kidding! I saw a movie at that time with a children catcher who would smell children out and capture them with candy. That mad catcher was the same character as in my dream. He had a very long nose and he is very evil and has a big top hat.

Th What would he do to the children?

Cl He would capture them because this land they are living in - there are not supposed to be children living in, only adults, so the children live in caves and stuff.

Th What a myth … about the conflict of being an adult and being a child…

Cl Yeah! And I would never make it to the bottom of the slide before not waking up before. He was just down there and I would make myself wake up in screams…and trying to get up the slide…it was slippery (motions).

Th It is slippery, isn't it? You have slipped down a few times … but you keep climbing back up!

Cl Yeah! Yeah (laughs).

Discussion: Childhood Dream and Addiction

In his seminars, C.G. Jung has pointed out that childhood dreams contain life patterns or life myths, the stories and dream-like strands about who we are and what we struggle with throughout life (Jung 1984). These dreams depict core life themes and difficulties we wrestle with in life. Some of the dream figures, affect states and relationships are closely allied to our everyday consciousness while others remain

alien, incomprehensible, utterly strange or scary. Mindell calls the "dream architect", the one who dreams up dream image and reality, our fate maker, the mysterious source of process (Mindell 2000). As we explore ourselves, as we grow and develop in life, we come closer to the origin whence our perception and manifest life processes arise, to the effect that we gain more awareness and power so that we can become truly the architects of our own lives. This is what the concept of an individuation process implies.
Mindell pointed to the connection between these earliest dreams and memories and chronic symptoms and addictions. He holds the view that when we unfold the altered state the addict is searching for until its meaning is experienced, then we very likely will find the same information reflected in the childhood dream (Mindell 1989c).

Our long-term process has channels of its own: childhood dreams, early memories, chronic symptoms and relationship patterns, addictions, altered states we experience time and again, accidents and our situation in the world, all these processes mirror, when unfolded with awareness, a process logic (Mindell 1985): they express in different modes the same information which wants to come to awareness. Not until the person integrates (understands and lives) the process will it continue to appear in dream, symptoms, addictions etc.

This present childhood dream is interesting, of course, as it gives an exceptionally clear snap shot of the process of the later heroin addict. In his dreaming, the 5 year old child already knows what fate he is up against: an evil children catcher with a giant syringe, a deadly danger.

All we know is that the client is fatherless and the mother has him in a cod besides her bed, which he resents somehow. He longs for contact with both, wants to be the beloved child. The dream tells the story, both personal and cultural, of the child having no place in the land of the adults, feeling exiled and condemned into hiding. The longing of this child is to return to mother and father, to the womb-like time and a place of childhood. He wants to share the bed with mother and feels rejected. The father has abandoned him and he feels wrong.

The image of Mad Hatter with the syringe tells of a deadly force in his life. In the perspective of Don Juan, the Yaqui shaman, this power represents his ally. He is either going to succumb to it and loose the battle or wrestle the ally to the ground and gain access to the powerful potential himself. The child is up against the children catcher and his power and either perishes or grows into that exact power.
Today, in his life as an addict, in the recovery process, the very process depicted in the childhood dream is still happening: the fight with the children catcher is far from over. Sometimes he succumbs to his powers, gives up and gets stung by the syringe, other times he is a grown up fathering and mothering himself.

12.1.3. Unfolding the heat

(Cl and Th stand eyes closed, feeling, sensing inward. The client folds his hands over his chest and senses inwardly, for some minutes in silence)

Cl Nice and warm. Yes, it is!

Th To express that nice and warm feeling in a movement… again. How would that be like…? (client and therapist are standing and moving their arms, then the client unfolds his arms completely, stretches them to sides, opening up his chest). If you could live out of that state in everyday life…how would you relate to people…?

Cl Calm!

Th How would you relate to yourself from this state?

Cl Calm, warm, loving, forgiving…

Th Relate to yourself calm, loving and forgiving. (Th models self-love): Oh, my dear (client name), I love you! (Th strokes his chest).

Cl Great child!

Th This is what you yearn for … And the drug seemingly get you in that direction. Only in that direction though. They never really get you there. Doesn't get you all the way home into your childhood…

Cl It is very true (hands on chest)! I have just seen some photographs I have never seen of me as a child…and not knowing that child. But seen a beautiful and very happy child and very at peace.

Th (jumps up and down with excitement being the child). I am the little guy. Yes, I am very happy. I am very happy. It is a great world here!

Cl (watches and smiles). It is. I am not scared because I was a very happy child.

Th Yes…want to go there, become him and slip into him? Be him? Isn't that wonderful?

Cl That is more than wonderful!

Discussion

During the first part of the session, the therapist operation aimed at accessing the altered state by following and unfolding those unintentional signals, which the client communicates when describing the addictive state, in their respective channels. The "secondary signals" appeared first in proprioception. Deliberate channel changes from proprioception to movement helped strengthening the embodiment of the state. Following almost immediately the first sequence, the therapist intervention still aims unfolding and exploring the altered state of consciousness, represented as feeling/sensing and movement.

How is the altered state unfolded and maintained in the session?

In the beginning of this sequence, the therapist helps the client stay with the experience, first in the proprioceptive channel, by joining him in his attempt to sense inward. The therapist models inward sensing. He allows for silence and mirrors the client's position as well as joins him in the task. This is an supportive measure which follows the client's feedback. The therapist intervention is useful only as long as the client engages in the task. As soon as the client shifts his attention to another process, it can become useless and needs to be adjusted.

The therapist facilitates expression of the proprioceptive state in another channel to globalize the experience, make it more general, more deeply felt and more completely represented: the therapist asks the client to express the feeling in movement and models some gestures in the kinesthetic channel. Positive feedback by the client is immediate: the client's movements become bigger, larger, more extended, they go beyond what the therapist does.

Transfer of the altered state into the present moment

In this example, unfolding of the process starts with the client entering the altered state in movement. There are virtually no limitations as to what a creative therapist can propose at this point. Process work encourages *filling out the channels*, reflecting a process in as many channels as possible or as is appropriate in the moment for a complete client experience of the process. The use of creative means to express the secondary state helps the client to deepen her experiences during a therapy session and prepare for a transfer to relationship or worldwork:

- visual (color, paint…)
- auditory (songs, poems…)
- kinesthetic (movements, dance…)
- proprioception (sensing, feeling…)

From the new state, from the place of embodying the secondary process in the session, the therapist helps the client transfer his experience into relationship or into the world (channel) in some realistic scenario. Oftentimes, it is in the relationship to the therapist or in role play in the present moment that the client can use and practice the new state and thus learn, step by step, to integrate his new mind/body state in a useful way.

From proprioception to movement to relationship, the process flows through channels less occupied by the client. It is in the experience of the addictive state that the client usually finds: deeper proprioceptive experience and a new state of being where self and larger context, relationship and world, merge into a unified whole. The process approach to addiction teaches the client that he or she can live the NCR processes in CR by modeling the core of the experience without drugs.

What is the client process?

The secondary process or altered state the client is working on could be called *the child*, or, *being child-like.* Some attributes of the child state are being very happy, calm, forgiving and loving. However, beliefs at the edge do not allow the client to enter

the world of such child-like experiencing. The edge appears in momentary signals (reaching a ceiling in movement). The mythic "children catcher with a syringe" in the childhood dream is a powerful secondary figure, an ally, further away from awareness. This process and its guessed connection to aggression and power are not addressed yet.

In-session, in following the theme of the child, the therapist unwittingly jumps into the role of the child. One can speculate that the therapist was dreamt up to fill in this role. Now, the client needs the experience. The next step in the transfer process will entail the therapist helping the client to step into the experience of the child and relate from the standpoint of the happy child which feels loved, cared for and appreciated from deep inside.

12.1.4. Heroin, Near-Death Experience and Coma

Th What did you take Heroin for? What kind of state …were you aspiring?

Cl Ironically, I was drawn to use H because I liked the people who live on the edge and at that time the “gothic era” was rather popular where people dressed like this children catcher guy. I felt great in this whole scene and the dark music and the club scenes and ah…I had a little clubbing store and sold retro clothes. I was very much part of this whole scene, living in different places where this was prevalent and of course not really…being afraid of needles, definitely afraid of needles, like I believe most people really are.

Th Um…

Cl I spent about a year where I said: no, thank you, I don’t do that, and did my drinking, but got by, don’t remember a whole lot of abuse when I still was very young. I socially did stuff, drank, and then it came to the point where the people that I idolized, musically, artistically … I began to learn and tried H and did Heroin. I was overcome with this urge to find out what a certain drug gave …like it had some mystical something …some eye opening experience that I needed to experience in order to live in this realm …

Th An eye opening experience that you were hoping for, some…

Cl …some awakening. Something that, say Janis Joplin and David Bowie and all these people that I've heard who have tried it for the dreams … but no one ever told me of the sickness and the physical urge and the sickness of it all.

Th What about the state itself when you did it first?

Cl I would have dreams that were ah, very beautiful, with music and colorful and soft and ah … very comatose like state of dream, heavy dream, and the body being in perfect comfort. I had absolutely no pain in any part of my body. I felt really no feelings of fear, happiness or sadness, just complete comfort.

Th Neither happiness, sadness nor fear, just comfort, absence of pain, comatose almost.

Cl …and I can relate to it as when I was going into a coma for three weeks, almost that sense. With 21, I had a near-death-experience (NDE). I went to the light and everything…It is almost like that. It is very much like that. It is very warm, comfortable, womb-like…
Th There might be a parallel between the NDE and the ASC - in trying to get to some similar kind of experience …Somehow that state seems so meaningful – some kind of a spiritual process, going toward the light. When you came out of the coma you started using heroin?

Cl Shortly afterwards, yes.

Th Hmm …as if you needed to go back there … I want my "comatose state", there is something about it that is beautiful!

12.1.5. Discussion

Attracted by the counterculture on the West Coast in the late 70-ties and 80-ties, in particular the life style, mood and fashion of the gothic era, the client yearns to live on the edge. He searches nothing short of a spiritual opening, a mystical experience, an awakening to some vaguely felt supernatural dimension.

The "Goths" are attracted by the sacral, the mystic, they loved rituals, dark places, candles, dress in black retro clothes, faces white and pale. There is an attraction to the morbid, to death. This is the playground of the syringe man and the stage for the client's life myth to unfold. The figure from the childhood dream re-appears in gothic clothes and recruits the client who unconsciously falls into him, becomes him. Possessed by the mythic figure of the children catcher, in his heroin addiction, he abuses himself, physically and spiritually, and denies the inner child the love and happiness it deserves. This time the child slides right into the syringe, although the fear of needles remains.

The terror and fear the child feels in the face of the "children catcher with the giant syringe" may at origin relate to a real life event, an abuse experienced by the child. We simply do not know and the client does not remember any life events around age 4-5. However, the figure is archetypal: the myth that gives rise to the symbol of "children catcher" expresses itself in the body as a threatening illness and as an addiction. The first occurrence of grand mal epileptic seizures as well as spinal meningitis, both at age 21, lead to comatose states and near-death experiences. Epilepsy remains a life long process. In addition, the heroin addiction too brings the client back to dream-like comatose states, self-induced NDE that allow him to come closer to the experience of light and back to the womb.

The description of the comatose state and the altered state merge and appear, at core, to be very similar experiences. For the client, the altered state entails supernatural experiences of light and a perfect womb-like feeling of warmth and comfort. Returning to the womb, to the blissful amniotic universe, as well as experiencing the light in NDE lie at the core of many transformational processes. In rituals of death and rebirth the neophytes often were lead into a cave, the womb of the earth, for an experience of annihilation of the old self and the rebirth of a new and free identity.

The process has its own logic: the same information is expressed in many channels, in the childhood dream, in body symptoms and in the addiction process until it is integrated with awareness into everyday living. At the core, the search is a spiritual one: for an expanded consciousness which includes the child and the adult and has access to that ultimate feeling the child desperately missed: safety, love, warmth, comfort. Being at home in self and in the world, realizing that they are ultimately the same.

12.2. Roanne: Edges to believing in her dreams

Roanne is a 26 year old Hispanic-White woman, with a college degree who for the past two years, works full time as a photographer for a company in PDX. Her work requires frequent travels to locations along the West Coast.

