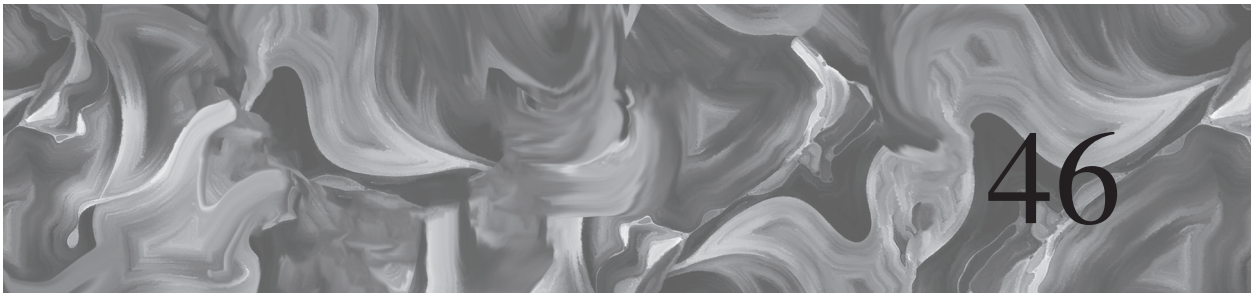

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Populating Recovery: Mobilizing Relational Sources for Healing Addiction

Pavel Nepustil

I don't ever wanna drink again
I just, ooh, I just need a friend
(Amy Winehouse 'Rehab')

This is an invitation to inquire into an irreducible, emergent phenomenon (Shelby, 2016) that is called addiction, and more specifically into the transformational process that is usually described as recovery. We will first look at the conceptualization of addiction and recovery, both in general and in relational theory, and then I will describe two types of practices in the addiction recovery field that respect the complexity of addiction and at the same time are coherent with social constructionist theory. For the first one, I will invite you to my therapy room in Brno, Czech Republic, and for the second I will take you to a friendly service in Manchester, UK. Finally, we will go beyond the scope of professional addiction and recovery services and sketch an image of a society that is inclusive, inviting and appreciative of transformational processes and does not build barriers for people who travel from one lifestyle to another.

DO WE NEED THE WORD 'ADDICTION'?

Between 2013 and 2016, a large group of European researchers, brought together by project ALICE – RAP (Anderson, 2017), attempted to find a conceptualization of addiction that would serve as a common platform for all the different disciplines that are concerned with addiction, such as medicine, psychology, sociology, criminology, public health, etc. They finally concluded that we do not need a special word like 'addiction' for capturing the main message of all the different conceptualizations and suggested that the most appropriate term might be 'heavy use over time'. They argue that it is exactly heavy use1 for a prolonged period of time that seems to be the most salient feature of

this phenomenon for all the disciplines. For them, the term 'addiction' is not only redundant but it also dichotomizes people as having, or not having, addiction, dominantly regarded as a disease, '… without giving sufficient weight to the fact that the underlying phenomena are continuous' (Anderson, 2017: 17). Being identified as an 'addict' is also stigmatizing, since it unreasonably gives a fixed label to people, sometimes even without them being aware that they have such label (i.e. when others around them identify them as such).

This is an interesting conclusion given the fact that the original goal of medical professionals, who were mostly responsible for the widespread use of the word 'addiction' in the professional field in 20th century, was clearly the opposite. They were trying to help people who were regarded as immoral, evil or spoiled, and thus stigmatized by the society, by giving them the identity of those who suffer from a disease called addiction and who need help. And there was also the promise that medicine would find an underlying cause of addiction and then it will be only a small step to find the cure. But we can hardly regard this project as successful. Be it the allergy to alcohol (Silkworth, 1937) or addictive personality (Fischer, 1973; Lester, Burkman & Gandica, 1976), all of the theories were either rejected or did not fulfill the search for a cure.

Even today, medical professionals in the addiction field continue this project of searching for an underlying cause of addiction, and some of them believe that there is a clue in the structure of the neural system that explains addictive behavior. The addictive behavior makes changes in the neural network structure. When this change occurs, a pathological process disables the person from taking control over him/herself (Volkow et al., 2013). Unable to control their impulses, people with addiction need professional treatment to help them gain this control again.

