



Centring Emotion in Addiction: The Emotional Nexus Recovery Model

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Abstract

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ARCHIVAL RECORD

Centring Emotion in Addiction: The Emotional Nexus Recovery Model

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Addiction is increasingly understood as a condition shaped by interconnected biological, psychological, social, and spiritual elements that contribute to its onset and persistence. Although various treatment and recovery models demonstrate some success in reducing substance misuse and promoting abstinence, they often give little attention to the role of emotional experiences, particularly shame. This discussion examines the importance of recognizing emotion, with an emphasis on shame, in the addiction recovery process, advancing the understanding that addiction serves a purpose in reducing emotional suffering and fostering survival. The Emotional Nexus Recovery (ENR) model integrates biopsychosocial-spiritual and emotion-focused frameworks to promote a holistic understanding of addiction that positions emotion as a central guide in the recovery process. Limitations of the model and directions for future research are discussed.

Keywords: *addiction, biopsychosocial-spiritual, Canada, emotion, recovery, shame, treatment*

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1. Introduction

It is estimated that, worldwide, half the adult population uses psychoactive drugs on a regular basis, far more if caffeine is included in the totals. In Canada, adult drug use from 2007 to 2020 remained relatively steady with two major exceptions: cannabis and opioids. Alcohol remained the most commonly used psychoactive agent, with approximately three-quarters of those 15 years of age and older using the drug annually. Not surprisingly, given the change in status from illicit to legal in 2018, cannabis has seen the greatest increase in reported use in the 21st century within Canada, with nearly one in five adults indicating using the drug at least once in 2020 (Canadian Substance Use Costs and Harms Scientific Working Group, 2023). Interestingly, cannabis misuse has decreased (McDonald et al., 2025), however this has not prevented cannabis from becoming the leading cause of psychoactive-related hospital admissions among youth (Canadian Institute for Health Information, 2026). Despite a far lower rate of use than either alcohol or cannabis, the drugs that have received the most media and political attention have been opioids. Taking into account population size, North America continues to have the greatest rate of illicit opioid use globally, approximately 4% of the population (Csiernik, 2026). The influx of opioid prescriptions beginning with the introduction of oxycontin in 1999 created an opioid dependence epidemic in Canada, with a 24% increase in opioid prescriptions between 2010 and 2014 alone (Eibl et al., 2017). Between January and March 2025, Canada experienced a reported 1377 opioid deaths (Government of Canada, 2025). It has been estimated that the cost of substance use to Canadian's is more than \$49 billion annually and leads to over 200 lives lost per day

(Canadian Substance Use Costs and Harms Scientific Working Group, 2023). Likewise, overdose deaths in the United States have reached unprecedented levels as between June 2022 and June 2023, over 106,500 individuals alone died with opioids being the primary driver of fatalities (Centers for Disease Control and Prevention, 2023). Neither substance misuse or the opioid crisis is an issue only in North America as opioid misuse is a major problem in public health worldwide (Health–Americas, 2023).

2. Foundations of addiction

It has been well established that addiction has several distinct interconnecting elements (Csiernik, 2026; Csiernik et al., 2023). Notable biological factors responsible for the commencement and continued use of substances include genetics, chemical and hormonal imbalances, physical health, nutrition, sleep and the impact of withdrawal (Yazici & Bardakçi, 2023). By continuing to use substances, a tolerance to the psychoactive drug will often form, leading to the brain and the body requiring an increasing amount of the substance to remain in homeostasis (Csiernik, 2025). Additionally, psychological factors such as mental health, trauma history, cognitive processing, stress, and motivation have a connection to addictive behaviours (Yazici & Bardakçi, 2023). Not only do psychoactive agents move users away from their natural homeostatic level of anxiety, creating a sense of euphoria, but they also provide an escape from psychological turmoil (Fisher, 2022). Mental representations, if inaccurate, may lead to destructive thought processes, emotions, and behaviour, including substance misuse (Rakfeldt, 2023). The quality of social factors in an individual's life has been associated with reduced risk of relapse in

those recovering from substance misuse (Yazici & Bardakçi, 2023). It has been argued that substances may be used as a replacement, in some situations, for interpersonal connection and thus, social support and capital are deemed vital for recovery (Chen, 2022; Maté, 2021).

