Trascend addiction. A person is not their addiction

Transcender la adicción. Una persona no es su adicción

Antonio García Patiño
Clinical Psychologist
ORCID: https://orcid.org/0000-0002-4242-1597

Received: 14/02/2022 · Accepted: 11/03/2022

Cómo citar este artículo/citation: García Patiño, A. (2022). Trascend addiction. A person is not their addictionn. *Revista Española de Drogodependencias*, *47*(1), 22-32. https://doi.org/10.54108/10002

Abstract

This article aims to be the epitome of a trajectory, of a line of action maintained over time and framed in a vision of the person, not as an object of treatment, but as a responsible subject and co-builder of the response to an addictive problem.

Transcending addiction is freeing the gaze from an archaic, oppressive and stigmatizing paradigm. It is, likewise, to establish a horizontal, purposeful and motivating relationship, instead of the prevailing vertical relationship. The technical should not favor the relational.

Transcending addiction is going beyond a diagnosis; go beyond the consideration of mental illness, to be able to focus the process on the person and, fundamentally, on the healthy part, on the uncontaminated part, in order to achieve their free being.

Since identity is an affective, cognitive and active need, it must become the basic pillar of treatment. It is not about rehabilitating addictions, but generating the possibility for a person to rediscover themself on the path of their existence.

One day a lament was heard: "I am not my addiction, don't make me believe it".

Keywords

Trascend, Relation, Process, Person, Perceive, Paradigm, Freedom, Identity, Addiction.

– Correspondence:
Antonio García Patiño
Email: angarpa@hotmail.com

Resumen

Este artículo pretende ser el epítome de una trayectoria, de una línea de actuación mantenida en el tiempo y enmarcada en una visión de la persona, no como objeto de tratamiento, sino como sujeto responsable y co-constructor de la respuesta a una problemática adictiva.

Transcender la adicción es el liberar la mirada de un paradigma arcaico, opresor y estigmatizante. Es, así mismo, establecer una relación horizontal, propositiva y motivante, en vez de la relación vertical imperante. Lo técnico no debe priorizar a lo relacional.

Transcender la adicción es ir más allá de un diagnóstico; ir más allá de la consideración de enfermedad mental, para poder centrar el proceso en la persona y, fundamentalmente, en la parte sana, en la parte no contaminada, para la consecución de su ser libre, ser libre para.

Siendo la identidad una necesidad afectiva, cognitiva y activa, debe constituirse en el pilar básico del tratamiento. No se trata de rehabilitar adicciones, sino generar la posibilidad de que una persona se reencuentre a sí misma en el camino de su existencia.

Cierto día se oyó un lamento "yo no soy mi adicción, no me lo hagáis creer".

Palabras clave

Transcender, Relación, Proceso, Persona, Percibir, Paradigma, Libertad, Identidad, Adicción.

INTRODUCTION

Addictive behaviors can be studied from the most serious, conscientious and validated investigations, just as those same behaviors can be defined from theoretical distance, based on the prevailing medical-psychiatric paradigm. But we can also find many reasons that give or fill an explanation of addictions from daily interaction beyond diagnosis and from personal knowledge beyond a clinical history.

Seeing the subject through the opaque glass of the addictive epistemology that has always accompanied us, underlies all intervention, prompted us to carry out our work, our intervention, with blinders, with lenses that reduced our perceptual field, and, therefore, our response in search of solutions.

The addictive paradigm, for many years, has been marked by a series of professionals who in many cases coordinated, shared and imposed on other actors, from a justifying generalization of actions and by professional habituation. A paradigm that apparently led us to successful results from the medical-psychiatric diagnosis.

When we learn the diagnosis and its keys, we tend to see a person with the same problem as another person with a similar problem, even if it has nothing to do with it!, and from here... we act checking the diagnostic similarities to convince ourselves that similarities in treatments and outcomes. It becomes clear that we forget "something", the most crucial and important thing, the differences of people and, therefore, we see them as just another case. We also obviate

in the intervention that "a person is not his addiction". (Gema Villa and Antonio García).

Did the permanent identification with a pathology, disorder, lead us to some therapeutic benefit? Did it bring us something or perhaps it chronicled a state of unease of despair? We fed the addictive memory through the systematic mortification of the person as a way of recognizing their disorder.

