

Seeing Emotion as Information

How do we weather the storms of life in recovery?

BY MARK WOODFORK

Emotions are information. Fully understanding what this means in recovery takes time and practice. From a knowledge-based standpoint, one can learn that emotional energy flows through our nervous system in our bodies and minds. This flow of energy is essentially an affective, value-based information system (Siegel, 2001). From a practice-based standpoint, if we are tuned into this ancient information system, then we can feel whether acting on impulse is necessary in a given situation or responding after careful consideration is prudent. When we practice paying attention to this flow of emotional energy, we are strengthening neural pathways in the brain and body. From a brain-based perspective, bringing attention to our emotional states focuses our mind both on the flow of neurochemical energy in our bodies and between the layers of our triune brain. This impacts on the brain stem (associated with maintaining basic bodily functions like respiration and heart rate), the limbic region (associated with basic emotions and drives), and the neo-cortex (associated with consciousness and the ability to think and communicate with others) (Siegel, 2007).

The flow of emotional energy and information is bi-directional from top to bottom through our brain and body. The practice in recovery of attending to emotional energy takes place largely in the dorso-medial, ventromedial and dorsolateral prefrontal cortices that are located in the forehead area of our brain. These structures are essential to our “executive attentional” processes, and in conjunction with the orbitofrontal, insula and anterior cingulate cortices that sit slightly back and below the prefrontal cortices, represent the higher executive structures that monitor and modulate the lower mid-brain limbic system (emotion and motivation) and the brain stem (associated with basic drives and emotions) (Siegel, 2007). These structures have been essential to the survival of our species. Focusing the executive attentional

circuits brings awareness to subtle shifts in our states of mind. This awareness precedes the process of finding the right words to describe our basic emotions and to express one’s needs and values in recovery. When practiced in daily life, this process can strengthen the neural pathways in our brain and body for emotional awareness. The more quickly one is aware of a shift in their emotional state, the more likely they are to be responsive (versus reactive) to various situations and relationships in recovery.

Importantly, when we use the word *emotion*, we are talking about a state of being in a particular moment in time, for example: feeling excited, proud, happy, calm, lonely or some other emotion. These words carry information about what a person needs and/or values in that moment (Panksepp, 2009). The more in tune we are with the emotional state, the more likely we are to be able to express what we value or understand what we need right now. Emotions are information. To use weather as a metaphor to describe this process, as we develop a day-to-day practice of paying attention to our emotional states, we can more accurately delineate between a temporary emotional storm (e.g., a reaction to something someone said that upset us) or a larger emotional weather event that has clouded our consciousness for the day or the week (e.g., a mood that cannot be attributed to an activating event, but none-the-less is causing distress and is in need of some exploration).

From a neuroscience perspective, this process connects the energy and information flow between the upper and lower parts of the brain and central nervous system. As Alan Fogel details in *The Psychophysiology of Self-Awareness: Rediscovering the Lost Art of Body Sense* (2009), this process of attending to our bodily states increases our “interceptive” awareness, which is our ability to feel our internal bodily states.

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Preventing Harm and Duty to Care. Subsequently problems arise regarding the admission and treatment of medical marijuana patients. Conflicts between state and federal laws make it difficult for chemical dependency providers to balance compassion for the patient with the consequences of civil disobedience. Because chemical dependency professionals are not on the list of health care providers protected under Washington law they are risk of practicing outside of their scope and jeopardizing the creation of working relationships with their patients. Conflicts in laws and opinions regarding the efficacy of medical marijuana compounded by Federal legal definitions that marijuana has no medical value compromise a chemical dependency provider's ability to improve the options and choices a medical marijuana patient may have to treat acute medical issues related to addiction to alcohol or other drugs. Lack of knowledge in the chemical dependency provider community about marijuana and its potential for use as a medicine and various risks to the user's health dependent upon the route of administration complicate the chemical dependency professional's ability to evaluate the myriad of mixed messages patients and providers receive regarding marijuana. Lastly, the question of what degree does the use of marijuana to relieve symptoms of a recognized medical condition impair a patient's ability to make progress meeting goals and objectives on a treatment plan and will this ultimately require the termination of the patient/counselor relationship requiring potential life and death decisions to be made by a chemical dependency professional.

This overview of the problem does not come without an overview of some basic solutions. Each agency providing addiction treatment services in Washington would be well served to develop policy and procedure for admitting or choosing not to admit qualified medical marijuana patients into their program. For agencies making the choice to do admissions, issues like therapeutic dose verified by testing parameters defining the limits of THC metabolites should be defined. Rules

related to dosing pre-treatment, during treatment and post-treatment should be concretely stated and definitions regarding how the agency defines relapse need to be clearly presented to medical marijuana patients. Finally, expectations and training for providers regarding documentation regarding conditions for admission or referral, progress or lack of progress attaining treatment goals and criteria for discharge would need to be implemented.

For chemical dependency professionals, each will need to make decisions regarding the personal values, biases and understandings of their responsibilities as providers of services to alcoholic and drug addicted individuals. These decisions will ideally incorporate the guidelines provided in the NAADAC code of ethics, research and discussions with peers about the implications of attempting to provide addiction treatment services to qualified medical marijuana patients. These decisions will ultimately inform how each individual provider will engage in the discharge of his or her duties providing services to the community of patients requesting addiction treatment services.

This article in many ways only scratches the surface of the problem. It poses many more questions than it answers. But in consideration of all the many mixed messages that exist about marijuana as a medicine, recreational diversion, legalization/decriminalization, creator of tax revenues, etc. it is important that conversation begin somewhere.

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Essentially, this process opens up communication of information through the "crossroads" of our brain, i.e., the orbitofrontal, insula, and anterior cingulate cortices, which brings awareness from our bodily sensations into our executive attentional areas, i.e., the dorsomedial, ventromedial and dorsolateral prefrontal cortices.

Significantly, the neural pathways related to this level of embodied self-awareness are relatively slower than the pathways related to other intellectual activities (e.g., solving a math problem). This is due to the fact that interoceptive pathways involve unmyelinated nerve fibers (Fogel, 2009). Myelinated nerve fibers speed up transmission of energy and information through neural circuits. Therefore, in considering brain processes, this level of embodied self-awareness is going to be much slower and take more time to develop (particularly in early recovery) than the relatively rapid fire ideas and thoughts about oneself that enter the mind as "self-awareness." In short, this practice may entail slowing down, taking a deep breath into our body and trusting the information that comes from our physiology (i.e., from our "gut" and our "heart") — information that can guide our response to an emotional event in recovery (Woodford, 2012).

In summary, when the processes of paying attention and increasing emotional awareness are engaged in the middle prefrontal region of the brain, several important functions of the brain are enhanced that are essential for developing a relationship with oneself and others in recovery; namely, attuned communication, empathy, insight and intuition (Siegel, 2007). Although these functions are severely compromised by addiction, when we repeatedly slow down and reflect on our

emotional experiences, we are working out the muscles of our mind to increase our ability to respond well to high-risk situations in recovery. Over time, this process strengthens new neural pathways related to self-regulation and emotional development (Fosha, Siegel, & Solomon, 2009), which is at the heart of developing an integrated sense of self that can weather the storms of life in recovery.



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