She saw the ad in the paper for this research trial and responded to it with interest. She appears somewhat guarded yet curious, with very good verbal skills, and open to engage.

Roanne was born to an upper middle class family and has one sister who is two years her younger and does not have a drug history. Her father is Mexican, hardworking, with a very successful business, the mother white Californian, a painter who exhibits her work. The client affirms that in her family they get along fine, at the same time, however, believes that her depression and addiction are connected to the family atmosphere. She describes the father as very controlling and overprotecting: "I could not be myself, he would not allow me to be who I wanted to be." She left her parent's home about three years ago and lived alone, and, for the past year shares a flat with her partner.

Since age 17 she suffered from depression and has had bouts of suicidal ideation. She has seen various psychiatrists over the years for short periods of time and is currently taking anti-depressants. She has never been in psychotherapy apart from the drug counseling sessions in the methadone program.

Roanne began to drink alcohol and smoke marihuana daily at age 12 -13 and all through high school tried LSD, mushrooms, benzodiazepines, cocaine and speed. She snorted amphetamine for almost 2 years, then started to use heroin at age 21 years for 3 years. 2.5 years ago she enrolled in the methadone program and is currently on 93mg LAAM (long lasting methadone). She underwent residential detoxification twice, however, with no serious attempt at follow up.

12.2.1. The bald man with green blood

Th What is your childhood dream?

Cl I don't remember the whole thing but it was … I have two cousins, two boy cousins that are twins and … and me and the cousins were trapped in some crazy mansion or something or some crazy big place that … I remember us being d*ownstairs*, like down in a basement type or *below* you know.

Th Um…

Cl …and the guy who was trapping us there was a big bald man and one of my cousins took some scissors that cut his head, his bald head and it was green blood.

Th Wow

Cl But I think that I read some science fiction book and that's where all those images were came from.

Th Aha. you read about the bald man…?

Cl Yeah, the green blood and the bald head, yeah…I can't remember what it was now. You know, it was just I believe it came from that book but I had it a few times and that's why I remember it. I must have been about 10 because I was reading… a novel.

Discussion

In his seminars on childhood dreams (1984), Jung would speculate that childhood dreams or early memories were personal myths, containing a person's long term process in a nutshell. With Roanne, the therapist did not explore the dream, therefore no personal associations are known. In collective terms, however, the myth tells us about a dangerous place, deep down in a basement of a mansion, where a fight takes place between an old bald green-blooded man and the children. When one of her cousins who she likes very much, cut the top of the man's head, she notices that the big bald man's blood is green.

The collective amplification has the house as a symbol of the self, here a luxurious mansion, the cousin twins may represent aspects of self who are taking up the fight. The basement may represent parts of self not yet discovered, unconscious aspects,

which are incompatible with the upper part of the house (self). The movement in the dream has an archetypal quality: in the "journey through the night" (Nachtmeerfahrt) the heroine gets in touch with deeper aspects of herself, her green vegetative nature, her natural impulses. The dream suggests that for that purpose a journey into the underworld must take place, a trip into the unknown. Her individuation process leads her deep down and inside to get become sensitive to the lesser-known parts of herself, the instinctual forces, the source of life itself.

The childhood dream was asked as a reference for an understanding of the long term process. We will get back to it in the final discussion of the case.

12.2.2. The heroin state

Th What kind of state would you get into, what kind of state were you looking for?

Cl Well, even before I would even …do the actual drug, the whole ritual of doing a drug, and getting the drugs… and things like that would be very exciting …ah…just excitement and …ah ... I felt almost like sitting there with the excitement. And the actual, you know using drugs I would say it was probably just calm…it brought me calmness …where I could feel at peace with me, I guess.

Th Aha.

Cl Like I think that I grew up reading, you know, books and studying artists and people that were drug addicts. I always felt that I could relate. I think I kind of romanticized it. I always knew that I would want to try heroin, you know, I went looking for it because I had learnt a lot about it before I even did it.

Th Artists … fantasies... What is your highest fantasy?

Cl Of course, now I know, you know, I know I know the truth of it but…

Th And your original fantasy, almost like a dream…

Cl Yeah, almost like you do exist in a different world that most people don't know about, and you do get away with a lot of things. You see a lot of things most people don't, you learn about a lot of things, you know, other people don't.

Th Hm…

Cl And as an, you know, artist I was always wanted to have as many different experiences as I could. And I always related to, you know the seedier (smiles) side of life and I was always interested in it and may be that was because I didn't come from that, you know. My parents were pretty … you know, upper middle class and I was always comfortable. I did not have to struggle for that kind of life, you know

Discussion

The therapist begins to explore the altered state the client is yearning for. The client gives a primary process description of her original experiences with heroin. Her ideas and arguments, naturally, are connected to who she thinks she is and how she identifies herself. A person's understanding of the addiction and the altered state as well her personal explanation of how she got to be an addict are important. The symbols and labels point to the deeper experiential process the person yearns; it is in these descriptions that doors to the dreaming process open up.

For Roanne, like for many other narcotic addicts, typically, the chase for the illicit drug provides thrill and excitement and makes for an important element in the overall drug experience. For her, the central drug experience, the effect of the drug itself, brings about calmness and peace. It is like she needs both these antagonistic states, the "up" movement and the "down" relaxation.

In her description of the experiencing of the drug the client offers two equally important states to work with. The client's feedback and the therapist's process will determine which aspect to explore first.

Using combinations of drugs with antagonistic effects is a common phenomenon in drug addiction. Most heroin addicts use a mixture of heroin and cocaine in so-called speedballs, others use cocaine and alcohol, amphetamines and benzodiazepines or, with legal substances, a combination of coffee and alcohol, cigarettes and hot chocolate etc..

These combinations are not random. Our observations show that addictive substances are often coupled. The process hypothesis holds that of each such pair,

one substance is used to support the primary process, another substance is used to access the dreaming dimension or secondary process. The self-medication hypothesis may be valid not only for severe addictions but also for less harmful use of legal substances and food. In addition, while the effects of one particular drug fit the need of the primary state (identity), the effects of another drug fit the longings for far out altered states.

Roanne describes her process as being curious and looking to the cultural avant-garde for inspiration. She has a desire to live creatively and to escape the bourgeois life style and the sense of meaninglessness she feels connected to it. The urge to transcend the normal state and have experiences at the edge of living, is another core element in addictive process. She want NCR experiences, like a shaman, she wants to see what common people do not see and often do not seek. Her spiritual growth must include the underworld, the instinctual side of life and the unknown parts of her own self.

The addiction engages her potentially onto the individuation path that revolves around an inner center. The goal is to grow and become independent of her family of origin, of the collective values and follow her very own values in transcending CR living and embracing inner and outer missing parts of reality. She finds them if she starts to listen to her dreaming and reaches deep into her own nature - descending into the cave - to wrestle with the unknown.

12.2.3. Journey into the Underworld

Th How fast do you feel the rush? Can you show it with your hands…how would it come on…?

Cl Well you know, you have that feeling and it's kind of like…(sharp in-breath, stretches upper body, head up, eyes closed) for a second, when it hit you, you know.

Th Ok. (exaggerates the sharp in-breath)

Cl I think that is what you're … what people are chasing. You get that immediate feeling and that immediate *strong*, *really stro*ng (stresses it) feeling when you can taste it and really feel it.

Th Um…Just feel that first moment and that … (stretching upward). It comes like that …

Cl Right. It kind of, you know, mellows out and then you're just kind of like in a sleepy state.

Th I want to find out what it is particularly for you…everybody has a different experience. What is it for you? Just go back to it and feel that up … and that down …

Cl (goes back inside, head down)

Th When you have a glimpse of it, a sense of it, hold it. Sense what interests you the most.

Cl You mean that I can find it? I just don't believe that I can … that it is something, you know, that I can … make myself to…

A few minutes later the client, eyes closed, engages in an inner fantasy journey, mostly visualizing

Cl (inward) I am picturing a metal shaft … but that I am stuck inside. I don't know if it was me but somebody falling out…like coming feet first out of that metal.

Th Um…

Cl (pauses for 20 seconds): This is weird but I am picturing ah … like skeletons, like corpses kind of …but …bones.

Th Take a good look at those bones…

Cl You know …like flashing. I don't feel like I am there but like … images, you know, just flashing images.

Th Um… you say you're not there but see these images flashing?

Cl I don't know. I feel like I am looking at it so … in a sense I am there but not in that place where I can explore it. Since I only get a little look….

Th Bones, skeletons…

Cl Dirt and rocks in the cave….And now it's … more like corpses kind of like that have been decayed.

Th Just follow your dreams and be in that cave.

Cl Dirt with some kind of light, piece of light, illuminating the dirt so that I can see that it was dirt but otherwise it's dark…

Th That's a good place to be… just be there and notice what happens next.

Pauses 20 seconds

Cl Now all of a sudden I am outside on the top of a building, hanging from the top of a building but seeing ah ….lots of … you know … metal … structures, metal lines … you know … very industrial. Like all of a sudden like I shot up (motions) and out and on the top of a building.

Discussion

In the first part of the segment, the client is beginning to re-access the state, starting out from the description of a climax, accompanied with a deep in-breath and a whole body motion upward. For a moment, she actually is getting close to feeling the rush. With her eyes closed, connecting to a deep inner sensing, she is chasing this immediate *"strong, really strong feeling when you can taste it and really feel it."* This is what she is hunting. As the therapist tries to help her attend to this "high", she lets go into the mellow sleep that follows it. Keeping her attention on the intense feeling and asking her to go deeper into it again, she reacts in disbelief. The edge figure comes up and announces: one cannot reach the altered state without the drug. The client is tempted to believe the inner figure that keeps her hooked to the magic pill, the drug experience, as the only way to feel great. One could speculate that it is precisely this feeling of distrust vis-à-vis her bodily sentient experience, a feeling which she marginalizes, that makes the need to be in touch with it all the more compulsive.

In the second part of the excerpt, the client engages in a fantasy journey into the underworld where she finds herself in a cave. Like Alice, she falls through a hole into a magic land. Spontaneous images of being stuck in a shaft and falling feet first into another dimension are reminding of the shaman traveling through a narrow space into the underworld. Roanne enters a dark cave, the land of bones, skeletons, decaying corpses and dirt. Not unlike the directions given in her childhood dream, this fantasy again mirrors the archetypal journey through the night that the heroine undergoes for transformation.

Edges and beyond

The client does not trust her fantasy yet. As an observer she feels not part of it. At the edge to exploring the cave and its dark corners - the dirt lights up - more thoroughly, images change and she feels transported to a skyscraper, high up into the sky, hanging from one of the structures. The change of topic in terms of visual images indicates that the client got to an edge in staying with the murky, the muddy, the dark and venture into the unknown. She will need help to focus her attention to dealing with her edges and amplify the exploration into the "dirty" aspects. The alchemical opus comes to mind: in the vessel of a trusted relationship, the first step entails the "cooking" of the "prima materia" until the undifferentiated state of the "nigredo" separates into its aspects so that the depression can be worked on and transform.

12.2.4. Doubting her dreams

Th …one part that is trying to feel, and another part that you noticed too…

Cl Right. Then there is this other part in my mind where I am thinking: well, these images are *just* coming up because of noises I am hearing outside and things I've been seeing the last couple of days: Oh, that's because I was just in Seattle up on the space needle looking down at all those buildings and all this metal, you know…I am just trying to rationalize everything.

Th (role plays): Oh….but I want to dream!

Cl Right!

Th And have a wonderful experience!

Cl Right (laughs)!

Th And be loose and open and say: ho! And experience myself and life…

Cl Right! That's why it is so hard for me 'cause I do try to intellectualize everything. I think that is a *big issue*!

Th Now … you've just seen yourself hanging from a building and seeing all this metal. Then this other part comes in and says: "You were just there! It makes sense that you would see that." How do you react to that voice?

Cl Just that it makes sense. The way I look at dreams, you know, I think that dreams all come from like experiences you are having … Your dreams are *nothing new* …nothing you haven't seen or experienced or thought of.

Th "That's depressing!" I would say on the other side: "Life is miserable without dreams."