And all of this brought us back to another strange personal paradox, people trapped in addiction and trapped in the solution. To some of them we only leave the diagnosis without further response, producing a complicated simple thought: if she cannot be a person in the world and there is not a minimum trust or, simply, understanding towards me, and only a name is named that is moves and identifies me, I don't want to be that name, it's me!

In the words of P. Coelho: "What drowns someone is not falling into a river, but staying submerged in it."

And we believed that the time had come to stop the identity and philosophical turbulence of the subject with addiction and, on the one hand, the values of respect, dignity, acceptance, and, on the other, the new concept of Mental Health, to walk towards a new conception of the addictions.

Identity is an affective need in terms of feelings, cognitive in terms of self-awareness, and active in making decisions. Therefore, it must become the basic pillar and engine of addiction treatment as it is the result of a personal history and a changing social reality.

Each person represents or presents a unique event and, by not taking this event into account, the explanation that can be offered is framed and adjusted to the model, like a Procrustean fact, lacking any flexibility. Abounding in a dramatic paradox, in the name of freedom we build chronic and recurring archetypes.

Much of the truth is found where it is not seen, where we do not look: and this happens because we ignore something essential that may be found in the world of the other and, also, because perhaps we get lost spinning around the world of theories and not we seek where the answer truly lies, in person, in your world and in the consciousness of your being.

Each person has an addiction to discover, but, instead of exploring a new experiential world that is offered to us, we refer to the already known model to offer a diagnosis that is justified, not that broadens the understanding of the subject, and thus we move through places established commons.

Behind or beyond each addiction, understood as a subjective reality or shared reality, there is at least one person, almost always several people who exist and are in the world. I want to remember here, a very young patient, with "diagnosed" polydrug addiction who told me: "I want you to teach me how to die, I want to die without feeling it". Behind an addiction there is a great personal world.

Going beyond the complex simplicity of the supposed explanatory and descriptive principles is perhaps too pretentious an objective, but it is no less true that to consider addictive behaviors as meta-existential is to go beyond those principles.

An experiential master's degree in addictions contains in its curriculum true lies, double deceptions, cognitive duplicities, emotional manipulations and self-manipulations, addictive "schizophrenia", which is a multiple luck of being in the world without really knowing what state one belongs to.

Says a maxim: "Each carnival mask is different." Therefore, an addictive hermeneutics adjusted to the person and the social and cultural reality in which it develops is necessary. Addictions are not mental illnesses, but rather a mental construction that varies in each culture, in each historical moment and in what the "normopaths" (M. Lutz) consider normal or pathological.

But we must link the answer to the person, in such a way that when she is not interested in her recovery but herself, then and only then, will she be in the right place and at the right time, to understand that rehabilitation is not an end , it is a process; and the consequence of the will to meet itself will overcome the addictive will.

PERCEIVE/PERCEIVE ONESELF

The experience caused by an addictive process will inevitably produce a profound change in the vision that a person has of themself and their social/family environment. The degeneration that will occur in this process will lead the individual to feel relationships, social interactions as threats.

When we observe these people from the perspective of addiction/problem, the same existential difficulties that the individual feels and suffers, will experience them as suffocating and we will look at them from stigmatizing positions. The gaze cannot be exclusive; too often it is the theory that determines what one can observe and we cannot maintain a routine way of looking at the person in front of us.

It is important that from the first interactions people with an addictive problem perceive the "expert" as someone they can trust, someone capable of understanding them and helping them, with their experience and knowledge, to build a response, to find a way out and develop your personal growth. And it is transcendental and basic to generate this perception because, and it is well known, the person who in a stretch of his life has been immersed in an addictive experience, will present a high degree of distrust in others, whether they belong to a social environment or another. Too many times they have been judged, condemned and viewed with suspicion.

We must modify the perspective of the participants in the construction of the recovery process, in such a way that useful and effective solutions can be generated as a result of a new vision of the situation.

Sometimes, the most, the only thing that people with addiction have is a diagnosis and through it they perceive themselves and are perceived. It does not look beyond, we do not see that we do not see. Well, reputation is built on what has been heard or is known and not on the behavior of the subject, and this is so, insofar as experts have developed a special relationship with the addictive problem and, consequently, a specific language with its characteristics, the practical possibilities and the danger of transmitting an image of the subject, ending up being their own prisoner.

The loss of emotional environments considered as their own, of connection with the supposed "social normality", of reaching a physical and psychological distance with the consequent relational loss, will lead individuals to an isolation that, in all probability, will lead to a a feeling of loneliness with the consequent associated emotions, emptiness, helplessness, hopelessness, etc., which will generate even more vulnerability to the supply of consumption and the risk of perpetuating it.

