

**Addictive Thinking**  
**Understanding Self-Deception**

**Second Edition**

**Abraham J. Twerski, M.D.**

**with a foreword by John Wallace, Ph.D., CAC**

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## Chapter 1

### What Is Addictive Thinking?

Interviewing Ray, a young man who had been admitted to a rehabilitation unit for drug addiction, I asked, “What made you decide it was time to do something about the problem?”

“I’ve been on cocaine for a few years,” Ray replied, “and occasionally I’d quit using for a few weeks at a time, but I’d never decided to stop for good before.

“For the past year my wife has been pressuring me to stop completely. She used to do cocaine too, but she’s been off for several years now. I finally got to the point where doing coke wasn’t worth the hassle, so I decided to give it up completely.

“I sincerely wanted to stop for good, but after two weeks I started up again, and that proved something to me. I’m not stupid. I now know that it is absolutely impossible for me to stop on my own, maybe.”

I repeated Ray’s last sentence several times because I wanted him to hear what he had just said. But he could not see what I was trying to point out.

I said, “It is perfectly logical to say, ‘Maybe I can stop by myself.’ It is also perfectly logical to say, ‘It is absolutely impossible for me to stop by myself.’ But to say, ‘I now know that it is *absolutely impossible* for me to stop on my own, *maybe*,’ is absurd because it is self-contradictory. It is either ‘absolutely impossible’ or ‘maybe,’ but it cannot be both.” Ray, however, was unable to see my point.

I have repeated this conversation to a number of people, and even seasoned therapists initially show no reaction, waiting for the punch line. Only after I point out the contradiction between “absolutely impossible” and “maybe” do they see the absurdity of the statement and the distortion of thought taking place in this man’s mind.

### Distortion of Thought

The phenomenon of abnormal thinking in addiction was first recognized in Alcoholics Anonymous, where the highly descriptive term *stinkin’ thinkin’* was coined. Old-timers in AA use this term to describe the “dry drunk,” or the alcoholic who abstains from drinking but behaves in many other ways much like an active drinker.

Distortions of thinking are not unique to addictive disorders, however; nor are they necessarily related to chemical use at all. Thought distortions can be found in people who may have other adjustment problems. For example, one young woman was procrastinating turning in her term paper for a class.

“Why don’t you finish it?” I asked.

“It’s finished already,” she said.

“Then why haven’t you submitted it?” I asked.

“Because I need to do some more work on it,” she said.

“But I thought you said it’s finished,” I remarked.

“It is,” she said.

While her assertion appears illogical to most people, it can make perfect sense to someone who thinks addictively. Furthermore, although distorted thinking does not necessarily indicate addiction, the intensity and regularity of this type of thinking are most common among addicts.

We all recognize that the statements “The term paper is all finished” and “I have to do more work on it” are contradictory. But Ray’s statement, “I now know that it is absolutely impossible for me to stop on my own, maybe,” may not appear absurd until we stop to analyze it. In normal conversation, we generally do not have time to pause and analyze what we hear. Hence, we may be deceived by, and accept as reasonable, statements that are meaningless.

Sometimes these contradictions can be even more subtle. For example, a woman, asked whether she had resolved all the conflicts connected with her divorce, answered, “I think so.” There is nothing patently absurd about this woman’s answer, until we pause to analyze it. The question “Have you resolved the conflicts?” means “Have you done away with the various uncertainties and eliminated the emotional problems incidental to your divorce?” That is what the word resolved means. The answer “I think so” is thus an assertion “I am still uncertain that I am certain” and is really meaningless.

### **Thinking Processes in Schizophrenia**

To understand more fully what we are talking about when we use the term *distortion of thought*, let’s look at an extreme example of it, the system of thinking used by a schizophrenic person. As absurd as a particular distorted thought may be to a healthy person, it may make perfect sense to a schizophrenic.

Therapists familiar with paranoid schizophrenic patients who have delusions of grandeur know how futile it is trying to convince a patient that he or she is not the Messiah or the victim of worldwide conspiracy. The therapist and the patient are operating on two totally different wavelengths, with two completely different rules of thought. Normal thinking is as absurd to a schizophrenic as schizophrenic thinking is to a healthy person. A typical schizophrenic’s adjustment to life in a normal society can be described in terms of a baseball manager who orders the team to punt or a football coach who calls for stealing a base.

