"When I took drugs I felt better." Considerations on the body, from the abuse to the therapeutic community

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Abstract

The article explores the anatomy of the body dimension in drug addiction, it considers how body changes at the same pace as the transformations of relationships that the individual has with the substance of abuse and with the context.
The word anatomy, derived from the Greek ἀνατέμνω that means to cut, manages to represent the intent of the text: to dissect drug addiction in its becoming flesh.
This is an experience strongly oriented by bodily sensations than for theirs strength require - or rather impose - constant attention to the somatic aspects. This happens in the body that abuses, this happens in the abstinent body.
In drug addiction, where acting out becomes the balancing tool of negative experiences in a panorama of affective dysregulation (Porcelli, 2004), the chance to form an alliance with the body must be considered essential, because the body knows, it knows us (De Toffoli, 2001) and becomes the canvas on which elements that "have no words" find expression, elements that can recover their own dimension of thinkability in therapy.
The therapeutic community becomes the space in which this attribution of meaning can be operated, translating bodily aspects that the patient can scarcely consider or even ignore, in narratives about his experience.

Keywords: drug addiction, body memory, substance function, mute trauma, therapeutic community, verbal and non-verbal communication, mirroring

Body memory

The body dimension in drug addiction can be understood as a sort of passage that allows the clinician and the patient to access understanding of experience. When patients talk about their history of abuse of psychotropic substance, clinicians often find themselves catapulted into vivid tales, studded with descriptions about bodily sensations characterized by a sometimes overbearing intensity. The substance becomes the organizer of the experience, so that the abuser reads reality in a two-dimensional way: with the substance, which generously gives pleasure e calms the pains or without the substance, which causes psychological and physical suffering typical of abstinence.
The patient decides to narrate himself mainly through the body, recalling memories strongly anchored to it, traces that sometimes seem to be the only ones fixed in his psychic memory. It's not unusual, in fact, that from the fog that envelops various contents concerning the period of drug addiction, emerge flourishing memories of what the body once experienced, memories so flourishing as to appear recent even

after many years. The patient may be confused about what happened outside of his encounter with the substance, about family climate, about his relationships, about his everyday life commitments, even the temporal dimension can appear faded in memories of the person but this poor definition is counterbalanced by millimeter precision of his/her somatic memories, such as those related to the orgasmic sensations of the heroin flash or the explosiveness of an expanding body after using cocaine, a body – using the definition of a patient - "who wanted to party".

Functions of the substance

If we try to do a survey of psychotropic substances, we immediately realize that we are in front of a universe whose huge breadth - at this moment – we'd rather grasp than analyze, starting from a first and perhaps obvious premise relative to the specificity of the mechanisms of action of substances which, causing different effects on the central nervous system, produce different bodily modifications, whereby the effects of stimulants are - for example - very different from those of sedants. This lead us to an equally fundamental premise: it's not casual if people develop addiction to one substance rather than another one, the fundamental discriminant is about the effects of *that* drug, and the drug effects primarily concern the body.

The desired effects can be considered as the expression of a need to which the body lends its voice; a body can ask to shut down and not feel pain or it wants to feel full of energy, thus guiding the choice of the substance to searching for. This orientation tells much about the person and his functioning and it opens a door on the wounds the person is attempting to heal as for example happens in "traumatic drug addictions", as Cancrini (1982) defined it, in which having experienced one or more important traumatic events means that heroin often becomes the drug of election by virtue of its anesthetic properties, capable of relieving pain perceived as not tolerable otherwise.

The soma becomes the laboratory where the drug addict searches and establishes delicate balances, exploring and manipulating sensations thanks to different method of consumption, to *timing*, to the choice of substance, but also to the combination of drugs. In fact conditions of poliabuse are frequent, such as the association of alcohol with cocaine to "*dampen*" or to reduce unpleasant symptoms such as insomnia and to rest the exhausted body; or the use of heroin together with various other substances, including cannabis, useful for appeasing abstinence or amplifying its sedating effects.

The dialogue that is established between the individual and his body is probably the most frequent interlocution that the person experiences in the acute phase of drug addiction, hence the narration of the somatic memories we were initially talking about, it is not the narration of the "*high*" or the withdrawal, but the precious testimony of a history about needs of care and about the care of one's own needs.