Our actions will reach patients determining certain responses in them and modifying their perceptions, that is, they will be influenced. Any word, gesture, attitude, can make the person with whom we interact believe, mature, grow, ...or plunge into a personal crisis, seeing a world without a future, because one ends up being what others believe one is.

It's just that I'm not that one; don't make me believe.

VERBAL ENVIRONMENTS - LANGUAGE

"Winning is a process that involves changing how we talk to ourselves"
H. Kristera.

It is undeniable that language is the means to develop a co-construction of the therapeutic process and we must bear in mind that at the same time that we define words and unravel their meaning by describing the world and the moment in which we move, those same words They define us, they tell us who we are, they take over us! They make us or at least make us believe that we are.

We cannot underestimate, when using certain terms, how much words influence our forms, attitudes and behaviors. The words sick and cerebral, drug addict, etc., will end up constituting a style for the person, a way of being in the world, since they will induce that person to believe they are sick, to consider themselves a drug addict, gambler, etc., by assuming the meaning, the content of words.

The diagnosed chronicity, the "for life" that it chains, can generate, provoke discouraging expectations in the person, abandonment of the intention to change because there is probably no defenselessness against the addictive disorder.

Words can modify the importance of a fact, of being and even of a "being in the world". Naming a person with his addiction is not the same as naming him as "brain sick", as it is not the same to make the designation in the "person" than in the terms "addict", "sick", ... addiction, disease , then, at that very moment, the last terms will take over the first and we will thus come to speak of an addict, a sick person, without naming the person.

"People build ourselves in relationships and communication is the process that makes them possible"
X. Guix I Garcia.

Any moment in life occurs immersed in conversations and, basically, where we will feel the reality that surrounds us and in which we feel alive. Sometimes, in treatment, there is no dialogue. There is an imperative monologue in which one of the two parties does not participate.

If we want a powerful, positive reality outside of the addictive space, we must generate an open, thoughtful conversation where a solution can be produced.

A true conversation requires attention from the attitude, and stillness in time, the pause to share moments, to develop shared decisions to create new realities.

There is a word, a concept, namely parrhesia, "parrhesia resorts to dialogue and you to you". J.M. Esquirol. Generating a dialogical space in which language is shared in meaning, content and common in ideas and meaning.

RELATION

Perhaps the time comes when uncertainty, emptiness and self-hatred take over the person, at that moment it is essential to

set the purpose that moves them towards a future, perhaps uncertain but future after all.

The experienced helplessness falls like a slab in the form of a diagnosis. And these people with addiction suffer suffering that is not only a consequence of their addiction but also of a family/social relational environment, which can take the addictive suffering to unbearable extremes, thus perpetuating a search to find someone who does not stigmatize or marginalize them, in short, not humiliate them.

What differentiates us from people with addictions, neither more nor less, is where this addictive society establishes the limit between normal consumption and addiction and that once it is overcome, the individual goes on to become an addict. What's more, we would have to stand up, what normality are we talking about? We cannot ignore that addictions are written by societies, cultures.

More often than not individuals with an addictive disorder feel that they have to be grateful for the fact that they are "tolerated"; but the attitude of those who tolerate can become offensive because they do not want to be suffered but to be seen as equals and to feel accepted.

Thus, starting from a healthy modesty, we can speak to them recognizing that we do not have the solution, but we can accompany them in the search, on the path of co-construction of the solution. People in your relationship lend information to each other in search of solutions. We can redirect the relationship to a place where the most human part of addictive behavior finds the answer. We consider it wrong to see only the disease of patients and ignore health.

The therapeutic relationship is one of the pillars where the effectiveness of the intervention is based, since the deficiencies suffered at the relational level are one of the most painful effects. The attitude with which we relate will be the genesis that will develop contexts where constructive changes occur.

We must be aware within the relationship, of our service function. The expert must make it easier for the patient to access his abilities, aptitudes and possibilities so that, when the time comes, he can disassociate himself from the relationship. Intervene to create new possibilities avoiding tight reductionism, since the phenomena, changes, that occur will derive from the relationship, overflowing the personal sphere.

The relationship cannot be vertical, we advocate a direct, horizontal and purposeful relationship; what is essential is that it be based on mutual respect and tolerance. The technical should not prioritize the relational, in order to create a relationship that links the participants, we exist as beings in relationship. The patient cannot look at the professional from the depths of guilt or submission, but from an equal plane to be able to build the solution. Obliged to respect and listen to them and to endow the relationship with a seriousness that destigmatizes the individual.