Cl I mean, that makes sense, no?

Th "No dreams?"

Cl I think they are dreams but I think they are manifestations of reality.

Th "No juice!"

Cl Well, I don't know.

Th You don't know that yet…I am happy to see you start to dialogue, right now, between one that's dreamy, has pictures and things that just pop into your mind… and the other who sort of rationalizes them.

Cl Right. It's just really hard for me to really let go, you know, to being on that imaginary plane. One way I got there is doing drugs.

Th Were you in an imaginary place then …with drugs?

Cl Yeah. I maybe more than without them.

Discussion

This segment shows the debate between two parts and although there is no resolution yet, the client becomes aware of the conflict around rationalization versus dreaming or believing in her imagination.

The therapist uses a two-chair technique without physically moving. He is speaking from a role, an inner part, and plays out the disbeliever, the one that rationalizes: Oh, this isn't a dream, nothing new, plain old reality! The therapist intention is to elicit the responses form the other part, the one that just went through a fantasy journey. However, at this point, the client spontaneously identifies and agrees with the voice and has no means to debate it. Sadness can be felt in her suffering over the conflict. There is an oppressive quality to the part that rationalizes her uncanny experiences:

that inner part disavowing her fantasies, her dreams, her inner journey and not allowing quite yet a letting go and an entering the stream of life.

To abandon the dreaming background of reality is a program on how to create a depression. "…It seems to me that ignoring the Dreaming is an undiagnosed global epidemic. People everywhere suffer from a chronic form of mild depression because they are taught to focus everyday reality and forget about the Dreaming background" (Mindell 2000:7). An inner critic is discarding her dreams, her imagination, and her subtle perceptions. She sacrifices her inner life, her non-consensual experiences on the altar of consensus reality. CR disavows NCR experience and adheres to a primary process of common everyday experience where only the objective, the measurable counts. As Mindell points out, the high incidence of depression in our culture may be a reaction to the decline in our belief in dreaming, in the irrational, magic, uncanny NCR experiences that underlie all measurable phenomena.

12.2.5. The family inside

Th Maybe somebody in your family represents these sides in you?

Cl Ya! My Mom is an artist, you know, and really connected to the creative side, you know, and my Dad's the total opposite and always telling me "life is doing things you do not want to do."

Th Ouch. How depressing!

Cl Right. So that…you know, I was always connected to the creative and wanted to learn from my Mom all about it. He's always telling me: "No, you just get a job and you just do it because you have to do it!"

Th That's a program to get a depression.

Cl Right. Now I can see how that works against me...

Discussion

Mom and Dad represented inside as inner parts in conflict. The father, an immigrant from Mexico, worked hard at realizing the American dream. He made a career as a businessman and married a white Californian woman and settled into a life of success

and money. According to the client's perspective, for him those values count in life even though you might not like it. His wife seems to have a different attitude. She follows her dream and has a career as an artist. She represents the imagination, the Dreaming, art, life.

In this short vignette we see that the critic acts like the father. She has internalizes the father and as an inner figure he oppresses her inner life just like her real father used to inhibit her freedom. As an edge figure his voice reverberates and echoes whenever her sentient NCR experience want attention: this is not significant, does not count in this world. The figure is defending a cultural and a private primary process. The two parents in the client act like two myths colliding. The worlds of CR and NCR clash, a collective drama repeated in an individual life.

12.2.6. Waking up

Th There was a calmness you said and a peace.

Cl Yeah. I just remember the first time that I did it. I remember exactly where I was, exactly what everything looked like and I remember even…being able to … just closing my eyes and everything felt good, you know, my body felt good and where my mind was going felt good…

Th Aha. And we are going to explore what “good” means. It is just a label. What it really feels like is different for everybody. How does "good" feel...?

Cl I don’t know. That’s as close I can say that it was …more like a *dream state*, you know. There was no pain, no physical pain…I can’t … I don’t know the words to describe what the physical feeling is.

Th Um…a huge experience!

Cl Yeah, I mean, it was a huge experience. I had been looking for it for a while, you know, before I had done it so I am sure I had a lot of expectation about what it was going to be like but I don’t think it was…ever really what I expected… It was almost like… even when I do hallucinogens I get into this mind state where I think I can figure out all the questions about life that I’ve had. You know feeling very philosophical I feel like… like my mind *is* opening to things I can’t see regularly, I can’t understand regularly just because I am not connected to it and I think you can get that way through meditation.

Th Aha.

Cl And I think heroin brought me there *as well* the first time.

Th That's deep. So it's an opening, a connection to something philosophical, a connection to something spiritual…

Cl *Right*! Yeah. Exactly it was. It is …it was almost a spiritual thing for me too… I am sure because….

Th Because…

Cl Feeling like I could actually *be at peace* with who I was and what the world is around me, you know. Well, I think that I just inherently have this negative attitude like towards the world. Like a lot of times I...look at people or look at situations happening and …and think how *sad* it is and how *futile* that day-to-day living and everything is a struggle instead of ….you know…other people look at it and see the *beauty* in things. I mean I am capable in seeing the beauty in things and a lot of times I do, but as a whole, you know, I connect with … with the *sadness*…

Th In your normal state of mind you sometimes feel depressed or sad….it makes sense to feel all that. On the other side you wake up to the beauty and the wonder and you have more connection to that and that's gonna be your healing…

Cl Right!

Th …for depression *and* the drug addiction, same thing.

12.2.7. Discussion

The therapist approaches re-accessing the state by giving only a minimal input. He mentions the description of the state the client has given prior. Immediately, she represents the scene of the event visually. The altered state the client refers to is represented as a feeling / sensation. First a visual image (looking), then the cue to the proprioceptive channel in the closing of her eyes (and verb "feeling"): "I remember …what everything looked like and I remember even … just closing my eyes and everything felt good"). She confirms that assessment immediately by referring to the physical feeling, which she cannot describe. ("I don't know the words to describe what the physical feeling is").

Here we are at the dream door into the river of experiencing, about to enter the altered state by following its signals and unfolding it deeper toward its conclusion. It is a dream state and gets her in touch with another dimension. A state she describes as a

sort of a spiritual opening to a feeling of oneness with herself and the world, an awakening to the beauty, the wonders and miracles of life.

This is in contrast to her primary state in CR in which she experiences herself as depressed and critical, cynical about life and overwhelmed by the futility of it all. Inner criticism and limiting beliefs that foster doubt to dreaming and NCR experiences form the condition for her depression. The sense of meaninglessness and futility that she describes characterizes most addicts and often lies at the root of the process of addiction (see Frankl 1963).

Her search for meaning may have led her to use drugs. Now, learning to open up to NCR experiences without a drug is a new avenue for the client to the state of well being and oneness which she ultimately yearns for. In order for her to be able to follow her dreams and bodily experiences, another step in the awakening process will entail the confrontation with the critic and the doubter inside. Picking up the negotiation with belief systems which inhibit her dreaming may be the royal road to change and movement toward easier access to the altered state of wonder, awe and realization of beauty.

In this short session, the client started to gain more awareness of two conflicting sides in her and learn an inner conflict resolution technique: confronting the rationalizer who steals dreams from the position of the one who has experienced oneness of self/world and is longing to get back there again.

Part XIII: Process Structure Analysis

For the qualitative analysis of the client processes two judges reviewed the transcripts and the corresponding videotapes to answer the following question:

What are the altered states following the therapist intervention?

According to Tart (1983), altered states are alterations in the normal functioning of the mind, specific new patterns of consciousness emerging, which are recognizable not only by the person having the experience but also by outside observers. For Mindell, altered states are states of mind which are different from the usual ones (1989). Altered states are secondary processes, disavowed experiences or, states of mind not associated with ordinary identity. Some of the markers that indicate occurrences of altered states are channel changes into less occupied modes of experiencing, like feeling, sensing, moving, relating with a sense of being in touch with inner felt referents. Cues to particular channels can be found the qualities of the voice, in body positions, eye movements, breathing patterns and, in syntactic structure of sentences and use of verbs (see part XII; Mindell 1985b, 1989b; Bandler and Grinder 1975, 1976). As the person consciously moves into an altered state, the experience is being associated with a new part of self.

The research objective was to find out by means of objective judges whether altered states of consciousness occurred at all in these sessions and to what degree the judges would reach consensus in determining altered states segments (see results). In a first examination of the transcripts and the videotapes, the judges marked segments for the occurrence or absence of altered states, and the agreement was analyzed quantitatively. In a second and third review of the material, the judges were to describe *what* altered states happened based on the client's verbal and non-verbal behavior. Analyzing process structures of altered state segments the judges would name the altered state for each client and determine the modes or channels in which these experiences occurred. In a next step, the judges would condense the altered state description into the core message.

13.1. Process structures 1-13

The results of process structure analysis are presented below. For each client primary process, secondary process and some corresponding channels of experience as well as main edges are listed. The judges' assessment is based on transcripts of segments and videotapes. Typically, every client in the study would identify as an opiate addict, except client (6) who identifies with taking a medication (methadone) against addiction. In contrast, (1) and (12), also in methadone programs, see themselves as dependent on opiates.

Client 1

Primary processes: I am a mother and a full time student. I am stressed, nervous and anxious, I am depressed. I suffer from occasional panic attacks.

We might say that this woman identifies with being a mother, a full time student, stressed, nervous, tired, depressed, and occasionally panicked. From these statements we might deduct possible secondary processes. One could hypothesize that the experiences of being taken care of (the child), of having something to teach the world, of being relaxed, and of being identified with her personal power (the power in the background that causes panic attacks) are further away from her awareness.

Secondary processes: lotus position (kin.), feeling heat from solar plexus like a small ball of fire (propr., vis.), being the sun radiating heat, white and yellow (propr., kin., vis.), feeling energy (propr., kin.); feeling relaxed (propr.)

The urge for heroin can be seen as a reaction to the everyday tension, the depression and lack of energy the client experiences. We might see, at the core of her yearning for drugs, an attempt to connect to her center (sun), her personal power, and to her energy, which wants to expand into the world. One can speculate that what's trying to unfold in her life is a power that emerges from within and that radiates outwards (perhaps this connects to the teacher, the power behind the panic attack, the force chasing her in her childhood dream). As the client goes in and out of experiencing being on fire, being the sun radiating out, she comes to edges in connecting to the

pulsating energy, the sense of her own power. Her edge beliefs need to be explored and her struggle supported to picking up the power that has been haunting her in the childhood dream, and which wants to be confronted and integrated into everyday life.

Client 2

Primary processes: I'm depressed, I do a lot of self-editing, self-censoring. I am a student. I am lonely. I miss companionship. My girlfriend rejected me. I cannot fully express what I feel. I cannot fulfill my potential in relationship and in the world.

The client identifies as being depressed, self-critical, lonely and missing intimate relating. In his mind, some unknown force keeps him from expressing his feelings and realizing his potential in relationship and in the world. For the client the drug effects cover up loneliness and enable him to connect intimately. Possible secondary processes are related to a person who has intimate feeling contact to self and others, possibly also a leaner and teacher in the world. One could speculate that for him the one who make decisions and is able to draw boundaries in relationship is a secondary process.

Secondary processes: Feeling heavy (propr.), floating (kin.), hot (propr.), my skin is warming up (propr., rel.), feeling sense of sharing and intimacy in relationship (rel.)

As the client begins to access sensory-grounded experiences and feelings, a sense of warmth and heat, particularly in his skin, he warms up to a sense of intimacy to self and others. At the same time, there are strong edges to going deeper into his sensations and feelings. His need for intimacy and relationship is touched upon but not yet expressed in the moment. In follow-up sessions, the beliefs around the edge keep him stuck as well as the inner critic who edits his spontaneity need to be addressed. Possibly, an aggression potential lures as a secondary process behind depression and harsh inner criticisms.

Client 3

Primary processes: I am depressed. I am lonely. I am in recovery and 90 days clean. I am afraid of and cannot associate with people in- the scene. I want to work as a group facilitator with adolescents.

The client identifies with working hard on recovery, however, afraid of relapse potential. He is depressed and lonely, and experiences difficulties associating with people outside the drug scene. Possible secondary processes hinted to are the adolescent in need of guidance and the counselor who could be the helper. In the aggressive potential behind depression may lie the strength and power to pick up the counselor and help the adolescent.