Viewing substance misuse as a behaviour that serves a functional purpose helps to conceptualize why people may continue to use substances even when it conflicts with their values. This inconsistency between behaviours and beliefs is referred to as cognitive dissonance (Festinger, 1957) and may lead to uncomfortable feelings of moral tension or conflict (Hashemi & Vogel, 2024). As people typically desire consistency in terms of their behaviours and values, those experiencing cognitive dissonance will often take action to reduce the discomfort it causes (Tse et al., 2022). The most common way of reaching cognitive consonance is by changing attitudes to be more consistent with current behaviours, rather than changing behaviours to be more aligned with attitudes (Harmon-Jones & Mills, 2019). Even so, cognitive dissonance is recognized as a powerful motivator for change within substance use behaviours, as some individuals will decide to change their usage to be align more with their values (Tse et al., 2022). Hashemi and Vogel (2024) identified that in circumstances where psychoactive substance use is normalized among peers, messages about moderation and harm reduction may be more acceptable than promotions of abstinence, as cognitive dissonance will prevent the acceptance of this rigid practice. While potentially helpful in motivating change, cognitive dissonance may also produce emotional reactions, leading to increased substance use, to avoid negative feelings or an alteration of value systems to support drug-using behaviours (Harmon-Jones & Mills, 2019; Tse et al., 2022). This is one reason why the emotional state of the individual is a critical aspect underlying the development, maintenance, and escalation of substance misuse to become an addiction.

Negative emotions have been linked to substance use in multiple understandings of addiction, including negative reinforcement, tension-reduction and social learning models (Batchelder et al., 2022; Peralta & Steele, 2010; Smith, 2021; Wilson 1988). Maté (2021) argued that addiction originates in pain, whether openly known or subconsciously. One reason for individuals beginning and continuing to use psychoactive substances is that drugs work, even if temporarily, in reducing feelings of emotional pain and suffering (Barnett, 2024). Individuals who use substances to avoid or relieve negative emotions have been shown to develop addictive patterns of use more quickly than those who reported other reasons for their administration (Wilcox et al., 2016). This avoidance of emotional experiences can lead individuals to lose their ability to be emotionally present, becoming, as Maté described, “emotional amnesiacs” (2021, p. 39). Emotional dysregulation then becomes even more prominent, and addiction more severe, as use continues (Wilcox et al., 2016). This has led to counsellors in this practice area advocating for the incorporation of emotion-regulation training and supports for those with addiction issues to improve overall well-being, by first understanding the purpose that substance use serves (Barnett, 2024; Chen, 2022). Additionally, attachment theory explains how early attachment to an emotionally present caregiver is vital to developing a healthy sense of self and the ability to regulate emotions (Ainsworth, 1973; Bowlby, 1958; 1982; Parolin & Simonelli, 2016). Substance use, then, instead of being internalized as a moral failing, is recognized as a learned behaviour used to suppress very real and unbearably painful emotional experiences (Barnett, 2024), while filling a void of lost connection (Maté, 2021). By identifying these experiences that lead to their

substance misuse, the individual is in a better position to learn to work with these feelings and develop alternative coping strategies (Barnett, 2024).

Even with a strong motivation to change behaviour, difficult experiences can lead to fluctuations in emotional arousal and a breakdown of cognitive processes (Barnett, 2024). This can manifest as either hyper-arousal or hypo-arousal. Hyper-arousal occurs when emotions feel as if they are flooding or overwhelming the body, leading to reactivity, while hypo-arousal is the logic system’s attempt to override this emotional process, leading to dissociation and shutdown (van der Kolk, 2014). Psychoactive drugs used to manage hyper- versus hypo-arousal aim to modulate the autonomic nervous system, either calming hyperarousal, the fight-or-flight state or stimulating an immobilized, numb state, hypoarousal. While individuals self-medicate using a range of substances stereotypically stimulants are used to address feeling of hypoarousal (Khantzian, 2003; Wagner, 2017) while depressants tend to be used to address hyperarousal (Dagan & Yager, 2020; Duranceau et al., 2014; Lader, 2011). Siegel (1999) proposed that between these two states is a window of tolerance where one is able to make accurate decisions and productively experience emotions. People with addiction issues are more likely to use their substance when outside of their window of tolerance as a way to manage overwhelming or underwhelming emotional experiences (Corrigan et al., 2011).