However, there is a line of criticism of this disease model that, at the same time, does not want to disregard the notion of addiction itself. Lewis (2015), Satel and Lilienfeld (2014) and others confirm that the neural network changes with developing addiction. But, for them, this does not mean that addiction is a disease, disorder or pathological process. Building upon the widespread notion of neuroplasticity of the nervous system, Lewis (2015) says that our brain is constantly changing, especially when it comes to learning. And addiction is a special kind of learning process that involves, as with any other kind of learning, a habit formation.

> … the brain changes that underlie addiction and recovery are more normal than abnormal, though their outcomes can be extreme. Addiction may be a frightful, devastating, and insidious process of change in our habits and our synaptic patterning. But that doesn't make it a disease. (Lewis, 2015: 44)

This developmental theory of addiction focuses on explaining how these kinds of habits are formed and sustained and why it can be so difficult to step out of them.

With these ideas in mind, we might be aware that the process described by ALICE – RAP researchers (Anderson, 2017) as heavy use over time has, after all, some specific features that make it worth having a special name. The history of the word 'addiction' goes back to an ancient era (Rosenthal & Faris, 2019) and for most of the time it was far from being regarded as a problem inside a person, or even specifically a problem at a level of the central nervous system. The main feature was and is always a passionate relationship with some entity or behavior that demonstrates itself in actions of a person and is so strong that it is almost unthinkable to change it. This kind of relationship might create problems, and often very serious ones, not necessarily only for the person but also, or even exclusively, for the social network of the person. As Alexander puts it (2008: 29): '[Addiction is] overwhelming involvement with any pursuit whatsoever (including, but not limited to, drugs or alcohol) that is harmful to the addicted person, to society, or to

both.' In this chapter, we will be focusing on exactly this feature of addiction because, in the end, it is the harm for the individual, family, community or wider society that makes addiction our 'business' as practitioners.

RELATIONAL NOTIONS OF ADDICTION

From a social constructionist point of view, it is rather valuable that there is a vast range of definitions of addiction because this reflects the relational process of unfinished and ongoing defining and re-defining. At the same time, it is important to notice that this relational process takes place also at a more intimate level, in the lives of people who call themselves or are being called addicted. For social construction, addiction is not something strictly internal or external, but it is somewhere in between, in the negotiation of meaning over and over again with oneself and others (McCullough & Anderson, 2013). And this process, in itself, is significant because it is during these interactions that the identity of 'user', 'heavy user', 'addict' or other is defined and later maybe reified.

Gregory Bateson (1971) wrote a chapter where he attempted to formulate a theory of alcoholism. We can regard this publication as the first account of a relational theory of addiction. He applies cybernetics and systems theory to the issue of addiction, and his starting point is that when we want to think about the system of an alcoholic,[2] we need to include alcohol in this system. When alcohol is taken out of the system (i.e. when a person attempts to stay sober), it destabilizes the system and so there is a strong tendency to get back to the previous homeostasis. Bateson also uses his notion of symmetrical and complementary relationships, asserting that alcoholism is 'born' from clearly symmetrical roles that escalate. For example, when people want to keep pace with their drinking friends, even if they have more and more problems connected to alcohol, they tend to continue in their addictive behavior even if they experience negative consequences. At the same time, they reject the complementary roles, into which their employers or intimate partners often invite them by, for example, an authoritative style or overprotection. These relational patterns that support the addictive behavior are not easy to abandon. Bateson (1971) offers an example of Alcoholics Anonymous (AA) as one way out of this dilemma, which is a dramatic transformation from symmetrical relationships towards a purely complementary relationship, in the case of AA represented by assertions about powerlessness and higher power.

More recently, the relational view of addiction was also conceptualized by Hughes (2007), Mudry (2016), van der Eijk & Uusitalo (2016), Graham, Young, Valach, and Wood (2008) and Alexander (2012). They all build upon research that shows that the roots of addiction, development and recovery are happening in relationships, social networks, and the practicalities of everyday life and have a big connection with the social and cultural context. Interestingly, there is also a growing body of research that adopts the relational conceptualization of addiction dealing with non-substance addiction such as sex or gambling (Mudry, 2016; Reichertz & Moell, 2019; Rogier et al., 2019; Van der Linden, 2015; Venuleo & Marinaci, 2017; Vogel, 2008). In these studies, the relational essence of addiction is even more visible because there is no material component (such as a drug) that could be blamed for activating addiction. The picture that these studies paint is not simple or linear but rather very complex. Addiction, from relational point of view, is a phenomenon that cannot be reduced to a biological or family system. We always need to take into account various systems and networks where addiction includes, for example, a person in the material world, community and whole society.