Secondary processes: Feeling warm, hot, soothed, all pain ceases (propr., rel.). Self-soothing, self-caressing (propr.). Feeling loving to self and others (propr., rel.), comforted in womb-like state (propr.). Being a great child, loved, accepted and happy (rel., propr.).

Heroin use brings about NDE[1] - during which experiences of light and detachment in a perfect womb-like state predominate. Against the backdrop of feeling rejected as a child, his yearning is to return to the womb, his spiritual home. In the session, the process is reflected in the client's work on self-love and self-soothing, being the happy child and the parent who adores and soothes the child. However, this "high" is threatened by the "children's catcher", a powerful figure with a giant syringe (childhood dream) that is murdering the child. The long-term process revolves around confronting the aggressive inner "killer" of the child to procure its power and use it in everyday life rather than act it out unconsciously.

Client 4

Primary processes: I was sexually and physically abused by my father, rejected and abandoned by my wife. My family was taken from me. I feel hate and resentment. I

[1] Near-death experience

have heroin, my girl. She doesn't reject me. I feel a brand new world high, and the shit of it all. I am going to take myself out.

The client identifies with being the victim of abuse, rejection, abandonment and loss. He feels rage, hate and resentment. The drug helps him warding off these overwhelming affects and soothes him with unconditional acceptance and peak feelings. In the disillusionment suicide threatens. Secondary processes, by implication, are a positive father, self-love and self-acceptance, the power in the aggressive suicidal tendencies to overcome aspects of self that need to die.

Secondary processes: Seeing dreams, vivid colors (vis.), a raccoon playing (vis., kin., rel.), people relating with me (rel.), a girl moving (kin., rel.), being a child and being a good and loved child (propr., rel.)

In the session, accessing the yearning for a brand new world high, the client came to edges to sensing his body, his feelings and relational needs in the moment and instead, would divert into visual fantasy and imagery. He also experimented being "the girl" (which may relate to the "heroin" state), a comforting, accepting and loving part of self. In the background the perpetrator lures, the negative father, whose power is split off, and which reappears in his suicidal tendencies. Further therapeutic work may help him pick up the aggression and "kill" internal aspects of self rather than acting out. In the long-term, possibly, the client may be able to take over the energy of the father and learn to father himself and give the inner child the love it deserves.

Client 5

Primary processes: I am gay. I have shame and guilt. I got raped in prison. I am angry. I am working on praying for the abusers but would rather shoot them. I lost my partner of twenty years to an overdose. I am depressed and suicidal. I have attempted to kill myself three times.

The client identifies as having shame and guilt, anger, feeling depressed and suicidal. As the victim of homosexual rape, instead of praying for them, he would like to kill the

rapists. In addition, the loss of his partner to OD[2] and several attempted suicides point to the aggression in the background, the figure of a "killer". Also, possibly, a spiritual process of detachment and transformation is inherent in his wish to die.

Secondary processes: Being dead, being in "nothing" state, no thinking, no feelings, "no mind" state. In contrast, feelings of sadness, mourning, grief, anger, rage are disavowed (propr., rel.). Having superior weapons on an island, being left alone, and providing a safe haven for gay people (rel., world).

On heroin, the central experience for the client is "death". In session, the client turned inward for long periods of time and got close to experiencing a "no mind" state. One could speculate that in the "no-mind" state lies an attempt at detachment from the primary identity. If he is to live, he is to be "a dead man in life": the "no mind" state may provide the detachment he needs to use his weapons for, instead of, against himself.

First, his edges are to "burning the wood" - his anger and rage, the sadness, grief and pain - to become truly liberated. So far, in addiction, in depression and suicide attempts, he is turning his anger against himself and acting it out (learning, in treatment, to pray for his rapists may amplify the depression since there is no avenue for his anger but against the self). The inner rapist and the homophobic are murdering him. Long-term work will need to address their power and help him use it for building a safe haven in the world for himself and his brothers and sisters.

Client 6

Primary processes: I feel better now on methadone. I can hold a job down. I don't have to lie, cheat and steal. I work in a tattoo shop. I live with my parents. I have a terrible sweet tooth.

The primary process is that of an adapted 32 year old man who lives with his parents, loves sweets, and occasionally works in a tattoo shop. He identifies with being on medication (methadone) which makes him feel better. By implication, secondary

[2] drug overdose

processes are all the feelings he needs to medicate against, being independent, his own parent.

Secondary processes: Moving, floating, swinging (kin.), feeling of having no bones, no tension (propr.), calm, no stress, relaxed, tranquil and serene (propr.), totally comfortable inside, in tune with everything within me (propr.), release (hand motions) (kin.)

In-session he accesses relaxation, release and a sense of being-in tune with core self, calm, still and serene, which may, in part, be close to the medicated primary process. On the other side, both strength and power to care and fight for self appear somatized in tensions and in the disquiet he experiences. His central edge may revolve around the childhood dream of a drive-by shooting, in which a tough guy shoots at him and his friend. One might speculate that the process in the background is to be tough and street-wise, pick up the underlying aggression (the one shooting, his rebellious life style, rebel clothing, defiant attitude) and move toward integrating his power rather than acting it out unconsciously.

Client 7

Primary processes: I am alone. I don't trust anyone. I have a void inside. When I stop drug usage, I need to fill the void with something else. I have not yet grieved the death of my father. I believe in God, spirituality is my key to recovery.

The client identified with being alone, not trusting, feeling empty inside. He has recently lost his father and yet not mourned the loss. He believes in God, a Higher Power which is, for him, the key to recovery. One might speculate that the sense of "something" with which to fill the void is secondary, also the father (fathering himself), feelings of grief, someone who trusts others and can be trusted. By implication, further away from awareness is God, or spiritual experiences he yearns for as prerequisites for his recovery.

Secondary processes: Feeling mild, meek and easy; comfortable, relaxed, good from head to toe (stroking himself) (propr.); fulfilled, not missing anything (propr.). (Arms

upward, moving full circle): there is a completeness, a wholeness coming (kin., propr.); (moving) going slow and easy (kin.); close to God, spiritual fulfillment (propr., rel., world).

One of his edges is to trust, to opening up to feelings and to others. His very first memory depicts affectionate relationships to father and grandmother, with associations like "being home" and "belonging". In-session, the client is fluid in going over edges to self-love (stroking himself, touching heart/chest), moment-to-moment ease and spiritual fulfillment instead of inner void. He is working on trusting in people (the therapist in session) and in God and integrating his belief in a Higher Power into everyday living. The power that corrupts that trust and alienates him from self and relationship time and again, may be the ghost-role in the background, a figure implicitly present but not identified in the process.

Client 8

Primary processes

I am married and we have a child. I am in court with the state over custody. I was in the military so I am trained to do whatever is said and show no emotions. With my wife the dominant one, I did the submissive role in S&M role-play with customers. I would realize that we could share and trust each other. In the end, I was using everyone for my ends.

Primarily, he is identified as fighting for the child and the family against the state; as a submissive, in control of emotion, using everyone for his ends. One could speculate that one secondary process is being in power and father himself; another, being the child in the family. His yearnings are for deep mutual sharing, love and trust.

Secondary processes: Soothing, relaxing, centering, happiness, warmth, love (propr., rel.); (embracing self) accept yourself! (propr., aud.); I feel like a baby being rocked, feeling love (propr., kin., rel.), feeling of self-validation and self-love (propr.)
For him, the yearned for state is lustful, warm, euphoric, being together and sharing anything, feeling nurtured, child-like, safe. In-session, he could access feelings of self-

love and self-soothing, holding and stroking himself, being a loving father to self. He felt that there was a more…he could not reach yet. A first childhood memory is a vivid image of an old loving couple at his Grandma's (who stands for love and family). A second memory, at age four, is the family in shock because of the murder of his aunt. Perhaps, a long-term process revolves around integrating the figure of the "killer", now unconsciously disrupting the family, undermining happiness in relationship, belonging and trust, and redirect it to "kill" the addiction and the saboteur of family life. Follow-up work will focus on integrating self-love and using the essence of that state in his everyday relating.

Client 9

Primary processes: I am self-critical, angry and critical of others. I'm angry with my parents. I am afraid to be alive. Fear is running my life. I am in a fight with God. I don't have the answers. I cannot win the game.

The client's primary process is being self-critical, angry and critical with parents, other people and God. She feels afraid (of life), is in a fight with God, desperate for answers. She is in a spiritual battle with God about the meaning of life. Secondary processes, by implication, are feeling confident, feeling her anger, expressing herself clear and direct in relationship, being a parent and, ultimately, being God. In an infinite game there are no losers, and the answers come from a deep source within.

Secondary processes: Feeling comforted, peaceful (propr., rel). Feeling I matter to God, to the universe (rel., world). Feeling carried (kin.), safe, happy, loved and accepted (propr., rel.). Abstinence periods are related to the mystery, to having enough God in me.

On opiates, God is wrapping a silk comforter around her. On opiates, she loves herself and others better and feels she matters to God. In session, one of her edges is to feel close to or be God. If she felt God, she would know she mattered and that all was ok. She is shy to feel and express her anger and be direct in relationship. The long-term process around her fear of death and disavowed aggression appears in her first

childhood memory: the fear of dying in the fangs of a vicious aggressive dog. In the intervention session, edge work revolved around negotiating with God, picking up her anger, and identifying the belief systems, which stop her from doing just that.

Client 10

Primary processes: I am crazy. I am so hyper (manic) - it scares me. I am a ball of speed. On heroin, I don't worry. I have no pain. I feel alive and can take care of business. And it makes me so sick. I cannot stand it! Ten times I well nigh died of an overdose and once a man almost strangled me to death.

The client feels overwhelmed by affects that scare her. She feels on speed. She feels conflicted about the positive sides of the drug effects and the destructive sides. Secondary processes, in contrast, come up on heroin: she feels calm, has no worries, no pain, can take care of business and feels alive. Other secondary processes are the suicidal one and the killer in the background, appearing in OD's and as customer who almost killed her.

Secondary processes: You're in your damn nod! Wake up! (rel., kin.). Feeling wonderful, relaxed, good (propr.), (moving from side to side) feeling real comfortable (propr., kin.); (deep breathing, full arm movements, self-stroking) feeling so relaxed and ready to do homework! (Stroking herself): I am learning. Good girl! (propr, world).

After an initial edge to entering her process, as she begins to focus on her drug experience, her state changes and she slows down, centers, and soothes herself. An inner part appears with a wake up call, ready to clean up her act. At the end of the session an insight occurs: "The more I slow down, the clearer I can think. I am learning! Good girl!" She effectively practices re-accessing between sessions to soothe and calm herself. Follow-up sessions will involve working on the critic and its deadly aggression, confronting her suicidal tendencies - and integrate the killer to finish off the addiction rather than acting it out.

Client 11

Primary processes: I am on heroin maintenance. I am afraid of heroin. I am careful, I never lost consciousness on drugs. I saved many people who OD'd. I am self-conscious. I am afraid of intimacy, commitment and relationship. I am walking through my fears now relating to you in personal, intimate way.

Based on these statements, the client identifies as a cautious user who is afraid of the drug's lethal potential, never lost consciousness, a lifeguard for self and others. He feels in the grips of an inner critical figure censoring him and holding him back in relationship. Some secondary processes are, perhaps, the one who loses awareness or self-consciousness and OD's to the restricting suffocating aspects of his primary process so that he is free to relate to his intimate feelings and commit to his whole self. On heroin, he feels warm, self-confident and relaxed in midst of relating.

Secondary processes: (Leaning back, turns slightly, kicks head back): kicking back, it is you and it's not me (rel., kin.). Feeling comfortable in my own right (propr., rel.). Feeling self confident, intimate feeling for self: It is real calm (face relaxes, breathing slows): I don't need anything!

In-session, the client is up against the fear of feeling and expressing emotions as his emotional needs for intimate relating get subjugated by the edge figure, a suppresser that chokes the flow of his many feelings. In his childhood dream, his mother (who stands for love and passionate living) fell into a ditch and drowned. The little boy watched helplessly without being able to save her. In the yearning behind the need for drugs, in the altered state, a self-confident person appears who feels comfortable, self-assured, more intimately connecting to himself. A calm and confident figure emerges who sets boundaries, feels present in his own right and fulfilled from within. Next to integration of this new personality state, follow-up sessions would focus on the edge figure that disavows feelings and needs.