When outside of the window of tolerance, individuals cannot learn from their experiences and struggle to remain in control of their behaviours (van der Kolk, 2014). The limbic brain system works as an internal alarm to alert one to danger and will cause an individual to react in a way that will protect them from harm, making it vital to human survival (Csiernik, 2026; Maté, 2021). Within this context, substance misuse and addiction can be understood as a brain pattern developed for survival to protect an individual from emotional harm by dulling painful feelings (Maté, 2021; van der Kolk, 2014). Continued substance use causes further dysregulation of the limbic system, leading to minor adversities feeling overwhelming and unbearable to those with an addiction (Lin et al., 2024; Wilcox et al., 2016). This view moves us beyond the simpler disease model that was prominent in forming views regarding addiction in the middle part of the 20th century to the more comprehensive neurobiological theory of addiction. Additionally, by increasing awareness of emotional experiences, an individual can expand their window of tolerance to better navigate difficult life stressors and reduce time spent in survival mode. Through this, people with an addiction are better able to make rational decisions about whether or not they want to use substances, without the overwhelming emotional destabilization that occurs during hyper- and hypo-arousal states aligning with trauma-informed models of counselling and support (Barnett, 2024).

Another perspective, the self-medication hypothesis, views substance misuse as an adaptive tool of survival from overwhelming emotional suffering (Chen, 2022). Using substances as an avoidance strategy serves to protect the sense of self from situations that seem unlivable and is one example of how individuals will react in ways that seem maladaptive when faced with pain (Fisher, 2022). This implies that addiction is not a behaviour that exists outside of emotional experiences and is instead deeply interconnected and driven by them (Barnett, 2024). People with mental health concerns have an increased risk of addiction due to the impact some substances have in mitigating or relieving symptoms of mental health conditions (Lin et al., 2024). Thus,

individuals will do what they feel they need to in order to find or maintain some level of emotional safety and survive (Chen, 2022). Addiction overtakes the natural emotional survival system, leading to temporary feelings of safety through substance use, which makes one less equipped to navigate ongoing emotional turmoil without their substance of choice (Barnett, 2024).

3. Shame: An under-recognized contributor to addiction

Emotions are both a necessary and challenging component of human existence, forming an indispensable part of the sensory system and a vital component of who someone is (Maté, 2021). Hawkins (1995) introduced the emotional frequency chart, identifying a range of emotions based on his concept of power versus force. Low-frequency emotions require force, meaning that they are negative or life-reducing, while high-frequency emotions exert power and are considered positive or life-supporting. Hawkins identified shame, described as self-loathing and destructive energy, as the lowest frequency emotion that an individual can feel. The concept of shame has been a key element of many theories attempting to explain or provide insight into the development of an addiction, including the moral model, disease model, attachment theory, personality theory, humanistic theory, psychodynamic theory [object-relations], and social learning theory (Csiernik, 2026). Additionally, societal narratives and discrimination regarding addiction can lead those who misuse substances to internalize self-stigma. Stigma is additionally reinforced through structural and systemic barriers that exclude people with an addiction from the opportunity to recover (Chen, 2022; Fisher, 2022). Negative self-conscious emotions, such as shame, arise from an evaluation of the self in comparison to others and often lead to feelings of being less valuable or less worthy (Batchelder et al., 2022). Shame has been described as the most overwhelming emotional experience that one can face, as it attacks the very core of who that person is (Barnett, 2024). Those who feel shame then, either from their substance misuse or factors leading to or arising from it, continue to use substances as a way to self-medicate and avoid this emotion that has been deemed unbearable (Chen, 2022). Psychoactive substances effectively reduce the intensity of feeling these emotions, acting as a protective factor to facing emotional pain; however, this also results in a loss of the ability to engage in other activities or behaviours to overcome difficult life experiences moving forward, increasing an individual's reliance on the substance (Barnett, 2024).