The question to answer would be, what kind of relationship can we build so that the person in front of me, or next to me, can use it in their own development process?

The acceptance of the individual with an addictive disorder will generate in them the feeling of being valued as a person who is and is in the world. And the condition for that acceptance to exist is the understanding, of their feelings and emotions, of their attitudes and behaviors, in short, of their, all of them as a person.

We speak of freedom, but the person who comes looking for an answer does so conditioned by their situation, by a strong social burden that imprisons them, stigmatizes them and restricts their image and definition of themselves.

When a person goes to a center, association, anywhere looking for an answer or solution, and is recognized as having a problem of addiction or problematic consumption, they stop being an addict "in themself", to be an addict in relationship. The relationship is what heals. That meeting will enhance their ability to change and develop confidence in their potentialities that, perhaps, he ignores.

We can make them feel influenced by our attitudes, by some gesture, because we lead them in the belief of being able to grow, mature, enjoy... or immerse themselves in their own personal crisis, because they will take them to their darkest side, they want to get out of. You end up being what others think you are.

PROCESS: FROM ADDICTIVE BEHAVIOR TO BEHAVIORAL AUTONOMY

A definition of addiction is presented to reflect on the process. "Addiction as a 'life event', which will lead the individual with an addictive disorder to a dysfunction in their activities and behaviors and to a dysfunction in their cognitive and emotional sphere". (Garcia Patiño, A. 2017).

The starting question would be: what can a person with addiction do instead of the addictive behavior? In the intervention, the person, from the first moment, must feel free because he is a being that belongs to a society within which he relates and communicates.

One day a patient expressed a phrase that perhaps summarizes without the possibility of improving it the feeling of the diagnosis and the burden of the definition of addiction: "Every day I wake up with the same dead." What is the result of so much daily effort, so exhausting? Restarting the effort. The most intense despair seizes one when realizing that it is necessary to begin again. Sisyphus myth. "I can't stand myself anymore, I can't stand my addiction. I can't bear any more slavery, I can't tolerate any more loss of freedom."

If we convert, the individual becomes a person who only suffers, without possible expectations, they will be unable to have a vision of the future, a hope, a life purpose. How can we relieve suffering? Through respect, accompaniment, understanding and empowerment.

When we propose an intervention, it is usually dictated as expert professionals with little or no participation from those who live their addiction, these people being beneficiaries of our intervention and obediently submissive to the indications. The patient must feel subject to their recovery process and not the object of treatment.

The approach that has brought us here is to work with what will make change possible and not with what prevents it. It is a proactive, motivating, cooperative approach that leads the participants to the co-construction of the solution. What is relevant is the person as a being in the world and as a source of solution for her own addiction. Co-building implies mutual respect, support and joint action.

The recovery intentionality is based on a motivation to achieve, never on a fear of failure, fear of "receding". Clinging to certain

ogres, which at first are considered basic and that could be constituted as a primary solution, can later prevent the achievement of other greater benefits and, perhaps, the ultimate goal. To become hostages of certain achievements is to forget about what the final goal, freedom, supposes.

In each and every one of the individuals there is something that does work, its identification is the basis of the process that has to present us the potential of the person for the impulse of it; if we remain in distinguishing and differentiating disabilities, what we will obtain will be failure.

If we start from a proactive principle, it will be possible for the person to develop with their positive assets, with their strengths and aptitudes, the resources that they still have. Working with all the good things in people, what's more! The need to be what the person is will be generated; to recognize themselves in their actions and in their decisions; to feel in what belongs to him, be they actions or behaviors, be they states, emotions or feelings. The need to be well with oneself is born.

When the process of responding to an addictive situation begins, an identity dilemma appears because the individual will ask himself: who am I?, and how to answer that question, from the healthy part or the contaminated part, from the person or the diagnosis, from the appearance or the depth of being.

Everyone who has gone through an addictive experience, in one way or another, has experienced a disintegration of their self; we have to show them that they can regroup it, in order to rebuild another variety of their existence, of the game of living and that they only need to be the people they are, for the pieces they have, to re-experience the feeling of being alive and looking the future with many possibilities.

Propose the search for the meaning of life in those moments of uncertainty and ambivalence, as a process of growth and balance both psychically and emotionally, affectively and socially, to continue believing in the possibility of change, to continue believing in the person.