Client 12

Primary processes: I am in relationship, I am a photographer and an artist like my mother. I am depressed. I am sad. I feel the day-to-day living is futile, a struggle. My father would not allow me to be myself. I do not believe in dreams, I intellectualize.

This client identifies with partnership, profession as well as her depression and sadness. Primarily, she seems to feel oppressed by what she calls life's futility, the daily struggle, her rationality and, perhaps, some no-dream hard-working ethics. In contrast, heroin is connected to excitement. It would make her feel at peace with who she was and with the world around her. In the state, she would experience in a kind of spiritual opening, the beauty of life. Based on her description, the father's ideology is setting up the edge to dreaming, excitement and the perception of beauty in life while her mother a an artist seems to represent a secondary process.

Secondary processes: (Sharp in-breath, stretching upper body, eyes closed): immediate strong feeling of an ecstatic "high" (propr., taste). Feeling excited (kin., propr., rel.), feeling at peace (propr.), living in a separate reality with non-consensus experiences (rel., propr, vis.). Dreaming an earthy cave, the dead, corpses, skeletons, dirt (vis.).

The fantasy trip in-session is an exploration into the unknown sides of herself ("Nachtmeerfahrt"), her deepest nature, her instinctual side, connecting to her disavowed parts ("dirt"). Perhaps her central edge, she doubts the reality of her dreams, and cannot go deeper into experiencing her yearnings as a strong rational side casts doubt on virtually all her experiences. Her childhood dream (cut the head of green blooded man) and in-session imagery are congruent in pointing to her task which is to integrate both rational and dreaming selves. Follow-up work could focus on the edge belief systems (father), and the conflict with her yearnings for non-consensus reality, for art, excitement and beauty (mother). She will need contact with the aggressive potential, which is now directed against the self in her depression. The metaskills of the father will be useful to confront the father and cut through the one-

sided rationality to letting her dreams and her feelings express themselves more freely.

Client 13

Primary processes: I am twenty years old. I quit college. I have no job. I am depressed and worried. I feel alone. My father died of an OD last year, this week my friend OD'd. I would love to go to high school and tell students: don't do drugs! I value possessions, money, sex.

This youngest client in the study feels like a loser, without a future, depressed and worried. He has lost his father and a friend to drugs and feels terribly alone. Implied secondary processes are the father, the student and learner, a counselor who helps him clean up his act to live a productive life, fulfilled in work, relationship, and sexuality. In the background, however, the threat of OD or suicide lures, the killer who threatens to destroy the dream.

Secondary processes: Feeling good (propr.), lucid dreaming (vis., rel.). Time and space bend, no distinction between things, everything together, melting into each other, no edges (kin., propr.), feeling of numbness (propr.), being elsewhere, detached from body (propr.), my soul is lifting out of it for brief moments (kin., world).

In-session, the client had an edge to picking up the "drug counselor" who wants to clean up the addiction. In re-accessing the yearning, he engages in a fantasy trip and looses consciousness - bringing few conceptualizations back to CR. His central edge, perhaps, is to wake up and focus on his process with awareness rather than escape into unconsciousness. His altered state revolved around out-of-body experiences and experiences of oneness, all of which could be aspects of a spiritual process. This twenty-year-old, however, may not yet have a sense of self (to let go of). In letting go, he acts out the drug-state rather than using his awareness to focus on his inner experiencing. Follow-up work will need to help him access the emerging inner "drug counselor" who wants him to clean up his act. To that purpose, he will need to pick up his suicidal tendencies and use that aggression to "kill off" the hopeless addict and positively father himself to reach his goals in life.

13.2. Summary of processes and core messages (Table 11)

	PP	SP	TP/ALLIES	CORE MESSAGES
1	I am student. I am depressed, anxious, I have panic attacks.	Being the sun that radiates energy outward. Teacher. Connected to personal power.	Unknown power which threatens her life	SUN = SELF/ WORLD
2	I am depressed, feel lonely, rejected, I am self-conscious, self-censoring.	Having intimate feeling contact with own self and others.	Aggressive potential, the power to reject, to say "no".	RELATIONSHIP = INTIMACY, BELONGING
3	I am depressed, lonely, in recovery. I am a counselor.	Being the happy child, accepted and loved.	The children catcher, an aggressive figure destroying the child	CHILD = SELF
4	I am abused, rejected, and abandoned, suicidal.	Self-love, the child feeling nurtured, comforted, accepted.	A perpetrator, the powerful negative father.	CHILD = SELF
5	I am depressed and suicidal. I was raped. I feel shame, guilt and anger.	Self-love and acceptance. Feeling and expressing the anger.	No mind state. The power of the rapists, the killer	SELF/ WORLD = SAFE HAVEN FOR GAYS
6	I used to feel tense. I feel better. I live with parents and can hold a job	Sense of self, self love, power in the world	Aggression, the figure of the gunman	SENSE OF SELF
7	I am alone, I feel an inner void, I do not trust anyone. I believe in God.	Feeling meek, easy, relaxed. Feel God in everyday life and sensing spiritual fulfillment.	Power that corrupts trust and relationships	SPIRITUAL CONNECTION TO GOD
8	I'm married, have a child, in custody battle with state. Submissive, abusing others	Trust, self-love, intimacy and sharing in relationship. Father inner child and family.	Killer who disrupts the family, belonging and trust.	RELATIONSHIP = INTIMACY AND BELONGING
9	I am self-critical, angry. I am afraid of death. I am in a fight with God	Self-love, expressing anger in relationship, feeling close to God	The power which threatens her life, the vicious dog in her dream.	SPIRITUAL CONNECTION TO GOD
10	I am hyper, tense, as if on speed. I OD'ed 10 times.	Waking up. Feeling relaxed, comfortable, having a sense of self. A learner. Self-love.	The force driving her to hyperactivity; the killer	SELF LOVE: CENTERING
11	I am self-conscious, afraid of intimacy, commitment	Self-confident, fulfillment from within, in touch with and expression of feelings.	Police and prison system who tell him to clean up his act.	SENSE OF SELF / RELATIONSHIP INTIMACY
12	I am depressed, I am sad, life is futile, I am not myself.	Being her whole self. Believing her dreams	Negative father who won't let her be her self; a critic	SELF LOVE: DREAMS
13	I am a looser, I am depressed, lonely. My father died of OD.	Being conscious and awake. A drug counselor, cleanup his act.	Suicidal killer, critic	SENSE OF SELF: WAKING UP

13.3. Core messages

Process structure analysis is summarized in condensed form in the table above. Primary processes (PP) include the most salient descriptions of a person's momentary identification in-session; secondary processes (SP) summarize in-session altered states. Tertiary processes or allies (TP/ALLIES) are deeper processes which lie further away from client awareness but which are implicitly present in the material and referred to in-session. They are the biggest threats or challenges to one's life representing, at the same time, one's greatest power. Finally, altered states experiences actually achieved in-session are compressed once more into categories representing the core messages in the client process (CORE). While most processes touch on psychological, social and spiritual issues, the stated core message simply points to the most accentuated element in a person's process at the moment.

13.3.1. Psychological messages: Self-love

Some of the core messages revolve around images of the Self like the "sun" (1) or the "child" (3, 4). These dynamic symbols of the Self in the collective unconscious organize the individuation process and pull a person to grow and develop in life. Other messages can be interpreted as expression of a yearning to have a deeper connection with and more of a clear sense of self (6,10). The process of one client (12) revolves around her hesitation to entering and believing in her NCR experiencing. Her core process is the edge to the imaginary plane of dreaming, which she seemingly accesses with heroin (see 10.2 and below). The youngest client's process (13) revolves around waking up to a sense of self, to his inner teacher and clean up his addiction.

(1) The heat is coming from my solar plexus. I feel like a small ball of fire. Like the sun radiating heat.
(3) I am a great child, a very happy child
(4) I am a child and I am good
(6) I am in tune with everything within *me.*
(10) I feel calm and can think clear. I am learning! I am a good girl.

(12) It is hard to let go and dream.
(13) I love to go to high school and tell people: look, don't do that!

13.3.2. Self in relationship messages: Intimacy and belonging

Three core messages stand out to relate to self-love and, at the same time, to a deep yearning for trusting relationships, for the expression of one's deepest feelings in relationships and the creation of shared intimacy (2, 8, 11). The first client (2) yearns for contact and intimate relating and sharing, however, in-session comes up against a strong edge. For another (8), heroin brought about powerful intimate experiences, which he is trying to integrate without drugs: feeling nurtured, safe and completely at one. Yet another client (11) expressed his yearning to know himself and to share his feelings in intimate relating.

(2) I am able to express any thought about things that never came up in conversations before. We just bonded (motions) on another level I was not familiar with (edge).
(8) (Hears voice) Accept yourself! That is the love state…a validation of myself. I am open to share anything, to being euphorically together.
(11) I kick back and I am relaxed and comfortable in my own right. I am in touch with my feelings. Showing emotions and express them (edge); being personal, intimate with you and me now.

13.3.3. Social messages: A safe haven for gays

The core message in one client's process (5) is social and addressing the mainstream for its abusive homophobic attitudes. Also, it refers to self as well. He expressed his experience in a strong image: he would have his island and have powerful weapons with which to defend it; he would invite all the gays to come and live on the island - create a safe haven for gay people. The social message is important: the creation of a safe haven for gays against homophobic attackers. The same image perhaps reflects his psychological need too for a safe space, for inner peace against his anger, his suicidal tendencies and maybe even his internalized homophobia.

(5) I had my island and superior weapons. People wouldn't leave me alone and I would defend myself against them and then I would invite all gay people in - a safe haven for gay people.

13.3.4. Spiritual messages: Union with God

Two clients were referring to God as a healing power against their addiction. In re-accessing the altered state they got in touch with their deep spiritual need in the background of their drug use. One client (7) believes that spirituality is the key to recovery. He explained that since he was filling an inner void with drugs he needed to replace them by something else. In the session he was sensing spiritual fulfillment and the presence of God. The other client (9) is in a spiritual battle with God who she needs to feel close to but rather feels abandoned by most of the time. Whenever she feels close to God, there is no more battle. She then can stop using since she knows deep down that things are all right the way they are.

(7) Where there was an empty space there is completeness, a wholeness coming…I know it is God. Yeah. I know it is (extends arms all the way upward). It is like opening up. Wow. A total completeness…

(9) I am pissed at God. It feels like I can't find the answers or win. I continue to play a competitor I can never beat… If I could feel God I would know that all was ok (edge).

13.4. Edges

The focus of this study was to explore the altered states and discover the varieties of experiences addicts crave for. Therefore, less attention was given to the edge and the negotiation process at the edge. However, particularily with addictions, it is the edge against the altered state which often fuels compulsive drug use. The addict has come to believe in the course of his career that there is no way to faciliate the much needed state change other than by way of ingestion of a magic pill. Hopelessness prevails. The barrier to the yearned-for state seems insurmountable. Self-medication becomes a means to "tunnel" the edge to allow for experiences, at least temporarily and approximately, in the direction of the yearning. What may look like a "cure" to alleviate

the problem state, however, eventually becomes the addictive process itself precisely because the edge figures are not dealt with consciously (Hauser 2000).

An important goal in the therapeutic process is for the client to learn that the altered state is, in fact, accessible without the drug. This experience itself will teach a new way of managing the problem state - and continuous practice will ground the needed state in everyday life. In the recovery process, the client must learn to deal with edges by tranforming limiting beliefs associated with them so that the narrow and rigid primary process opens up. To facilitate the negotiation between parts of self at the edge, various forms of conflict resolution procedures like two chair techniques, role play, voice dialogue etc. can be usefully employed.

Since in unfolding the process, typically, one is confronted with inner figures inhibiting or limiting what we can feel or do, the carrying forward of the experiential process involves constant edge work.