Body and abstinence

The binomial view of a drug addicted body and an abstinent body risks to deprive the experience without the substance of its variety. The abstinence crisis is indeed the

immediate response to the interruption of use; it comes quickly, it is overwhelming and quickly it runs out. From a certain moment onwards, the body of the patient begins to suffer less and less from the lack of the substance; the physical sensations loss of intensity and so all the attentions previously channeled on body, turn to other. After the acute phase, when the symptoms typical of the abstinence syndrome are faded or completely disappeared, the patient is no longer absorbed in aches, pains and cramps and in all those physical sensations that had covered every thoughts from the moment the substance levels had begun to decrease. What happens, for example, at the end of the opiates withdrawal syndromes, that is one of the harder abstinence to deal with? This is a crisis that makes the body a catalyst of all the attentions because of the caliber of its symptoms, bearers of an exceptional symbolic value: the feeling of cold that seems to recall the need to be covered when the substance leaves the person undressed, the activation of mechanisms defensive such as the rise in temperature of the fever but also sweating, diarrhea and vomit, these all are reactions by which body tries to expel what could damage from the inside, these symptoms depict a body that through suffering, defends itself.
Once exhausted the pain of the flesh, the patient and the people around him forget that body that until shortly before was the central element of the abstinence experience, because the suffering that we could define "shouted" - by virtue of the invasiveness and intensity of the symptoms mentioned above – covered everything else. Furthermore, the body ceases to be the field of the battle against relapse; in the early stages the danger of going back to use the substance is in fact strongly connected to the need to put an end to those unpleasant bodily sensations. When this is over, who cares about the body? It often seems that the spotlight should be pointed at something else, at the history of the person and all the factors who favored the encounter with drugs and the marriage with this, it seems necessary to move on a psychic level, as if the two dimensions (body and mind) were really separate and separable.
But this fracture cannot belong to a therapeutic system that starts from tangible to arrive at the intangible and vice versa, in a circularity that does not have a beginning and end nor different sides, it is a circle, a continuum. The ability to confer abstinence a truly transformative nature, distant from its classic definition in terms of the absence of something, is supported by the possibility of endowing it with a meaning that is built on the bridge that connects body and psyche; this is what happens in a therapeutic context such as the community.

To see, to see oneself, to be seen

The focus is on the body in a system of care, taking a cue from the experience within a semi-residential therapeutic community for drug addicts.
A first consideration starts from the echo of words heard several times: “When I took drugs I was better ”, this is a phrase in which it is not unusual to come across in community contexts. It may happen to confront with the amazement of the patients

due to the understanding that since they stopped using substances, they began to suffer from new or supposed new physical ailments. This astonishment reveals a polarization completely opposite to the one of the phase of addiction but of equal intensity: previously the drug was the panacea for all evils, now it becomes the main source of suffering so the credence is that once the abstinence crisis is overcome, the body should exclusively enjoy the benefits of detoxification and must always be well. Patients read events more or less like this: *I took drugs and when I have stopped the assumption I started suffering a specific problem*. This type of construction configures physical discomfort as a iatrogenic outcome and this undermines the magical thought mentioned above for which *interruption of use = total well-being*, thus amplifying the siren's/substance's call. Another meaning can be provided by an alternative punctuation of the sequence (Watzlawick, Beavin, Jackson, 1967) because the beginning of the story is always arbitrarily fixed and what is now identified as the cause, can also be understood as the effect and vice versa. This can be a new reading: *I suffered from a problem and (for this) I started to take drugs, when I stopped I realized this suffering* or *I took drugs, a problem occurred (and I didn't realize it because the drug anesthetized me), then I stop taking drugs and I started to feel it*. What changes is not the existence of pain but the perception of it.

The case of Giacomo springs to mind in this regard, he's 42 year old when he starts community and is the bearer of a long history of drug addiction. He used cocaine for short periods but heroin was the primary substance of abuse and he's taking methadone for some time now. A few years earlier Giacomo had a terrible motorcycle accident which made necessary hip replacement surgery, the beginning of the therapeutic work - according to him - coincided with the worsening of his health condition. In fact, Giacomo begins to have serious walking problems that force him to use crutches to be able to go to the community. According to a symbolic perspective, it is interesting to pay attention to the crutches, because thanks to these we can find a key that allows us to exit from the perspective of explanation to assume the perspective of understanding. According to first reading (reductionist but certainly unexceptionable) the drastic reduction of amount of opiates (replaced in this case by methadone, a synthetic opiate) determines the feeling of a pain previously asleep. This thought is evidently correct but a trivialization like this risks to be translated into an equally banal approach to the patient, so maybe we would welcome his pain, while still supporting abstinent behavior. What is the price to pay for detoxification? Become aware of the inevitability of suffering, so inescapable that it risks to be put in the background.