The presence of shame and the temporary relief offered by substance use is often referred to as the shame-addiction cycle (Batchelder et al., 2022). Substance misuse and feelings of shame become cyclical in nature as the individual consumes drugs to sedate feelings of shame, which in turn increases feelings of shame for using substances (Chen, 2022). This shame associated with using substances has been linked to the idea of not being able to control one's desire to use, even when they wish to maintain abstinence (Chen, 2025). Additionally, avoidance of difficult emotions leads to increased feelings of fear about facing these emotions in the future, as one feels unprepared to do so. This increase in fear due to avoidance produces an increased likelihood of using substances, creating a cycle that is counterproductive to personal growth (Barnett, 2024).

There has been debate within the literature about the role that guilt plays in addiction and how this differs from shame (Batchelder et al., 2022; Chen, 2022). The key difference between

guilt and shame is the focus of the negative evaluation; shame can be conceptualized as a negative evaluation of oneself, while guilt is a negative evaluation of one's behaviour (Batchelder et al., 2022). Guilt has been argued as a potentially self-regulatory mechanism that can support people in decreasing substance use as they identify the behaviour, rather than themselves, as problematic, leading to desires to change. In contrast, shame is internalized as a personal deficit, and reparations may seem impossible or too abstract to be tangible (Chen, 2022). Batchelder and colleagues (2022) found that shame was consistently associated with increased substance use, while guilt was seen as associated initially with increased substance use, but potentially protective over time as substance use continued. Some researchers identify that both shame and guilt are connected to the development and maintenance of substance use concerns (Chen, 2022), while others describe shame and guilt as motivating factors for people using substances to engage in treatment (Jones et al., 2024). A negative association with self-forgiveness was identified for both shame and guilt, however a stronger association was present between self-forgiveness and shame (Hall & Fincham, 2005).

Since shame has been identified as playing such a significant role in addiction, there has been a search for strategies to mitigate its risks. Self-acceptance has been recognized as an important mechanism to address the cycle of shame within addiction and foster long-term recovery (Chen, 2022). Linehan (1997) defined the term 'radical acceptance' as the ability to feel painful emotions without needing to react to or change them. Only through the allowance and acceptance of difficult emotional states are individuals able to move toward changing their behaviour (Greenberg, 2017). Additionally, self-forgiveness and gratitude reinforce the recovery process and may be helpful in sustaining long-term recovery (Chen, 2025). Gratitude supports individuals in rebuilding helpful and supportive relationships and improving coping strategies (Nelson, 2009). Self-forgiveness, while identified as more difficult than other forms of forgiveness, provides individuals with an adaptive way to cope with difficult situations and emotions (Chen, 2025). Participation in 12-step mutual aid groups such as Alcoholics Anonymous or Narcotics Anonymous has been seen to foster self-acceptance, self-compassion, and gratitude (Chen, 2025), reduce shame (Chen, 2022), and reduce the risk of relapse in some individuals (Yazici & Bardakçi, 2023).

4. Treatment options

Given the complexity and multidimensional nature of addiction, a plethora of approaches to address the condition have been proposed. This includes a variety of common psychotherapy modalities that have been adapted to support those misusing substances who wish to abstain or reduce their consumption (Csiernik, 2026; Yazici & Bardakçi, 2023). Cognitive behavioural therapy (CBT) has significant literature supporting its use for people with substance use concerns, with an emphasis on identifying patterns in thoughts and behaviours that are associated with an individual's desire to use substances (Rakfeldt, 2023). Specifically, CBT for substance use focuses on challenging unhelpful or inaccurate mental representations and encourages active restructuring of these thoughts to increase an individual's ability to process their emotions effectively and thus, reduce harmful substance use behaviours. This approach views emotions as influenced by cognitions, understanding that challenging unhelpful thought patterns can help an individual feel better emotionally and thus, reduce substance use (Csiernik, 2026; Rakfeldt, 2023). Interestingly, one criticism of CBT is its lack

of direct focus on emotional processes (Leahy, 2015). Third-wave adaptations such as dialectical behaviour therapy (DBT) build on the initial concepts of CBT, with an added appreciation for self-acceptance and the ability to mindfully observe thought processes, without attempting to change them (Chen, 2022; Linehan, 1993; 2015). DBT and other contemporary models situate substance use as a learned behaviour that is influenced by environmental factors (Waldron & Kaminer, 2004). These approaches also contrast with CBT's strict focus on cognitions alone by using interventions that teach emotional regulation and distress tolerance, recognizing the importance of emotions for general well-being (Leahy, 2015).