Schizophrenic people do not realize that their thinking processes are different from the thinking processes of most other people. They can’t see why others refuse to recognize them as the Messiah or the victim of a worldwide conspiracy. Still, many people, some therapists included, may argue with a schizophrenic person and then become frustrated when the person fails to see the validity of their arguments. But this is like asking a color-blind person to distinguish colors.

Yet the thinking of the schizophrenic is so obviously irrational that most of us clearly recognize it as such. We may not be able to communicate effectively with a schizophrenic person, but at least we are not fooled by the delusions created in the schizophrenic’s mind. We are more frequently taken in by the relative subtlety of distortions caused by addictive thinking.

## **How Addictive Diseases Resemble Schizophrenia**

Sometimes people with addictive diseases are misdiagnosed as schizophrenic. They may have some of the same symptoms, including

- delusions
- hallucinations
- inappropriate moods
- very abnormal behavior

All of these symptoms, however, may be manifestations of the toxic effects of chemicals on the brain. These people have what is called a chemically induced psychosis, which may resemble but is not schizophrenia. These symptoms usually disappear after the chemical toxicity is alleviated and the brain chemistry returns to normal.

A person with schizophrenia, however, may also use alcohol or other drugs addictively. This presents a very difficult treatment problem. A schizophrenic is likely to require long-term maintenance on potent antipsychotic medications. Furthermore, a person with schizophrenia may not be able to tolerate the confrontational techniques commonly effective with addicts in treatment. Therapists teach addicts to desist from escapism and to use their skills to cope effectively with reality. No such demands can be made on a schizophrenic, who may actually lack the ability to cope with reality.

In a sense, both the addict and the schizophrenic are like derailed trains. With some effort, an addict can be put back onto the track. The schizophrenic, however, can't be put back on the same track. The best that may be accomplished is getting this person on another track that leads to the destination. This other track is not a "through" track. It has countless junctions and turnoffs, and at any point the schizophrenic may go off in a direction other than the desired one. Constant vigilance and guidance are necessary to avoid such turnoffs, and it may be necessary to use medications to slow the traveling speed and stay on track.

Being confronted with the thinking of an alcoholic, or someone with another addiction, can be as frustrating as dealing with the schizophrenic. Just as we are unable to budge the schizophrenic from the conviction of being the Messiah, so we are unable to budge an alcoholic from the belief that he or she is a safe, social drinker, or a safe user of tranquilizers, or a "recreational" user of marijuana and cocaine.

For instance, someone close enough to observe a late-stage alcoholic (or other drug addict) sees a person whose life is steadily falling apart; perhaps the addict's physical health is deteriorating, family life is in ruins, and job is in jeopardy. All of these problems are obviously due to the effects of alcohol or other drugs, yet the addict appears unable to recognize this. He or she may firmly believe that using chemicals has nothing to do with any of these problems and seems blind to logical arguments to the contrary.

A defining difference between addictive thinking and schizophrenic thinking is this:

- schizophrenic thinking is blatantly absurd
- addictive thinking has a superficial logic that can be very seductive and misleading

The addict may not always be as willfully conniving as others think. This person is not necessarily consciously and purposely misleading others, though this does occur sometimes. Often addicts are taken in by their own thinking, actually deceiving themselves.

Especially in the early stages of addiction, an addict's perspective and account of what is happening may look reasonable on the surface. As discussed, many people are naturally taken in by addictive reasoning. Thus, an addict's family may see things the "addictive thinking way" for a long time. The addict may sound convincing to friends, pastor, employer, doctor, or even to a psychotherapist. Each statement the addict makes appears to hold up; long accounts of events may even appear valid.

### **Obsessions and Compulsions in Addiction and Codependency**

The treachery of self-deceptive thinking may infect codependent family members as well as the chemically dependent person. Who is codependent? Various definitions and descriptions of codependency exist, but the one that seems most comprehensive is Melody Beattie's: "A codependent person is one who has let another person's behavior affect him or her, and who is obsessed with controlling that person's behavior."\*

The important parts of this definition are the words *obsessed* and *controlling*. Obsessive thoughts crowd out all other thoughts, and they drain mental energy. Obsessive thoughts may intrude at any time, and, strangely enough, any attempt to get rid of obsessive thoughts may only increase their intensity.

Trying to drive away obsessive thoughts is like trying to get a coiled spring out of the way by compressing it. The more pressure exerted against the spring, the harder it eventually recoils.