13.4.1. The edge to awareness: Waking up or not?

Maybe the first edge one encounters on the path of individuation is the edge to awareness of one's individual self as separate from the world. Following inner and outer events with curiosity is prerequisite to developing one's awareness. Waking up, then, may mean to become an alert observer of process while, at the same time, fully being-in-experiencing.

The youngest client (13) got deeply immersed in his experiences. He seemed without edges and came back from his inward oriented state with associations to spiritual processes. For him, space and time seemed to have dissolved and he experienced oneness and edgelessness. However, he was going into the altered state without much of an observer present and looked like he was on a drug-induced journey. When the therapist tried to help him focus on whatever his experiences were, the client reported that he had lost consciousness several times. This 20 year old man seemed more interested in the drug trip than in waking up and, at this point, the alert "drug counselor", an inner teacher, is still far away from his awareness. His process is

to wake up to his psychological development, which, at this point, is the secondary process that matters most. The spiritual process in the background may pull him toward transformation and detachment, to gain a renewed interest in self and life.

(13) I feel detached from my body, I feel like my soul is lifting out of it ... (Later, coming out of the experience): Drugs would make it even better!

13.4.2. The edge to experiencing: What do I feel?

All 13 clients in the study exhibited considerable difficulties to focus on their inner life, which is reflected in the relatively low scores on EXP and PI. The central edge in the work with addicts seems to be the "edge to getting into the process" (Mindell 2000:66). Their disinterest or rather, their difficulty with focusing on differentiating and unfolding their bodily felt experiences is typical for clients with psychosomatic symptoms and addictions. A life long training in marginalization of inner experiences, probably a consequence of trauma and neglect, can lead to somatization and/or addictive processes.

In the initial session the client (2) described his difficulty as being too self-conscious and as a result, feeling inhibited.

(Cl) I do constant self-editing and self-censoring …(Th) how does it limit you? (Cl) just not being able to express what I feel and um…keeping myself and my opinions on a subordinate level to those around me…I am not sure if (what I feel) necessarily is a valid contribution.

While he was exceptionally skillful verbally, in the experiential session, he had great difficulty sensing the flow of inner experiencing.

(Th) What do you notice right now? (Cl) (closes eyes and focuses inward for *a minute*) well...kind of like …um … a floating feeling (*another minute)…*but um…heavy…sort of hanging …all over my limbs…it's not unpleasant…

While the therapist tried to support the floating feeling, the heaviness, or encouraging his sensing into the essence of these experiences, the client would not, however, go any further and remained inward and silent.

(Th) Are you experiencing heaviness or floating or did experiences change? (Cl) A bit. I am becoming more aware of the kind of …flush and um…increased skin temperature.

How could the therapist facilitate movement rather than not? It seems, retrospectively, that the client's block to experiencing should have been addressed and worked on in the channel in which he is fluent in, namely, verbal. This could have been an opportunity to getting to know the inner editor or critic and engage in a dialogue between the editor / critic who stops and interrupts experiencing and the one yearning for intimate connections within and in relationship.

13.4.3. The edge to believing in dreaming: Is it real?

While some clients in the study had an edge to the process, others had more focusing ability. They used their attention to notice images, movement tendencies, body sensations or feelings and were awake to the negotiation process at the edge. However, they feel stopped or blocked due to doubting the significance of what they experience. This kind of "edge to significance" (Mindell 2000: 67) indicates that although there is interest, awareness and focusing abiltity, the client dismisses dream-like experiences as having no significance or meaning. These clients usually feel fenced in by the primary process and may use drugs to access dreams and escape the prison of CR.

The client's process (12) has been described in detail. Her edge is to believe in the significance of her experiencing. This time, the therapist tries to engage her in the negotation process between the consensus realist, the doubter, and the dreamer.

(Th) (role plays) I want to dream! (Cl) Right! (Th) And have a wonderful experience! (Cl) (alughs appreciatively). (Th) …and experience myself and life (Cl) Right! That is

way it is so hard for me 'cause I try to intellectualize everything…(Th) ….How do you react to that voice? (Cl) Just that it makes sense…Your dreams are nothing new…nothing you haven't seen or experienced.

In the negotiation, the client sides right away with the inner "realist" who does not value dreams, art, creativity, imagination. While intellectually she understands her "problem", nevertheless, she cannot experience their significance yet. However, the negotiation process has been initiated and follow-up sessions will help her have it out with the doubter and integrate dreaming in her life.

13.4.4. The edge to the universe: Fighting with God

This edge tends to separate us from the environment. While we cherish and need our separate identities and self-consciousness, however, the "edge to the universe" (Mindell 2000:69) also dissociates us from the world we live in and may be reponsible for much of the environmental destruction humans cause. Most people hold on to the belief that they are "other" than the environment, the world or the universe. They doubt the myths which inform them that the gods and goddesses they rever are images of their own transcendental and transpersonal experiences. According to Mindell (2000:70) the edge to the universe is linked to the fear of death, the dissolution of our personal selves in extreme states, to the fear of fate which shows up in our surprise when synchronicities reflect our intrinsic interconnectedness with the world.

One client's process (9) revolved around her fight with God. She needs to know that she matters to the universe, however, feels alone and without answers. Her fear of death runs her life, she says, however, on opiates, she feels close to and comforted by God. In the session, the therapist was trying to help her into the altered state by identifying with God and become the big comforter she so desperately searches for.

(Cl) I really feel pissed at God a lot of the time. It feels like the whole thing is stacked against you. It feels you cannot find the answers or win. I continue to play a competitor that you never can beat. (Th) God! Goddess! I am pissed at you. What game are you playing with me? (Cl) that is very true. (Th) I am human and…(Cl) I don't know the

answers (Th) I want an answer, God. (Cl) Yeah! I don't even understand the rules (Th) I am beating myself up for not doing the right thing and I am not even sure what the right thing is (Cl) Boy, is that *exactly* right! (Th) (whispers to her, Try to be God) Answer, God. (Cl) I never can feel God like I want to. I feel afraid to be alive. (Th) If you *could* feel God, what would you feel? (Cl) that it wouldn't matter what any person or anything did…(even) if you got killed…you would know that it was all o.k.

She would not pick up God, however, did feel herself melting like an iceberg in the light representing the spirit. For her, the addiction represents a spiritual search. Whenever she feels close enough to God she can quit drug use. "It does all seems related to the mystery you know, that's my experience with it." This client confirms Bateson's dictum that recovery demands a spiritual change (1971).

13.5. Discussion

Because there was an identified task, to facilitate the altered state, focus on conflict splits was less in the foreground. The author was aware that to single out one intervention to study its effects would prescribe a particular intervention at the cost of a more flexible approach. In the course of regular treatment, the process-orientation allows for an open-ended choice of diverse intervention techniques. Analysis of the client movements demonstrates, the author believes, how edges and critics fuel the addictive process by inhibiting access to the altered states the client usually self-medicates for. In a typical process work session, more focus may be given to the edge: hesitation, avoidance, theme changes, rapid and incongruent channel switches which accompagny client movement. The therapist's task is to facilitate incremental steps around the edge and follow the client's feedback. Some useful methods for working on the edge are

-attending to these moments of resistance and discover the hesitation
-discover the beliefs that come up at the edge and have a dialogue depicting the conflict
-look for an encouraging or loving model to help you
-change channels consciously, picture a feeling, move a sensation etc.

-create new patterns, dream into new behavior
-remember moments when you did do or feel what you feel inhibited to do or feel now
-value what limits you and discover its usefulness
-tell a story that embellishes the conflict, use art to express it creatively
Inner critics and negative figures need to be explores and interacted with. Disturbing, unknown powers, perpetrators and killers, in the form of suicide and addiction need exploration. These represent processes that lie furthwer away yet from awareness. Reflected in childhood dreams and first memories, they are part of the life myth. They represent the threat and the possibility of annihilation and, at the samre time, are the hidden source of the client's personal power. When addressed and worked through, potentially, the owning of those ill tempered secondary figures becomes one's powerful center, grounded in oneself, in relationship and the world.

13.6. Reaccessing - a relapse trigger

Diverse, external and internal cues can mediate craving and act as relapse triggers. Thinking and talking about drugs, people, places of use can trigger craving, especially in the early phases of treatment. Re-accessing the yearned-for state and feeling the effects associated with the drug-of-choice, therefore, can potentially evoke craving and be interpreted as a trigger for drug use. Eliciting internal images of the drug chase, memories of street life, recalling of time and places of use, visualizing drug paraphernalia, remembering using and feeling the effects of the drug, can be dangerous territory to tread in the beginning of treatment as most clients would readily admit.

However, it is important to remember that the altered state the client is inducing with drugs is not akin the state of mind the client is in when the state is unfolded without drugs. The yearning serves as a doorway into a process where the senses, our imagination, body and mind are engaged to complete a movement which culminates in feeling satisfaction and insight. In contrast, accessing a drug state leaves the person unaffected, edges and inner criticisms intact or reinforced. Thus, the addictive cycle.

The author advocates that re-accessing can be safe. Clinical practice on the one hand, and evidence from studies on behavioral/cognitive theory and procedures. On the bases of classical conditioning theory, cue exposure without possibility of using drugs, results in extinction of conditioned association. Cue exposure procedures have shown some promising results in extinguishing craving and diminish the urge for the drug over time (Institute of Medicine 1990). Beyond its potential use as part of an extinction procedure, it is important to emphasize that re-accessing the state is but one method in the larger body of interventions in the treatment of addiction. Cognitive-behavioral methods such as assertiveness and self-efficacy training, stress management, social skill training and contingency management are but some widely used approaches (Morgan 1996); individual and family therapy, drug counseling, 12-step programs in combination with or without maintenance programs are necessary instruments for successful orchestration of treatment.

Re-accessing the yearned-for state is best done in phases of treatment that call for expansion of awareness of meaning and purpose of the addictive behavior. In some phases, working on motivation for abstinence (Morgan 1996), in other phases, disciplined abstinence alone or in conjunction with the method presented in this paper prevail. Therapists and drug counselors trying to use the type of intervention proposed in this study need to discuss their intention and act in accord with the facility and the client they work with.

Further, it is crucial that the therapist makes sure all personality parts of the client are congruently in accord with the proposed intervention. The therapist should be careful in noticing and supporting any hesitations in the client and negotiate an inner debate between various sides of the client. Focusing on inner splits will take priority over going forward with the therapist intention. If the client is congruently interested in exploring the altered state, the intervention is to be presented with a sober attitude. It is important for the therapist to be aware of his/her own signals to avoid unconscious siding with drug use. The therapist's own inner work, clarity around her own issues and addictive tendencies, are essential.

The author proposes that cue exposure is part of effective treatment in addiction. Clients do experience craving and most triggering stimuli cannot be avoided (Childress 1993). In addition, since cue-induced craving may be one of the central factors in relapse, relapse prevention better deal with these states of intense craving. In conjunction with exposure, cognitive-behavioral techniques can be applied to extinguish the craving. One method uses recall of cues to increase the magnitude of craving only to successively extinguish craving by means of visualization: the client is asked to associate a color to an intense craving - then change colors; reduce craving by visualizing crushing it (Parker 2000).

In any case, the therapist should attend carefully to feedback from the treatment setting as well as listen attentively to clients, follow their feedback and take their concerns serious. Two clients in the study voiced relapse fears when asked to recall the yearning. In part, this was due to a conflict in treatment model. While their therapist taught them to avoid all cues, the process-oriented approach supported dissociation of drug and state.

Two examples are given below. The first example is client (10), the second one client (7):

13.6.1. Learning to be in the state without drugs

(Th) Just remembering the state is scary. (Cl) To go there, yeah…(Th) Because…? (Cl) Because it is a trigger (looks around the room to other therapists present). (Th) It's a trigger because you learnt to associate drug and altered state. (Cl) That's it! (Th) Now, you learn to separate drug and state and go to the state without drug. (Cl) That's right… this week, whenever I would get really hyper I stop and think about you…and sit down (takes a deep breath) and do this (leans back, closes eyes). And I say to myself, He's probably right, if I could learn to be in the state without the drug, I never do that heroin again. So I sit and do this (moves gently, eyes closed, deep breathing).