The transtheoretical model (TTM), in contrast, was developed specifically for supporting individuals who identified as having an addiction (Prochaska & DiClemente, 1983). This revolutionary model argued that individuals will cycle through various stages in the process of attempting to change a behaviour, represented as a spiral with a mixture of positive change and setbacks along the recovery journey. Techniques used to support individuals are informed by their current state of change, and throughout the entire process, individuals are asked to reflect on the pros and cons of changing their behaviour and the impact this would have on their life (Prochaska, 2008; Prochaska et al., 1992; Prochaska et al., 1994). Within TTM, emotions are recognized as fluctuating throughout the therapeutic process, resulting in one's willingness to change their behaviours (Hodgins, 2001). Specifically, the concept of dramatic relief, which refers to the negative feelings one associates with their addiction and the subsequent relief one feels when these behaviours cease, is considered a central motivation of change within TTM (Hodgins, 2001). Associated and used in conjunction with the TTM, but developed independently, was the construct of motivational interviewing (MI). MI is a method of counselling often used in partnership with TTM to increase an individual's intrinsic motivation to change by utilizing attribution, empathy, self-efficacy, and cognitive dissonance (Miller & Rollnick, 1991, 2002, 2012). MI has been seen as effective in supporting clients who are described as ambivalent to change or stuck in addictive behaviours (Canadian Centre on Substance Use and Addiction, 2017). Resistance in MI is seen as an emotionally protective mechanism reflecting ambivalence about change (Miller & Rollnick, 2002, 2012). While emotion-focused concepts are utilized in both TTM and MI, they are not the central focus of either approach.

Emotion-focused and emotionally focused therapies have also gained popularity as psychotherapeutic models that can be used to support those with substance-use concerns or addictive behaviours, as well as their families (Barnett, 2024). In contrast to CBT and related cognitive-behavioural approaches, and TTM/MI, as the name suggests, the focus here is upon the emotional aspect of substance misuse. While often used interchangeably, emotionally focused therapy and emotion-focused therapy are considered distinct practices, specifically in regard to the population being supported (Greenberg, 2017). Emotionally focused therapy was developed initially as a couple's therapy approach to encourage the expression of underlying vulnerable emotions and foster a change in the way the couples interacted with and understood one another (Greenberg & Johnson, 1988). In 2015, Greenberg proposed that emotion-focused therapy is an integrative term which encompasses all treatments that centre emotion as the focus of their interventions. Emotion-focused therapy for addictions emphasizes the role that negative emotions play in the onset and maintenance of substance use (Barnett, 2024). This approach focuses on building emotional fluency and awareness, as well as

an understanding of addiction as an adaptive behaviour used to protect individuals from emotional suffering (Barnett, 2024).

It has been well established that addiction recovery requires a holistic biopsychosocial intervention strategy, as illustrated by the various treatment approaches discussed above, that can support individuals in developing and maintaining general well-being (Csiernik, 2026; Csiernik et al., 2023; Yazici & Bardakçi, 2023). Additionally, peer-run 12-step groups such as Alcoholics Anonymous and Narcotics Anonymous emphasize the importance of spiritual connection, with addiction being identified as a hybrid condition with physical, mental, and spiritual elements (Fisher, 2022). As an outcome of the increased awareness of the benefits of spiritual support, the biopsychosocial (BPS) model for wellbeing, developed by Engel in 1977, was expanded by Sulmasy (2002) to formally acknowledge the spiritual domain, becoming known as the biopsychosocial-spiritual (BPSS) model (Figure 1). Fisher (2022) identified that spirituality in recovery involves individuals letting go and putting trust in a purpose greater than themselves. Substance misuse in 12-step programs are regarded as spiritual disorders which are created through the absence of meaning to life (Chen, 2025). Some benefits of including a spiritual understanding within addiction care include increased recovery capital in the form of community support, increased treatment adherence, and resources to counteract narratives of personal shame and guilt (Van Denend et al., 2022). Since these programs are peer-led, there is no specific focus on emotional processes. Instead, the groups follow the 12-step philosophy from the Alcoholics Anonymous manual known as the "Big Book," which provides a structured and standardized framework for maintaining sobriety and has since been adapted to support other peer facilitated groups (Alcoholics Anonymous World Services, 2001).