RELATIONAL RECOVERY

But what is the implication of the relational view for practitioners? To start with, it is noteworthy that most people overcome addiction without any formal intervention, which means that they do not use treatment services or any rehabilitation programmes including 12-step groups (Dawson et al., 2005; Rumpf et al., 2009; Sobell, Ellingstad & Sobell, 2000). Thus, natural recovery, as this phenomenon is sometimes called, can be seen not as an exception or side road, but rather as a major recovery highway. And as such, it might be more important to have a deep understanding of this process to realize how we can support it, rather than trying to develop and design interventions out of our (scientific) pre-knowledge and then trying to impose those interventions onto people.

In my previous work (Nepustil, 2016; Mudry, Nepustil & Ness, 2019), I studied the process of natural recovery with the help of 19 people who managed to move away from a lifestyle that was strongly influenced by heavy methamphetamine use. What I learned was that, in order to abandon this lifestyle and the identities connected to it, there had to be some disruption in the relational flow (Gergen, 2009) of which these people were part. Whether it was a police raid, illness, the death of someone close or other events, it was always an important feature that was mentioned when talking about initiation of the recovery process.

At the same time, a transitional process had to take place that made the shift from the previous lifestyle possible. Besides the person him/herself, there were other people taking part in this process, but also various places, and objects such as books or animals. I named this process the 'co-creating of transitional trajectories' because it was always a process of co-creation, step-by-step, with others, without knowing where it would lead. Of special importance is that there was always at least one person who was very significant in this process of co-creation, and mostly it was either an intimate partner or a friend.

Finally, I noticed that, in their stories, most people articulated arriving at a place which was very close to what Shotter (2009) refers to as a sense of belonging or 'being at home'. They found a space, be it a family, community, movement, religion, to which they felt they belonged, where they could fully and actively participate and that brought meaning to their whole life and beyond. Some of them mentioned that it was in clear contrast to what they experienced before they ran into the 'drug lifestyle' because, in their childhood and adolescence, they had feelings of not belonging, of disempowerment and loss of meaning. Again, this was a relational process that could not happen without others.

This view of recovery very much reflects what Price-Robertson, Obradovic and Morgan (2016) call relational recovery. They notice that, in the mainstream literature, the process of recovery is seen as a personal process stemming out of the philosophical underpinnings of individualism. Even if social factors are mentioned as important, they are seen as supplements of this process, thereby creating a dualism between the inner process of recovery taking place and the external social factors there to support it. Price-Robertson, Obradovic and Morgan (2016) propose that we substitute this view with a relational perspective within which we can study the interdependence of the individuals and their environment. According to these authors, this relational perspective places such issues as culture, systems of oppression and privilege, and social determinants of health at the center of the recovery process. They also see family and community members, and the relationships among each other, as inseparable from the individual process of recovery. Similarly, Best et al. (2015) describe recovery as a social phenomenon, 'a social contagion' that is transmitted through processes of social control and social learning.

Now, I invite you into two different places to show the relational construction of

addiction and recovery in practice, starting in my own office.

Thin Ice

I am sitting in my therapy room, listening to Klara, a 35-year-old woman, who carefully explains why she is refusing to move to her boyfriend's apartment and instead wants to remain living in her mother's place with her daughter from her previous marriage. Her boyfriend, Patrik, is sitting next to her. A few minutes earlier, I had asked Patrik if he would listen while I talked with Klara. He said yes and, as Klara and I talk, Patrik appears intrigued by what she is saying. The most salient reason Klara describes for not wanting to move to Patrik's apartment is Patrik's heavy drinking, which is also the reason they approached me half a year ago for therapy. When it appears that Klara is almost finished, I can see she is occupied with something. By slightly leaning my head to one side, I try to encourage her to talk.

'Well, there is one thing that worries me, but it is thin ice,' she says.

'Thin ice?' I respond.

'Yes, thin ice,' she says and now it seems to me that she will not go on. I look at her a little bit longer but I can see that she already does not want to say anything. I turn to Patrik:

'What were you experiencing when Klara talked?' I ask him.

He stays silent for a while, looking downwards. 'Well, there is this thing. I am afraid of being in my apartment alone. I am scared of being alone.' After about ten seconds of silence he adds: 'And it is something that has persisted since Lenka [his former wife] left home.'