The purpose of the whole process is to overcome the pathological lack of freedom to reach the freedom of the individual himself, because if not, we find solutions for people trapped in addiction and trapped in the solution! "And now that you have broken the wall with your head, what will you do in the next cell?" S. J. Lee.

The patient's decision-making puts in truth that, from the addiction, there is a freedom in himself that is based on deciding to jump out of it. "Recovering" will mean displacing an addictive lifestyle in which addiction was the impulse for the behaviors framed in that style, and occupying that nuclear place with the conviction that starts from knowing oneself free, from feeling free, with a lifestyle in which have no place neither the behaviors, nor the attitudes, nor everything that enslaves the person.

We know that addiction is a lack of freedom, but we are also obliged to know that it is not the total lack of freedom, and this reflection leads us to the core objective of the process, rather than "freedom from" it would be "freedom for" as the driving force ; freedom to be independent, freedom to decide, freedom, in short, to achieve self-realization.

When someone comes to consult, they generally talk about why, the subject makes

a narrative that is only referred to in the casuistry, causes that are often undefined and blurred. But sooner or later, in the course of the sessions, the question that confers and gives meaning to the therapeutic relationship appears, "why do you attend? Why do you attend?".

The intervention proposal in the process is to start from "the healthy part of the person" (Villa Bermejo, G. 2017), from the positive, with their feelings, their emotions, etc.

The part that is based on the person himself and not on the addiction, and not on the pathology, not on the disease; work from the value and not in the possible deficiencies. We cannot ignore that we work with people with addiction, and this order does matter!!

The healthy part exists in people, and is inherent in them from the impulse and tendencies to develop the capacities they possess. Hence, our intervention rests on this conviction, on the growth impulse and the desire for personal improvement of people that leads them to their self-realization.

In the process, neither the predetermined action nor the rigid model to follow can be valid, there are only patients and existential moments and it will be they themselves, with the necessary advice, who determine and generate the action to be carried out. The process builds itself and adapts to each situation and the person in that situation.

It must be adjusted and built according to and tailored to the recovery drive, not the addiction; of the new ideas generated and of the strategies that are proving effective, rejecting any rigid position and, from an empirical and continuously updated situation, recognizing people and their events and which ones are capable of being changed.

FINAL

We have long argued that addiction contaminates a part of the person, but it is not the person, because a part of it continues to exist despite not being free. People are not their addiction, it's them, them, and their environments without excuses.

We believe in the ability of the human being to use the repertoire of experiences and potentialities that he possesses and perhaps ignores. In other words, people have the resources to overcome the addictive problem that has led them to request help and, therefore, they must use those resources available to take care of themselves and not cede that responsibility to an external agent.

The effectiveness of the intervention will be based on the person's capacity to effect change, and this capacity will be developed in the encounter with other people. Each individual can improve and it is important, because each one has their own possibilities for growth.

The way to break with an addictive disorder is to expand one's abilities and the limitations that are experienced.

We consider that we have reached the agreement that addiction is the lack of freedom, when freedom and decision do not belong to the individual, but all the freedom of decision?

The scar of addiction exists, but the wound no longer exists. You can't keep poking around to keep it bleeding. The addictive experience must be assumed and it is irreversible because living is, but that does not entail living chained. The solution belongs to the patient himself and he is the one who has to give his life a meaning; sense so that the being is realized in him with all the emotion and existential intention of him.

When it comes to understanding and dealing with an addictive disorder from the individual, family, social or from the immensity of relationships, we must change our perspective so that our vision is less negative and the stigma disappears.

So when we look at a person with an addictive disorder, let's see a person and not a diagnosis, so that they can feel themselves as being in the world.

To finish: **Who only understands addictions, does not understand addictions.**

CONFLICT OF INTEREST

The author declares that there is no conflict of interest.

NOTE. This article corresponds to a line of intervention maintained over time, developed and agreed upon with Gema Villa Bermejo, an expert psychologist in addictions.

REFERENCES

Ambrosio Flores, E. (2002). Psicobiología de la Drogadicción. UNED. Dpto. de Psicobiología. Universidad Nacional de Educación a Distancia.

Becoña, E. (2016). La adicción "no" es una enfermedad cerebral. *Papeles del Psicólogo*, *37*(2).

Blech, J. (2005). *Los inventores de enfermedades. Cómo nos convierten en pacientes*. Edic. Destino, imago mundi.