The BPSS model, while not universally implemented, has gained prominence in addiction counselling practice (Csiernik, 2026). A critical dimension of this approach is the emotional component; an area explored to varying degrees by the various treatment approaches. As has been discussed, for many individuals with substance misuse concerns, the underlying emotional component is shame (Barnett, 2024; Batchelder et al., 2022; Chen, 2022; Jones et al., 2024). Drawing upon the established literature and practice in the addiction field, a distinct approach is proposed: the Emotional Nexus Recovery (ENR) model. The ENR model emphasizes the importance of emotions during substance misuse and the recovery process, focusing on shame as the key issue to explore and address in developing a foundation for decreasing or stopping substance use. The ENR model recognizes that a spiritually focused program fosters acceptance of the unknown through faith, hope, and purpose, which are often viewed as prerequisites for safety and meaningful lifestyle changes. To those who are struggling with a substance use disorder, their drug of choice is a primary tool of control or used to reduce the fear and anxiety of the unknown. Using ENR to express the human need underlying spirituality can help the individual separate religion, doctrine, and dogma from the spiritual process, again reducing the potential shame associated with rejection from the 12-step process due to a lack of belief in God. ENR is currently proposed as a brief intervention tool that identifies emotion as a barrier to behaviour change and improved quality of life. This awareness becomes a complement to other treatment modalities such as DBT and EFT, while most importantly reducing shame, allowing a person to progress through the TTM, and making strides toward less harmful coping strategies.

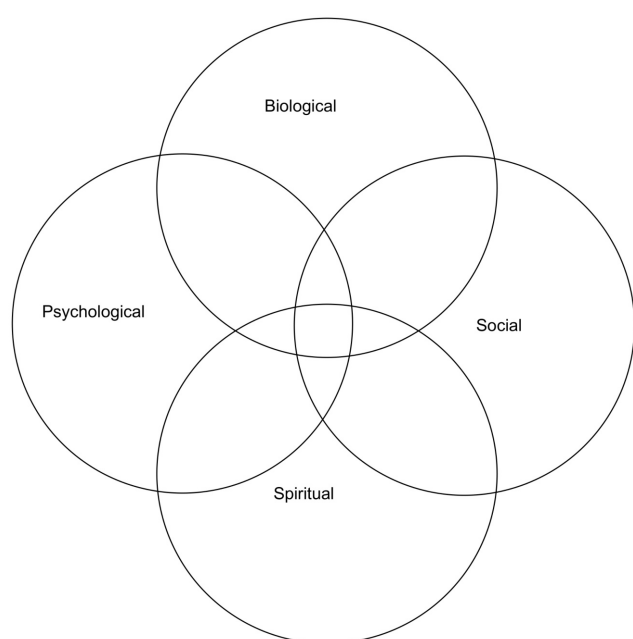


Figure 1. The Biopsychosocial-Spiritual Model

Adapted from Raffay, Wood, & Todd, 2016.

5. The Emotional Nexus Recovery model

The ENR model is a holistic approach for supporting those with addiction issues centring emotions within a biological, cognitive, social, and spiritual framework. While proposed as primarily an addiction recovery model, the concepts can be used to support overall well-being and quality of life for anyone searching for balance or stability. ENR incorporates elements of the BPSS and emotion-focused therapy models to conceptualize how everyday practices can help or hinder emotional well-being. By placing emotions in the center of the model, it symbolizes the ways in which biology, cognition, socialization, and spirituality affect an individual's emotional state. Conversely, it also recognizes that a poor or dysregulated emotional state, particularly one where shame is the dominant affect, can radiate outwards to impact all areas of well-being. To improve emotional functioning, it is fundamental that a framework for recovery recognize and name the importance of shame in the addiction process. The ENR model identifies emotional suffering, highlighted by shame, as the root of ongoing substance misuse and thus views emotional well-being at the center of recovery.