Then he talks about the situation when his wife left. How difficult it was for him to start living without her and without their kids. Klara is listening very attentively and slowly starts asking him questions about this and that, including questioning if the loneliness and memories of his former wife are also the reasons that urge him to drink. He responds thoroughly, trying to clarify, explaining himself. I am listening. Close to the end of the session, I ask Klara how she is feeling now.

'I feel calm and peace now. This was the thin ice.'

With regard to my long history working with addiction problems, people often contact me with these kinds of issues. Whether in the initial telephone call, they claim to want help for themselves or for the other, I am always trying to encourage them to come together. The decision is theirs but I tell them that it seems that they are all concerned and that it would make sense to me if they come together. The reason I do this is that, in this way, I can support the relational recovery process much more directly. Klara never had the possibility of having this kind of conversation with Patrik about his fear of being alone. He felt shame connected to this topic and Klara understood that it was 'thin ice'. But it seemed to be a really important issue for both of them and also for Patrik's recovery. It was another piece of the puzzle about how to understand this habit.

If we pay attention to my role as a therapist in this short example, we can see that I do not use any techniques, interventions or questions targeted at the topic of discussion. At the beginning, I am repeating a phrase that strikes me in the present moment ('thin ice') from the perspective that hearing her words can enable the speaker to better understand what she wants and does not want to say (Seikkula, 2011). I am also intentionally offering a listening position to the clients, first to Patrik, then to Klara, using Tom Andersen's notion of shifts between talking and listening (Andersen, 1995), and I help them reflect on their inner dialogues while listening. But, most important, I let the couple listen and talk to each other in a way that they have never experienced together before. This could not be achieved in individual therapy.

However, we could say that the practice of working with couples or families is 'thin ice' in the addiction field. Practitioners are sometimes discouraged from working with a family where someone is addicted and currently using: 'Experience shows us that family therapy with an addict who currently uses is difficult, mostly impossible'[3] (Čtrnáctá, 2015, s. 500). Family members are usually

invited into treatment only after the identified 'addict' starts his or her own individual treatment, goes through detoxification and makes some progress (SAMHSA, 2013). Contact with family members is also often used as an effective way to get the identified addict into treatment (Garrett et al., 1999).

However, recently there has been a growing interest and body of research that claims involving couples and families from the very start is useful. For example, research on 'Social behavior and network therapy for drug problems' (Williamson et al., 2007) shows that it is highly beneficial for everyone to include family from the very first contact. Similarly, Navarra (2007) promotes a relational perspective in addiction treatment and bridges the gap between the individual and couple recovery. And it is not without interest that even if we go back into the history of family therapy, we find that Speck and Attneave (1973), in their classic book on family network intervention, use an example of successful network interventions where a person with opiate drug problems plays a major role.

When working with couples such as Patrik and Klara, my work is greatly influenced by collaborative and dialogic approaches (Anderson, 1997; Seikkula & Arnkil, 2017) that inform me in developing collaborative relationships with couples as well as how to be responsive and attuned so that the dialogic process is enriched. From a social constructionist point of view, there is no doubt that it is beneficial to work not only with the afflicted individual but with the whole social network in any phase of the addiction/recovery process, for three reasons at least. First, the addiction process usually worries more people than only the individual, very often the other people are even more worried. Second, addiction is being sustained by the interactional patterns in the social network, so it is particularly important that these patterns become visible in the therapy room. And third, recovery is not a solitary process and since the therapeutic relationship is always temporary, having more natural relationships in the room that can be supportive seems to be very relevant.

Friend

Standing next to a busy road in the outskirts of Manchester, England, in a morning rush hour is not exactly where we would like to be right now and so we are happy when we can see that Peter's car is approaching the parkway. We, three psychologists from Brno, Czech Republic, greet Peter and climb into the back seat of the car. Peter is introducing the man sitting in the front seat – next to him. 'This is my friend Jamie,' says Peter, 'I am giving him a ride to the center we are visiting today.'

Peter is our guide during our three-day study visit and, at the same time, a co-founder of the organization Emerging Futures, that is hosting us. The idea to visit Manchester came to us when we were asked by the municipality of Brno to design a new service for people with addiction that could respond immediately, with a multidisciplinary team, and have a focus on recovery. I already knew Peter from the past. I know that he, himself, went through a very difficult life journey intertwined with addiction and mental health issues and also that we have a similar background as professionals – with an interest in participative, compassionate and dialogic work.