The crutch symbol instead allows to access to another representation in which the use of an aid is certainly connected to suffering but also to need. During the medical examinations, Giacomo will discover that the prosthesis has been infected for some time, the use of heroin has significantly cushioned the suffering, reducing the possibility of feeling the need and asking for help, heroin prevented Giacomo from

noticing what was happening, causing a drastic worsening of the situation that now risks leading to paralysis.
It is important to give back to Giacomo the photography of his arrival, characterized by a face furrowed by expressions of pain, while he limps on his crutch, it is the same image every morning, it is the image of a man who can now access to pain and also bear it, he can live with it, without being paralyzed by this. He is a man who learns to take care of its pain; in fact initially visits and exams were planned and performed under the constant supervision of community operators, because Giacomo showed evident difficulties in taking care of himself from a medical point of view and not only but over the months he begins to become more and more autonomous, indicating the strengthening of an adult part that knows how look after himself and can do it.
From the initial association therapeutic program - worsening of health conditions, the patient arrives at the association therapeutic program - use of crutches that have a support function and, not casually, take over from heroin, representing the transition from the need for denial to the need for support.

The case of Giacomo talks about a body to which is returned the right to be listened outside drugs, in the community this is a commitment that patients start to hiring and that is supported by operators, listeners through the eyes.
Through the body the person speaks to those who know how to listen: it says something the patient that quickly begins to gain weight or the patient who significantly loses weight, an unkempt body, not cared in aesthetic or functional aspects talks too. Be careful to all these aspects is fundamental in clinical practice and, in particularly, with drug addicts, whose pathology was understood as possible outcome of a dissociation of the link between the different symbolization registers of the psychocorporeal experience. The psychological reading of the states of the body does not it happens, or rather, it happens through a process that does not seem to be connected to any symbolic system. Psychic and somatic experience do not converge, so that the affective processes find neither verbal nor iconic form; rather they remain trapped in feeling and acting out. As Bucci (1997) argues, the multiple codes here dissociated do not seem to be intertwined, the subsymbolic system does not merge with verbal and non-verbal symbolic systems; there isn't that mixture of emotions, words and images that make the experience of oneself vital and unitary, therefore embodied. For this reason in community the deep sight on the body and its care are daily and constantly calibrated, with the aim of implementing the referential activity that Bucci was talking about, therefore to re-establish a connection between the codes. Taking up the axioms of the human communication of Watzlawick, Beavin and Jackson (1967) is executed a transition from the non-verbal analog register to the digital register (1) , in order to make the communication that occurs through the body thinkable and "spoken".
Images and functions are returned thanks to a game of mirrors: I see you and I return to you not only your figure but also the act of seeing in the triple form of verb; the

passive one by which the person is seen, the active one by which the person can see the others, the reflective one by which the person begin to see himself through the filter of his own eyes. What comes back to the person is himself, his reflection. To be seen as what he is - in the act of recognizing his existence - allows to add *here* something that seems to have been missing *there*, so that seeing and being seen becomes inherently therapeutic. As Winnicott (1967) simply says when speaks about functions, «when I look I am seen, so I exist» (p. 233). The "mirror" function embodied in the competence of being able to see himself with his own eyes is here a beneficial consequence; primary processes talks about an infant looking at the face of the mum: and «what does the baby see when he or she looks at the mother's face? (...) ordinarily, what the baby sees is himself or herself » (p. 231). "Ordinarily" is just an adverb that opens to other scenarios; «many babies (…) do have to have a long experience of not getting back what they are giving. They look and they do not see themselves» (p. 231). Simply «the mother's face is not then a mirror» (p. 232). From the point of view of identity structuring the process has significant implications.

Lacan (1949) "ordinarily" imagines a child mirroring himself; what the baby receives, in that one moment, is double and irreversible: in an instant it is clear to him that what is reflected is something else, extraneous, not of his belonging, it is not his; on the other, the instant continues with a feeling of jubilation, it is an instant of explosive joy: he is one!