The client affirms to practice the technique after a short introduction in the initial session - during which the author introduced it by necessity since she was very excited

and unable to focus. She voices concerns that remembering the state acts like a trigger, however, at the same time, states that the practice really helps her. The two conflicting sides seem to be reflected in a flicker of a loyalty conflict between treatment team (the boss is in the room) and myself during the session. The important message remains that drug-state and the mindful state her practice induces are two very different states. The former reminds her of the latter, which is a basic need, like a hotel room reminds her of home in some sense[1]. A bed, a table, a chair, a mirror, kitchen and bathroom, make it a temporary substitute for home. In addiction, however, a time-limited condition turned chronic and with it, the memory of home fainted. In the compulsion for drugs may be the urge - a vain attempt - to find home, a sense of belonging. In the practice, the client returns home to herself as she sits down and becomes aware of the present moment, in attentive contact with her body and mind.

13.6.2. Learning to separate the state from the drug

(Th) Let's separate them …drug and state (motions unlinking two parts). (Cl) I want that feeling (motions in one direction) …without the drug. (Th) Separate those …(Cl) Yes. I am done with the drug…though…it's difficult to separate the drug from the state because you be like thinking: wow …you almost like want it come back together (motions approaching two sides). (Th) Don't (intervenes bodily). (Cl) And you don't. So then you want this (right hand) without this (left hand)…(TH) Right. (Cl) And then when you think about how you got this (right side) with this (left side) to get that feeling you know it's all …it is not confusion …well, in a way it is …(Th) You get clear that it triggered that fear of … of using …(Cl) Yeah, big time. (Th) Maybe we can clear this up by talking it about right now…(Cl) right now! I know I don't need that drug (left hand) but I want this feeling (right hand). It is almost like …like …(eyes closed) being meek. *Mild!* That mild (rises hands and slow even motions), real mild state, you know this …(even, slow motion) mild. Just to be mild (motions even average). You don't have to be … (gestures up) way up there or you don't have to be way down there … (motions down) … Just meek. Being just even leveled, even keyed…(motions). (Th) Now, as you do this movement, try to feel it, sense it. (Cl) (closes eyes and hand

[1] Thanks to Dr. Max Schupbach who has used this metaphor in class.

motions even, smooth, slow). Just be meek …mild! Just leveled. That's a good ….good …good feeling right there!

This segment shows the difficulties the client experiences in separating drug and state. He is voicing his concerns that accessing the altered state is acting like a trigger for him. He demonstrates physically, with his left (drug) and right hand (feelings/state), the conflict he experienced in dissolving conditioned associations. His hands moving apart, realizing distance and again, coming closer again, modeling association of state and drug. He will have to deal with inner and outer cues and learn that he can safely rely on accessing feelings of well being without drugs. Again, the core message is to be mindful that drug-state and altered state accessed without drugs are dissimilar.

Conclusion

Re-accessing serves as an extinction procedure/ by itself may not be enough to prevent drug craving and relapse over time (Wilson 1992). One's ability to deal with adverse affects, feelings and moods, recognize and handle self-critical voices, develop enough self love to recall alternatives when cues become triggers, are crucial skills in the recovery process. Therapy can go further in the exploration of these proceeding moments before unconscious loss of self to the substance takes place. When relapse fears come up, there is opportunity to work on inner conflict splits. One client above accomplished just that when working on separation between a drug-induced state and a state elicited by following the feelings he yearns for purposefully. He demonstrated the conflict with his hands and had a dialogue. An interaction occurred between the drug - and the state and even a resolution when he found the feeling he was looking for in the moment.

In the other example, the client who in her own words feels "hyper", learn to access the state on her own. An inner (and outer) therapist encourages her to separate drug and state and to believe in her newfound possibility to mediate her own behavior. All she really needs to do is to remind herself that the yearned-for state is there, accessible and ready to be felt whenever she was.

Re-accessing a state serves to explore the experiential process underlying the compulsive drug use and discover subjective meaning in one's addictive behavior. As a tool, it aligns well with awareness work and furthers the client's motivation to explore herself with interest, track inner and outer experiences with curiosity to live the process rather than being lived by it.

The quintessence of loneliness

I am like a heroin addict
In my longing for the sublime state,

For that ground of Conscious Nothing
Where the Rose ever
Blooms.

Oh, the friend
Has done me a great favor
And has so thoroughly ruined my life,

What else would you expect
Seeing God would do!

Since we first met, Beloved,
I have become a foreigner
To every world
Except that one
In which there is only You
Or - Me.

Now that the heart has held
That which can never be touched
My subsistence is a blessed
Desolation

And from that I cry for more loneliness.

I am lonely.
I am so lonely, dear Beloved,
For the quintessence of
Loneliness,

For what is more alone than God?

Hafiz, what is more pure and alone,

Magnificently Souvereign,
Than God.

Hafiz

14. The process of heroin addiction

Mindell (1988) describes some common processes in addiction. Often, a depression is in the foreground and heroin serves to leave the pain and trouble of everyday living. This person needs help a) in dealing with painful feelings, and b) in learning how to reduce pain. In re-accessing a yearned -for state, the client learns an inner work practice to reduce the pain by accessing a more peaceful center. In other situations, when the client is lost in the state without awareness, it may be useful for the therapist to act out the drugged state to effect awareness. In a process reversal, the client might immediately produce a sober state and can then be engaged to help the "drugged one" out. Finally (Mindell 1988) considers that for some clients the use of heroin may be an expression of a shamanic calling. The client may need to explore the edges of psychology and spirituality by investigating their own altered states and healing themselves on their way to becoming therapists or healers.

From a process-oriented viewpoint Van Felter (1987) explored the purpose heroin may serve in the individual's psychology by re-accessing the state. In her analysis she found - consistent with the views of Krystal (1970), Wurmser (1974) and Khantzian (1974) - that heroin helped warding off dysphoric feelings, anger and rage. In her assessment, the process behind heroin addiction, however, is characterized not so much as a flight from as an identification with the inner attacker or negative father whose parental qualities are missing in the addicts psychology. In the altered state, the person seemed to fuse with some core qualities of the inner critic providing feelings of detachment, focus and discipline. She writes that the heroin-state protects the user from the negativity of the critic not only by strengthening defense mechanisms, but by providing access to a state of being in which the addict temporarily feels complete - being one with the father. In re-accessing the state, the addicts "…began to behave similarly to how the critic said they should, but could not behave" (1987:52), i.e. unemotional, concrete, functioning, disciplined, detached, relaxed and focused. The issue is to integrate the power in the background and learn to father themselves (ibid.). Heroin addiction is a

step in the right direction, however, when acted out unconsciously, the power remains unintegrated and what has been called "pseudo-individuation" replaces growth and maturation (Stanton 1979, in Van Felter 1987). She concluded that the addictive behavior tends to repeat unless the information or message contained in the altered state is discovered and integrated.

The present study explored the therapeutic process of re-accessing the yearned-for state quantitatively and found astounding movement or progress on the assessment instruments. This is strong evidence that clients did lean how to reduce their pain and find access to an attitude more centered, peaceful and mindful. The re-accessing sessions provided a means for clients to manage their states and have some power to elicit alterations of one's state of mind.

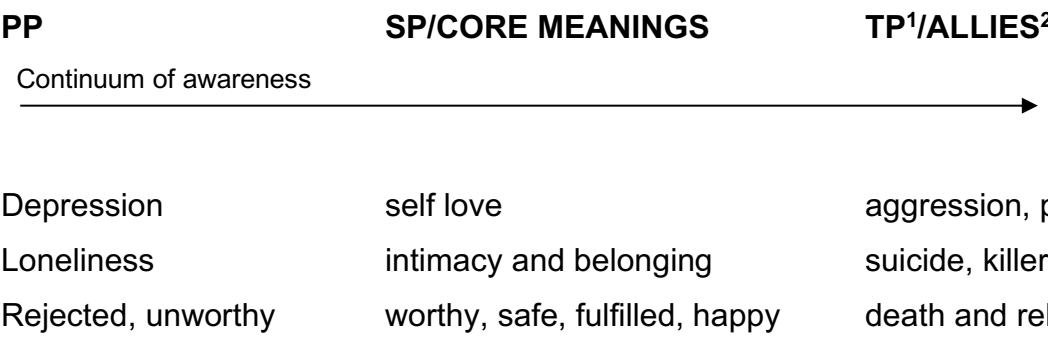
Qualitatively, the present study found that the typical process in heroin addiction revolves around a primary identity as a victim of depression, tension, loneliness, abuse and suicidal tendencies, coupled with self-medication in an attempt to feel whole. The "heroin state", however, brings one to the anti-chamber only of completion and wholeness but never to the Self.

In practicing mindfulness and attention to the need, the client can unfold his yearnings and achieve moments of grace: self-love, the child's happiness, the sun's radiance, intimate relating and belonging, safety, fulfillment, detachment, union and oneness with a Higher Power are some of the qualitative states in the background. Related to these, and further away from awareness, auto-aggressive and self-destructive tendencies are acted out, which threaten the stability of a fragile self-system. Primarily identified with depression and loneliness, in the drug use the client tries to find protection against aggressive impulses, which are often directed against the self, in suicide and death fantasies.

It is in the affects and parts furthest away from awareness where the most powerful allies tread, in the background threatening to annihilate the self. The integration of

these disavowed powers is a central process in heroin addiction. Qualitatively different from less dramatic processes, with heroin users, these secondary (or tertiary figures) are life-threatening. They are acted out in protracted suicide or attempted suicide and overdose. In the clients' life myths, in childhood dreams, first memories and illnesses they are present as an aggressive force, a negative father, a harsh critic, a perpetrator, a vicious animal, or a killer. An aim in integration is to use the power of the ally to "kill off" the negativity, self-destruction and the abuse acted out in the addictive process.

Figure 3: The process of heroin addiction



It is these powerful and aggressive figures, which threaten suicide and death. The meaning of addiction may lie in the archetypal processes around death (and rebirth). In addictions, in its suicidal tendencies, on the edge to death and annihilation, an attempt at change and transformation may be sought. Often, spontaneous altered states of consciousness mark the beginning of transformation of the primary process, which involves a death, or a letting go of one's known identity. Some of these transformational processes announce themselves in addictions or life-threatening symptoms, in near-death experiences, accidents, suicidal fantasies and attempts: "Individuals in the midst of radical transformation

[1] Tertiary processes or processes even further away from the client's awareness than SP or secondary processes
[2] An inner teacher or helper, a power that can become your guide into other worlds or that can kill you if not befriended (seen also Mindell 1993:95ff).

suffer the disorientation which accompanies the disruption of their old lives. Often, they feel like dying or killing themselves" (Mindell 1989: 50).

The search for transformation may express itself in the craving for drug induced altered states. As the addicted person searches to break out of the confinements of the normal state of consciousness, the addictive cycle sets in. Unconsciously, the addict may yearn for initiation, for a transformational death/rebirth experience (Zoja 1989) each time he uses, but fails, because the drug experience doesn't hold and cannot be integrated into everyday life.

The process of addiction demands nothing sort of the integration of death into life. The addict, is his search for altered states may be a shaman or a visionary enacting the missing collective rituals of death and rebirth which in prehistoric times, had been enacted in indigenous cultures all over the world for personal and cultural renewal.

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Appendices A-G

Appendix A: Process-oriented intervention in addiction treatment
Appendix B: Sense of Coherence Scale (SOC-13)
Appendix C: Experiencing Scale (EXP)
Appendix D: The Process Index (PI)
Appendix E:: Statement of informed consent
Appendix F: Video Release Form
Appendix G: Transcripts and video tapes

Appendix A

Process-oriented Interventions in Addiction Treatment

The process-oriented intervention used in this study was introduced by A. Mindell in a training seminar in 1989[1] and has recently been updated[2]. The author has used this type of intervention since 1990 in drug treatment centers with heroin addicts and with persons in methadone maintenance programs as well as in training seminars worldwide with all types of addictions and addictive tendencies.