After some 20 minutes, we come to the first facility Peter wants to show us. We are following him and Jamie and, as a first thing, he finds a manager of the place, called Tod, and he introduces Jamie to Tod. 'He is just out for couple of days', says Peter and we later understood that he meant that Jamie has just come out of prison where he spent the last three years. 'He might appreciate some information on what you are doing, some support, and if he could maybe stay here for a while and have a chat with the guys, that would be great.' Tod is smiling and he asks

Jamie: 'Would you like to have some coffee or tea? Yes? Great, OK, let me show you around.' He asks us to wait in another room and leaves us for a while with Peter. When Tod returns to us, we learn that he also struggled with addiction problems in the past as most of the staff members of the center.

This center aims to help people mostly coming from prison, most of whom have had drug and addiction problems. The important feature of these people is that often they do not have a place to go; their family usually refuse to take them back and, at the same time, they do not want to stick with their former friends because they are afraid of going back to prison again. One of the very significant features of this facility was that most of the staff members, and especially the frontline workers, had their own experience with addiction issues and, at the same time, they have been trained as 'recovery coaches' and work under continual supervision. Peter is one of the trainers and supervisors. But he does not train people to become professionals, he trains them to better know how to use their own experience to create good connections and caring and trusting relationships with others.

Involving people with lived experience with serious addiction in a system of care as lay therapists, sponsors, peer mentors, or peer counselors is not new. As White (2009) shows, this practice dates back to the 1930s and has a direct link to the development of Alcoholics Anonymous in the USA and then worldwide. From the beginning, there have been two main rationales for this practice. First, for someone who often experiences judgment, contempt and lack of understanding from the outside world, meeting someone who is or was in a similar situation might be beneficial in terms of creating a trusting relationship. Second, the experience of providing help for someone, being useful to someone, is an important part of the recovery process. People do not need only to be helped, they also want to help others.

The main link between the peer recovery movement and social construction is enhancing the possibility of human connection through the shared human experience. We could notice that Peter called Jamie 'my friend', had him in his own car and personally connected him to someone he was quite sure would be able to help him. None of this happens in the traditional professional setting where people with addiction are called clients or patients, where usually there is a policy that does not allow employees to take clients/patients into their own cars, and referrals are done routinely through a formal procedure. On the contrary, the way Peter and his colleagues approach newcomers is very natural, it is actually the way people usually become acquainted with one another – through shared stories, common language and understanding. Of course, all of this is possible even without having personal experience of addiction, but having this experience helps the worker feel more familiar, more at ease, and 'legitimizes' the informal way of relating.

The other important feature of recovery coaching that is highly coherent with social constructionism, as it is practiced by Emerging Futures, is that there is no single form of recovery that is specifically promoted or recommended. Recovery coaches help people discover and develop their own resources of recovery. They refrain from telling people what is right or wrong or from preferring one pathway over another. At this point, the lived experience with addiction can turn into a disadvantage because it is rather natural to perceive one's own journey as the best or even as the only one. And this is exactly where the training, constant supervision and community of recovery coaches are crucial. Through the experiential learning process, as part of a group of diverse people with different ways of overcoming addiction, the recovery coaches learn to recognize their own journey as one of many, while at the same time appreciating and honoring the unique journeys of others.

Lastly, these practices send an important positive message to the community and general public about addiction. People who are

or once were struggling with addiction are valued in Emerging Futures as meaningful and important members of society. This is in sharp contrast with the general public's view of people with addiction, where people defined as 'addicts' have traditionally the highest score on the charts of the most unpopular groups of people.[4] But it also paints a different picture than the traditional treatment settings where addiction is introduced as a chronic relapsing disorder with treatment and abstinence as the only viable option. This deficit discourse that has a tendency to escalate and transfer from professional to lay settings (Gergen, 1994) is replaced here with an appreciative view. This view recognizes every person as unique, having his/her own potentials, strengths, credentials and needs, and thus in search for their own recovery journey. Recovery coaches, with their very unique personalities and recovery pathways, are living examples of this view that cannot be shared only theoretically.