At the risk of oversimplification, we might say that the addicted person is plagued by the *compulsion* to use chemicals. A codependent person has an *obsession* with the addict's use and the need to control the addict.

Obsessions and compulsions are closely related. The term *obsessive-compulsive neurosis* has been used in psychiatry for many years. Both obsession and compulsion are characterized by the person's being preoccupied, even consumed, by something irrational. In an obsessional neurosis, it is an irrational idea that plagues the person. In a compulsive neurosis, it is an irrational act. The reason the two are joined in psychiatry is that in almost every instance where the person is obsessed with an idea, there is some compulsive behavior. In virtually every case of compulsive behavior, there are obsessional thoughts. The following story illustrates how obsessional thoughts work.

### **The Chair on the Desk**

While teaching psychiatry to medical students, I had a student who expressed interest in learning more about hypnosis. I felt that the most effective method of teaching this was to hypnotize him and allow him to learn firsthand what a hypnotic trance is and the various phenomena that can be produced under hypnosis.

This young man happened to be an excellent hypnotic subject, and in several sessions, I was able to demonstrate the various applications of hypnosis. Because I also wanted him to understand the phenomenon of post-hypnotic suggestion, I said to him: “Some time after you emerge from this trance, I will give you a signal—I will tap my pencil on the desk. At that point, you will get up, pick up the chair on which you are sitting, and place it on my desk. However, you will have no memory that I gave this instruction.” I then brought him out of the trance, and we continued our discussion about hypnosis.

After several moments, I nonchalantly picked up my pencil and tapped it lightly on the desk, while continuing the conversation. Within a few moments, the student, obviously uncomfortable, began to fidget. “I have this crazy urge to pick up my chair and put it on your desk,” he said.

“Why should you want to do that?” I asked.

“I don’t know. It’s a crazy idea, but I just feel like I have to do it.” He paused. “Did you tell me something like that during the trance?”

“Yes, I did.”

“Then why can’t I remember it?” he asked.

“Because when I gave you the suggestion, I told you that you would not remember it.”

“Then I don’t have to do it, do I?”

“I guess not,” I answered.

Shortly afterward, the student left. About twenty minutes later, the door flew open. The young man burst into my office, picked up the chair, and angrily placed it on the desk. “Damn you!” he said, and turned around and left in a fury.

This is the nature of an obsession or a compulsion, whether it occurs from a suggestion given under hypnosis or from a subconscious urge from some unknown origin. Just as putting a chair on a desk is nonsensical, a compulsive act can be irrational, yet the urge to do it may be virtually irresistible. Trying to resist the urge can produce so much anxiety and discomfort that the individual may give in to it simply to get relief from the intense pressure. With most obsessions and compulsions, this period of relief is quite brief; then the urge recurs, often with even greater force than previously.

Codependent people often behave in these obsessive-compulsive ways when they try to control an addict’s behavior or use of chemicals. They may be obsessed with trying to help the addict or, later, if their efforts have failed, with punishing the addict.

### **How Addiction and Codependency Are Similar**

Similarities between the behavior of an addict and the behavior of a codependent are striking. Addicts are usually looking for new ways to continue to use chemicals while trying to avoid their destructive consequences. A person might drink alcohol or use cocaine “only on weekends” or get a measured amount that will give the desired “high” but not enough to result in intoxication. When the efforts at control fail, addicts do not conclude, *I can’t control my use*. Instead, they tell themselves, *That method did not work. I must find another method that does work.*

In the same way, codependents will not conclude that since efforts to stop the addict have been futile, there is no way of controlling the addict. Rather, they look for new ways that will work.

### **Cause and Effect**

Does an addict's distorted thinking cause an addiction, or does the distorted thinking result from the addiction? This is a complex question, and cause and effect cannot easily be determined. By the time an addict enters treatment, several cycles of cause and effect have usually occurred, and anyone trying to tell which is which may be caught in a catch-22. In a sense, it doesn't matter whether someone's thought processes contributed to the addiction or whether addictive thinking is a symptom of addiction. In either case, treatment and recovery must begin somewhere. Since active chemical use stands in the way of success in treatment, abstinence must come first. After prolonged abstinence, when the brain again functions more normally, addicts can focus their attention on their addictive thinking.

This book is intended to help the addicted or codependent person identify his or her thinking processes and begin to overcome addictive thinking.