Part I -- Re-accessing the State

1. Therapist encourages the client to relax and choose an addiction or addictive tendency to focus on.
2. Now that you have chosen an addiction, name it. What is the state of mind that you hope the substance will create. Allow yourself to experience that substance, or rather, the state you hoped that the substance will bring you - without taking the substance. Can you feel the state in your body... (The client is now experiencing and therapist helps unfolding of experience and eventually asks client to make some sort of movements that express that state)

Part II - Experiencing the Root of the State

3. Again, remember the state you hoped that the substance will bring, the high you have once reached... Again, make hand motions or body movements that portray the state you hoped for...Now, slowly stop or let go of that motion or movement and just feel the energy or tendency left behind, that which gives rise to that state.
4. Sense the energy, the tendency behind taking the substance.... Explore the world at the root of your addiction...What does it feel like…What are space and time like at the root of your addiction...What is the atmosphere like in that world...Feel into that world...Give that atmosphere, that world expression and live it right here and now.. (Therapist follows feedback and verbal and non-verbal signals to help unfold and deepen the client's experiences and gives the experiencing a lot of time).
5. Now, ask yourself why you marginalize this experience so often and take a substance instead. In what way can you open up to this world and let it be present in your life... Make a note about the state and how to be more aware of its existence...

Part III - Integrating into Relationship

6. Again, feel the sentient essence of the impulse behind the addiction...Feel its essence...what atmosphere or style does this state want to create in your relating to others.. Use your imagination and create a new style of relating out of this state...Make a movement that expresses that feeling and relate from it...
7. Let others join you and bring them into that new atmosphere...Let them join you and co-create a dance, a story, a poem, a fairy tale.

[1] A. Mindell: Training Seminar "Addiction, Trances and Altered States", Eigenthal, Switzerland, 1989
[2] A. Mindell: Dreaming while awake. Techniques for 24-hour lucid dreaming. Hampton Roads Publishing, Charlottesville, 2000.

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[2] A. Mindell: Dreaming while awake. Techniques for 24-hour lucid dreaming. Hampton Roads Publishing, Charlottesville, 2000.

Appendix B

Sense of Coherence Scale (SOC-13)

Please keep on answering the questions giving only one answer to each question.

1. Do you have the feeling that you don't really care about what goes on around you?

1	2	3	4	5	6	7
very seldom or never						very often

2. Has it happened in the past that you were surprised by the behavior of people whom you you knew well?

1	2	3	4	5	6	7
never happened						always happened

3. Has it happened that people whom you counted on disappointed you?

1	2	3	4	5	6	7
never happened						always happened

4. Until now your life has had:

1	2	3	4	5	6	7
no clear goals or purpose at all						very clear goals and purpose

5. Do you have the feeling that you're being treated unfairly?

1	2	3	4	5	6	7
very often						very seldom or never

6. Do you have the feeling that you are in an unfamiliar situation and don't know what to do?

1	2	3	4	5	6	7
very often						very seldom or never

7. Doing the things you do every day is:

1	2	3	4	5	6	7

a source of deep pleasure and satisfaction — a source of pain and boredom

8. Do you have very mixed up feelings and ideas?

1 (very often) 2 3 4 5 6 7 (very seldom or never)

9. Does it happen that you have feelings inside you would rather not feel?

1 (very often) 2 3 4 5 6 7 (very seldom or never)

10. Many people – even those with a strong character – sometimes feel like sad sacks (losers) in certain situations. How often have you felt this way in the past?

1 (never) 2 3 4 5 6 7 (very often)

11. When something happened, have you generally found that:

1 (you overestimated or underestimated its importance) 2 3 4 5 6 7 (you saw things in the right proportion)

12. How often do you have the feeling that there's little meaning in the things you do in your life?

1 (very often) 2 3 4 5 6 7 (very seldom or never)

13. How often do you have feelings that you're not sure you can keep under control?

1 (very often) 2 3 4 5 6 7 (very seldom or never)

Appendix C

Experiencing Scale EXP

1 The chief characteristic of this stage is that the content or manner of expression is impersonal. In some cases, the content is intrinsically impersonal, being a very abstract general, superficial, or journalistic account of events or ideas with no personal referent established. In other cases, in spite the personal nature of the content, the speaker's involvement is impersonal, so that he or she reveals nothing important about the self and the remarks could as well be about a stranger or an object. As a result feelings are avoided and personal involvement is absent from communication.

2 The association between the speaker and the content is explicit. Either the speaker is the central character in the narrative or his or her interest is clear. The speaker's involvement, however, does not go beyond the specific situation or content. All comments, associations, reactions, and remarks serve to get the story or idea across but do not refer to or define the speaker's feelings. Thus the personal perspective emerges somewhat to indicate an intellectual interest or general, but superficial, involvement.

3 The content is a narrative or a description of the speaker in external or behavioral terms with added comment on feelings or private experiences. These remarks are limited to the events or situations described, giving the narrative a personal touch without describing the speaker more generally. Self descriptions restricted to specific situations or roles are also part of stage 3. Thus, feelings and personal reactions come into clear but limited perspective. They are owned but bypassed or rooted in external circumstances.

4 At stage 4 the quality of involvement or "set" shifts to the speaker's attention to the subjective felt flow of experience as referent, rather than to events or abstractions. The content is a clear presentation of the speaker's feelings, giving a personal internal perspective or account of feelings about the self. Feelings or experience of events, rather than the events themselves, are the subject of the discourse, requireing the speaker to attempt to hold on to inner referents. By attending to an presenting this experiencing, the speaker communicates what it is like to be him or her. These interior views are presented, listed, or described but are not the focus for purposeful self-examination or elaboration.

5 The content is a purposeful elaboration or exploration of the speaker's feelings and experiencing. There are two necessary components: first, the speaker must pose or define a problem, proposition or question about the self explicitly in terms of feelings or relate feelings to other private processes. Second, the speaker must explore or work with the problem in a personal way. The exploration or elaboration must be clearly related to the initial proposition and must contain inner references that have the potential to expand the speaker's awareness of

experiencing. These may also be evidence of and/or references to the process of groping or exploration itself.

6 At stage 6 the way the person senses the referent is different. There is a felt sense of the there-and-yet-to-be-fully-discovered, that is, of an unclear inner referent that has a life of its own. It is a sense of potentially more than can be immediately thought or named. This felt sense is more than a recognizable feeling such as anger, joy, fear, sadness, or "that feeling of helplessness". If familiar and know feelings are present, there is also a sense of "more" that comes along with the identified feelings.

7 The content reveals the speaker's steady and expanding awareness of immediately present feelings and internal processes. He or she clearly demonstrates the ability to move from one inner referent to another, linking and integrating each immediately felt nuance as it occurs in the present experiential moment, so that each new sensing functions as a springboard for further exploration and elaboration. (in: Klein, Mathieu and Kiesler 1986)

Appendix D

Process Work Index (PI)

1 The chief characteristic of this stage is that the content or manner of expression is impersonal. In some cases, the content is intrinsically impersonal, being a very abstract general, superficial, or journalistic account of events or ideas with no personal referent established. In other cases, in spite the personal nature of the content, the speaker's involvement is impersonal, so that he or she reveals nothing important about the self and the remarks could as well be about a stranger or an object. As a result feelings *or attention to inner processes* are avoided and personal involvement is absent from communication.

2 The association between the speaker and the content is explicit. Either the speaker is the central character in the narrative or his or her interest is clear. The speaker's involvement, however, does not go beyond the specific situation or content. All comments, associations, reactions, and remarks serve to get the story or idea across but do not refer to or define the speaker's feelings *or inner processes*. Thus the personal perspective emerges somewhat to indicate an intellectual interest or general, but superficial, involvement.

3 The content is a narrative or a description of the speaker in external or behavioral terms with added comment on feelings or private experiences. These remarks are limited to the events or situations described, giving the narrative a personal touch without describing the speaker more generally. Self descriptions restricted to specific situations or roles are also part of stage 3. Thus, feelings, personal reactions *and inner experiencing* come into clear but limited perspective. *Feelings, personal reactions and inner experiences* are owned but bypassed or rooted in external circumstances.

4 At stage 4 the quality of involvement or "set" shifts to the speaker's attention to the subjective felt flow of experience as referent, rather than to events or abstractions. The content is a clear presentation of the speaker's feelings *or experiences, being in touch with* a personal internal perspective *or inner experiences, or an* account of feelings *or inner experiences* about the self. Feelings or experience of events, rather than the events themselves, are the subject of the discourse, requiring the speaker to attempt to hold on to inner referents. By attending to *and/or* presenting this experiencing, the speaker communicates what it is like to be him or her. These interior views are presented, listed, or described but are not the focus for purposeful self-examination or elaboration.

5 The content is a purposeful elaboration or exploration of the speaker's feelings and experiencing. There are two necessary components: first, the speaker must pose or define a problem, proposition or question about the self explicitly in terms of feelings *or experiences* and relate feelings *or experiences* to other private

processes. Second, the speaker must explore or work with the problem in a personal way. The exploration *or unfolding* / elaboration must be clearly related to the initial proposition and must contain inner references that have the potential to expand the speaker's awareness of experiencing. These may also be evidence of and/or references to the process of groping or exploration itself.

6 At stage 6 the way the person senses the referent is different. There is a felt sense of the there-and-yet-to-be-fully-discovered, that is, of an unclear inner referent that has a life of its own. It is a sense of potentially more than can be immediately thought or named. This felt sense is more than a recognizable feeling such as anger, joy, fear, sadness, or "that feeling of helplessness". If familiar and know feelings, *experiences or inner processes* are present, there is also a sense of "more" that comes along with the identified feelings, *experiences or inner processes. There are deliberate attempts to move further into the unknown or into one's secondary processes.*

7 The content reveals the speaker's steady and expanding awareness of immediately present feelings and internal processes. He or she clearly demonstrates the ability to move from one inner referent to another, linking and integrating each immediately felt nuance as it occurs in the present experiential moment, so that each new sensing functions as a springboard for further exploration and elaboration. (adapted from: Klein, Mathieu and Kiesler 1986)

Appendix E

Statement of Informed Consent

I am freely consenting to take part in an alternative therapy session conducted by Reinhard Hauser, psychologist associate resident in Oregon (supervisor Dr. S. Straub) as part of a Ph.D. research study at the University of Bratislava, Slovakia under Dr. A. Heretik.

The study aims at exploring new treatment interventions in addiction work to complement existing approaches. My participation will involve an experience-oriented interview of one hour duration which will be video-recorded and transcribed. The interview consists of a series of instructions to focus inwardly on previously felt experiences when under the influence of heroin. The goal is to re-experience the altered state of consciousness without the use of a drug and, consequently, to learn a method to satisfy the inner need. I understand that the data collected is part of a dissertation project and may result in written publication of results in some form.

All material will be treated confidentially and will remain anonymous to all except to the primary researcher, Reini Hauser. My name will never be used and no statements will be made to reveal my identity. Sequences of the video recordings will be reviewed and rated by 3 professional psychologists who have an obligation to respect strict confidentiality.

The only discomfort to me, besides time spent in participation, may be associated with feelings that I experienced when in the addiction state. I may benefit, however, by recalling and reformulating these experiences and gain a new perspective on my addictive behaviors. I understand that the interaction between myself and the researcher does not replace, or be construed as, therapy.

The researcher will be available to me for a follow-up session to discuss any issues that were raised in the research interview. I understand that my participation will ultimately benefit clients by influencing the training of therapists and helpers in the field of addiction treatment.

My participation is entirely voluntary. I understand that refusal to participate will involve no penalty or loss of benefits to which I am otherwise entitled, and that I am free to withdraw my consent and discontinue at any time.

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Date Signature

Appendix F

Video Release Form

This clinical trial with heroin or methadone users requires video-taping of the research session. I …….am consenting freely to being video-taped. I understand that the tapes will be reviewed by the therapist/researcher as well as 3 other psychologists/therapists for data analysis who have an obligation to strict confidentiality. The tapes will be transcribed and parts of it may be published without use of names. The tapes will be stored with the primary researcher and no other persons then the ones mentioned will see the tapes. I can - at any time - call the primary researcher and ask to delete the tapes.

---------- ----------

Portland, date Signature

Appendix G

Transcripts

130 pages of transcripts, 52 segments / 5 minutes each, two from the first and two from the intervention session. Not included in the final version of the dissertation.

Video Tapes

Edited video tape with 52 5-minute sequences to the corresponding transcribed segments. 4 hours 30 minutes of tape. Not included in the final version.