MOBILIZING RELATIONAL SOURCES IN COMMUNITY AND SOCIETY

In the previous examples, I have shown that we, as relational practitioners, have various means for mobilizing the relational sources that can be beneficial in addiction recovery. In the first example of Patrik and Klara, I was someone who helped the couple to listen to each other and talk especially about topics that they do not usually talk about. This is a way to ensure that both can see how 'addiction' is connected to important life events and they can gain a deeper understanding of what is going on. The second example shows us how professionals can be connected with people with lived experience and how they can together help people with addiction problems form relationships based on trust, equality and friendship. These two examples aim to focus on the existing relationships and networks and make the best use of them.

But staying within the circle of family and friends is not enough. People struggling with addiction are part of larger communities and society, just as everyone else, and this is a level that can be very sensitive. The marginalization and oppression that people experience before developing addiction is often experienced not in the family or close networks, but at the level of the wider community. Ethnic and other diverse groups are good examples. Even if a family has strong ties and the relationships are loving, the reality of poverty and discrimination can be so overwhelming that one may not experience the sense of belonging and feeling 'at home'. Addiction can be a response to such a circumstance (Peele, Brodsky, & Arnold, 1992; Hart, 2013).

Following this line of thought, Best and Colman (2019) introduce Inclusive Cities, which is a vision that aims to minimize the barriers for addiction recovery '… as both an inter-personal and structural barrier to reintegration and to utilize the process of transformation as a means of generating inclusion and engagement as core values of a city' (p. 58). Their idea is to create an environment in the city where people in recovery will not feel alone but feel supported by people in the wider network. Unlike the current situation when people are visible while drinking and taking drugs but, in recovery, they become invisible, they want to achieve the opposite: recovery as visible and celebrated. They want to do it by active involvement of stakeholders in municipalities, businessmen, taxi drivers, and so on. Similar efforts in the US are recovery ready ecosystems models and recovery ready community frameworks (Ashford, Brown, Ryding & Curtis, 2019).

This vision brings one danger upon which the authors are also reflective. It might be hard to ensure that recovery is for everyone. In other words, while it will eliminate some blame for people who go through 'legitimate' recovery, it might challenge people who take another route or who do not consider themselves to be in recovery. Maybe, to avoid this,

recovery needs an even bigger change that is beyond the scope of this paper. Alexander (2012) talks about revolutionary change, a paradigm shift that is needed and describes a huge societal transformation from the free market society to the connected society built on strong ties between individuals, families and communities. In this sense, addiction is not only 'their' business, and it is also not only 'our' business as professionals. It is the business of us as ordinary people; it is the business of everyone. By building more connected, compassionate and participative communities, we will provide the best prevention and intervention for addiction problems possible.

In this line of thought, social constructionist practices in addiction recovery should be less targeted at changing individuals struggling with addiction and more at the community and societal level, because it is here where severe destructive forms of addiction are being made possible. We can imagine that diverse community members will be trained and supported to create an atmosphere where people who are at risk of addiction might find the help and trust needed to overcome their life obstacles and live a life they want. We can also imagine that communities would be more respectful to diverse lifestyles of people and would see people not through their deficits but through their talents and potentials. And finally, we can also imagine that there would be no one left completely alone in their sufferings; that there would always be at least someone like a recovery coach who comes to the person and says, 'Hey, I know how it sucks being in this situation. I was there once too.'

This is not to say that we should completely abandon the professional practices in which we are currently engaged while supporting the individual recovery pathways. But we should keep in mind that recovery cannot be an isolated process and that people need more than a relationship with professionals. Soon after my visit to Manchester, we organized very successful recovery coaching training in the Czech Republic and I started to invite recovery coaches into my practice as 'co-therapists'. At the time of finishing this article, I hardly ever work alone, usually in a pair with a recovery coach. And we almost never work with individuals, rather with couples and families. This is my current way of 'populating recovery' and I know that there are myriads of other ways that professionals can adopt, based on their specific contexts, that help people with addiction stay connected to our communities.

Notes

1 'Use' refers not only to substance use but use of any addictive products such as pornography, gambling, food, etc.
2 Bateson is using this term, apparently influenced by the AA movement. I do not use terms such as 'alcoholic' and 'addict' throughout this article because of their stigmatizing and labeling properties.
3 My translation (from Czech).
4 A large sociological survey in the Czech Republic showed that 'drug addicts' are a group towards which people across all social classes feel the greatest social distance. It was measured with the use of the Bogardus social distance scale that shows people's willingness to participate in social contacts with diverse groups (Prokop, Tabery, Buchtík, Dvořák & Pilnáček, 2019).

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