Camps, V. (2005). *La voluntad de vivir*. Edi. Ariel.

De Vicente, A., and Villamartín, S. (2007). La adicción no es producto de factores genéticos o de un desequilibrio bioquímico. *Papeles del Psicólogo*, *28*(1).

De Vicente, A., and Berdullas, S. (2019, 19 de septiembre). Bélgica se posiciona en contra del DSM, apostando por un cambio en el paradigma en Salud Mental. INFOCOP.

Elster, J. (2001). *Sobre las pasiones*. Paidos.

Esquirol, J. M. (2015). *La resistencia íntima*. Acantilado. Barcelona.

Ey, H., Bernard, P., and Brisset, Ch. (1965). *Tratado de Psiquiatría*. Toray-Masson. Barcelona.

Frances, A. (2014). *¿Somos todos enfermos mentales? Manifiesto contra los abusos de la psiquiatría*. Edi. Ariel.

García de Vinuesa, F., González Pardo, H., and Pérez Álvarez, Marino, (2014). *Volviendo a la normalidad. La invención del TDAH y del trastorno bipolar infantil*. Alianza Editorial.

García Patiño, A. (2003). Alcohol y Juventud. III Congreso Nuevas Técnicas en Alcoholismo.

García Patiño, A. (2021). Yo no soy mi adicción. Jornadas AMALAJER.

González Pardo, H., and Pérez Álvarez, M. (2007). *La invención de trastornos mentales. ¿Escuchando al fármaco o al paciente?* Alianza Editorial. Madrid.

Kuhn, T.S. (1975). *La estructura de las revoluciones científicas*. Fondo de Cultura Económica. México. Madrid.

Kuhn, T.S. (1983). *La tensión esencial*. Fondo de Cultura Económica. México. Madrid.

La Rosa, E. (2009). *La fabricación de nuevas patologías. De la Salud a la enfermedad*. Fondo de Cultura Económica. Lima. Perú.

López Castilla, C. J. (2015). La medicalización de la infancia en Salud Mental: El caso paradigmático de los trastornos de atención. *Papeles del Psicólogo*, *36*(3), 174-181.

Lütz, M. (2010). *¿Estamos locos?* Sal Terrae. Santander.

Maturana, H., and Varela, F. (2003). *El árbol del conocimiento. Las bases biológicas del entendimiento humano*. Edi. Lumen.

ONU. (2017). Informe del Relator Especial sobre el derecho de toda persona al disfrute del más alto nivel posible de salud física y mental. www.infocop.es/pdf/InformeONU.pdf

Pérez Álvarez, M., Fernández Hermida, J.R., Fernández Rodríguez, C., and Amigo Vázquez, I. (Coords.) (2003). *Guía de tratamientos psicológicos eficaces I – Adultos*. Ediciones Pirámide.

Pérez Álvarez, M. (2011). El magnetismo de las neuroimágenes: Moda, Mito e Ideología del Cerebro. *Papeles del Psicólogo*, *32*(2), pp. 98-112.

Pérez Pérez, T. (2017). El enfoque apreciativo, valiosa herramienta para construir cultura de paz. *Revista de la Universidad de La Salle*, (72).

Ordine, N. (2013). *La utilidad de lo inútil*. Acantilado Bolsillo. Barcelona.

Puerta, C., and Pedrero, E. (2017). La falacia de la adicción como enfermedad mental. Las drogas.info. Recuperado de: https://www.lasdrogas.info/opiniones/la-falacia-de-la-adiccion-como-enfermedad-cerebral/

Rojas Marcos, L. (2010). *Superar la adversidad. El poder de la resiliencia*. Espasa.

Rubio Valladolid, G., y Santo Domingo, J. (Eds.) (2000). Guía Práctica de Intervención en Alcoholismo. Agencia Antidroga. Comunidad de Madrid.

Tirapu Ustárroz, J., Landa González, N., y Lorea Conde, I. (2004). Cerebro y Adicción. Una guía comprensiva. Gobierno de Navarra. Departamento de Salud.

Villa Bermejo, G. (2016). Trabajar con la parte sana de los pacientes. Curso de Monitores. Huelva.

Watzlawick, P., and Krieg, P. (Comps.) (1998). *El ojo del observador*. Gedisa Editorial.

Wiener, N. (1995). Inventar. Sobre la gestación y el cultivo de las ideas. METATEMAS 40. Tusquets Editores.