In the history of the addict the mother doesn't return to the child this being *one* and *other* from her; the mirror gets broke, it's a *shattered mirror* whose fragments illusory will be united in the future by the substance of abuse, which it assumes the function of glue (Olievenstein, 1981).

Looking at himself and finding himself in the mirror years later becomes one of the therapeutic objectives that takes shape, among other things, in one of the community rules which requires daily beard shaving or, alternatively, methodical care of it. This might seems to be a mere and formal matter of image, instead it represents an appointment with oneself, with the Self, because to shave the beard, the person has to put himself in front of the mirror and this action helps to face up with himself.

So an unkempt beard becomes a message that requires to be grasped and its understanding can't ignore the context which - as Bateson (1984) states – "fixes the meaning». It's important to pay attention to the risk of remaining indifferent or even minimizing something that changes in the patient's body, this would alter the dance of the feedback that governs the systems in interaction, sending to the patient a dangerous disconfirmation sign. Seeing the other's body, grasping its oscillations and being touched by these is essential because the therapist can perturb the other one as far as he is perturbable, he modifies the communication that occurs through the body and is modified by it. Generalizing a concept key of the model proposed by Minuchin, Rosman and Baker (1980) relating to psychosomatic disorders, in fact, even more central than certain bodily aspects is like the patient relates to these and to the rest of the system and how the system organizes itself around those elements.

The volume of the body

One of the changes that is most frequently observed in the community is about body weight; sometimes this change develops outside of the awareness of patients who struggle to appreciate even significant variations, which has to be caught ad postponed from the others. Sometimes instead the patients ask the operators for feedback on theirs physical fitness: "have I gained a lot?" or "do you notice that I am on a diet?", thus making explicit the desire to be seen and mirrored.

Each experience needs to be explored together with the patient to allow a redefinition of meaning and value that gives depth to the surface. The body that get fat has the right to be connected not to binge eating and dysregulation of nutrition but, in some cases, to the need to fill the sense of emptiness that the abandonment of the substance has generated and that appears intolerable; eg patients often talk about meal for boredom, experiencing a space desertified rather than a space now available.

In the relationship there is space for the co-construction of these meanings, where the objects are symbols in transformation, for which the representation of the evolution of the body can also be identical apparently and supported by the same behaviors but not by the same processes, which are different from person to person but also within the same individual in a diachronic perspective.

As in the case of Gabriele, thirty-five years old with cocaine addiction problems which led him to have serious repercussions on the justice level. Since his entry in the community, Gabriele's warm smile and exuberance conquer everybody, he is expansive in an expanded body; in fact, he is characterized by a moderate overweight on which never misses an opportunity to be ironic, also because irony is the business card used to present himself to the world and to enter into a relationship with companions and operators quickly. Gabriel eats huge amounts of food which lead him to gain additional weight during the therapy program, he is aware of weight gain and says he continuously eats because of boredom, being able to see that void left by the substance that at the moment doesn't want to contact. He talks about his hyperphagia as a problem but never seems to be authentically upset.

The community offers a precious space - in the space that is the kitchen where together, every day, operators and patients eat the meal and that offers a cross-section representative of roles, modalities and boundaries that trace the map of the system.

The possibility of seeing Gabriele at the table every day allowed operators to grasp the relationship he had with food; the thought of those compulsive eating was inhabited from violent fantasies in which Gabriele was a hungry aggressor for food and at the same time victim but reality offered a different image. Gabriele seemed to be in love with food, in his usual curtains he talked with the dishes of the day, praised them for theirs beauty and goodness, in short, it was a tender affective relationship as it can be imagine with someone we have known for a long time, who has always loved us, someone who maybe even protected us. The value of this relationship indeed is tracked in Gabriele's history, he lost his sister for a terrible domestic

accident when he was few months old. He loses his sister and his mother too because the woman, following the bereavement, falls into a deep depression and can no longer take care of Gabriele who, instead, tries to take care of her through games, jokes and smiles, thus starting to structure his jester's script.
Matteo Selvini (2007) associates hyperphagia with an experience of weakness, also arguing that this "could be linked to various relational factors, one of which is the discontinuity of primary care: in the phases of loneliness the child has learned to self-sustaining with food. Or, in reinforcement of this, the attachment figure has tried to compensate for heri/his absences with food". This seems to have happened in the history of Gabriele who still today speaks of an extremely fragile mother, who spends hours in the kitchen cooking for him, for his brothers and their families.
With respect to the theme of loneliness it comes to mind how much the substance may have held company with Gabriele for a long time, so to food - always a faithful companion - it is now asked to be more, to be there instead of cocaine.
Gabriele's therapeutic program is interrupted following his arrest; after about a year of detention he returns free and returns to the community leaving everyone blown away by his conspicuous loss of weight. No one had ever seen him so skinny and even if he has a normal weight, he is perceived as frail, almost defenseless without that substantial layer of fat. He associates his loss of weight with the *"sufferings of prison"*, in particular he reports that he lived that year tormented by the anguish of being abandoned by his family; Gabriele is unusually thin and unusually sad. Optimism, smiles and irony seem to have left room for a pain that also marked his body, the image of the *cheerful fat man*, like described by Selvini in reference to an avoidant-histrionic personality, in which negative experiences are frozen, it appears scratched in its somatic and emotional aspects. Starting from the loss of weight, Gabriele manages to talk about his own suffering and terror of losing his affections for which he nurtures a sense of guilt and, at the same time, a profound lack of trust. These feelings and the thought of an ineluctable destiny of loneliness are familiar to the man to whom was always told that his little sister died while he was being nursed and therefore he always felt guilty of the tragedy and not worthy of care, of being the object of those attentions that in his experience had generated death and ache.
Gabriele's body is the witnesses of evolving processes in which the symbols are transforming: in its expansion it talks about the attempt to fill a void, in its reducing it talks about the contact with an emptiness which, like a black hole, sucks up everything, in its gradual regrowth (as will happen in the months following the resumption of therapeutic program) it talks about the possibility of feeding him unlike the months of detention in which - as he says - he was so sick that he couldn't assimilate anything.
Gabriele's elaboration work will obviously be long and complex but his case helps to understand the importance of grasping the body's signals and their evolutionary nature, escaping from the logic of the *deficit* because that signals are expressions that find a space unlike before (Bucci, 2009), and it is through the possibility of listening

to them and of doing it *with* the patient that we can search for the Batesonian *structure connecting* and we can broaden possible horizons, allowing the meeting and the contamination of the different constructions of reality (Elkaim, 1992).

Bibliography

Bateson G. (1979). *Mind and Nature*. Adelphi: Milan, 1984.

Bucci W. (1997). Symptoms and symbols: A multiple code theory of somatization. *Psychoanalytic Inquiry*, 17(2), pp. 151-172.

Bucci W. (2009). *Convergent Evidence on the Referential Process from Psychoanalysis, Cognitive Sciences and Neuroscience.* Study Day The Referential Process, Clinical Studies and Empirical Research, Rome.

Cancrini L. (1982). *Those daredevils on flying machines.* La Nuova Italia Scientifica: Rome.

De Toffoli C. (2001), *Psichesoma. The knowledge of the body in psychoanalytic work*. In C. De Toffoli *Body-mind transits. The experience of psychoanalysis*. Franco Angeli: Milan, 2014.

Elkaim M. (1990). *If you love me don't love me*. Boringhieri: Turin, 1992.

Lacan J. (1949). *The Mirror Stage as formative of the function of the I"*, XVI International Congress of Psychoanalysis, Zurich.

Minuchin S., Rosman B.L., Baker L. (1978). *Psychosomatic families*. Astrolabio: Rome, 1980.

Olivenstein C. (1981). The childhood of the drug addict. *Archive of psychology, neurology and psychiatry*, XLII: 431-444.

Porcelli P. (2004), *Updates sul costrutto di alexithymia*. 1° International Conference on Addiction. The era of excess: Clinic and psychodynamics of addiction, Palermo.

Selvini M. (2007). *The complexity of obesity: recurring situations and some ideas for therapy*. 2° Conference of the Mara Selvini Centers Association for Anorexia and Eating Disorders. Hyperphagia and obesity: which psychotherapy ?, Milan.

Watzlawick P., Beavin J.H., Jackson D.D. (1967). *Pragmatics of human communication*. Astrolabio: Rome, 1971.

Winnicott D. W. (1967). *Mirror – role of mother and family in child development*. In Developmental psychoanalysis. Armando: Rome, 2004.

Notes

(1) The fourth axiom of human communication postulates the existence of different modules of communication: the analog module (typical of non-verbal communication and able to define the nature of the relationships) and the digital or numerical code (typical of verbal communication).

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