Both the traditional BPSS model (Figure 1) and the ENR model (Figure 2) can be visualized using a Venn diagram. Biological factors such as sleep, nutrition, and medication, and social factors such as family connection, community supports, and friendship are common to both models. Spirituality can be understood as the belief that one is not in control of everything that may happen in life, and having faith that life will work out in the way that it is meant to, alleviating the burden of not knowing (Maté, 2021). The main difference between the ENR and the BPSS models is the understanding of psychological factors and their positioning. Psychological factors within the BPSS model include both cognitions and emotions (Van Denend et al., 2022). The ENR model separates these two concepts; the traditional psychological section from the BPSS model becomes cognition,

and emotions are placed in the centre of the model and thus the treatment approach. As discussed, emotions, particularly shame, are a critical factor in the development and maintenance of addiction and thus, in response, the ENR model position them as such. By centring emotions in this way, the ENR model is drawing on practices of emotion-focused therapy through an understanding that emotions are at the root of all behaviour, including addiction (Barnett, 2024). Emotions in this way are considered central to all aspects of life and, therefore, a necessary component of healing. This moves away from the traditional understanding of addiction, which often centres addictive behaviours as the core issue and the focus of interventions. Additionally, spirituality is identified as all-encompassing to biological, cognitive, and social practices, rather than a separate entity, as it is through spirituality that one can find meaning in the other three domains of life and process adversity during uncertain times.

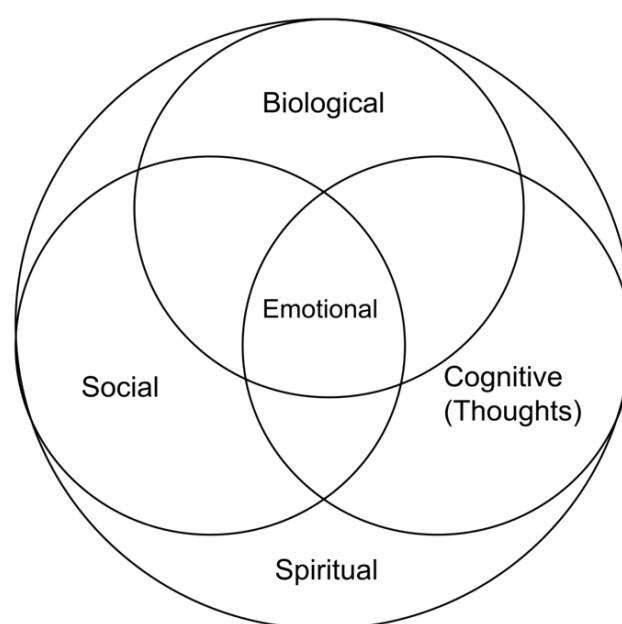


Figure 2. The Emotional Nexus Recovery Model

A common mantra used within the ENR framework is that people with addiction issues are emotional people who do not like their own emotions. Of course, affect, having emotions and being emotional, is a fundamental aspect of being human. "I don't like my emotions" can quickly evolve to, "I shouldn't have these emotions" which in turn morphs into the false belief that "if I have these emotions that I shouldn't have, I must not be normal." Not being normal leads to a state of shame, of one's emotions, one's behaviours and ultimately one's self. Applied to the misuse of drugs; the process of avoiding emotional experiences will be used to self-soothe negative feelings of not only shame, but also sadness and anger. Substance misuse has also been associated with difficulty in fully experiencing positive emotions, related to the concept of self-sabotaging due to discomfort with these emotions or fear that they will be followed by a loss (Joshalloo, 2013; Weiss et al., 2015; Weiss et al., 2018). The ENR model focuses on conscious awareness of emotional experiences and a desire to learn to feel these emotions in their full capacity. Rather than attempting to change emotional states, the focus shifts to understanding these emotional experiences and learning to coexist with them, beginning with shame.

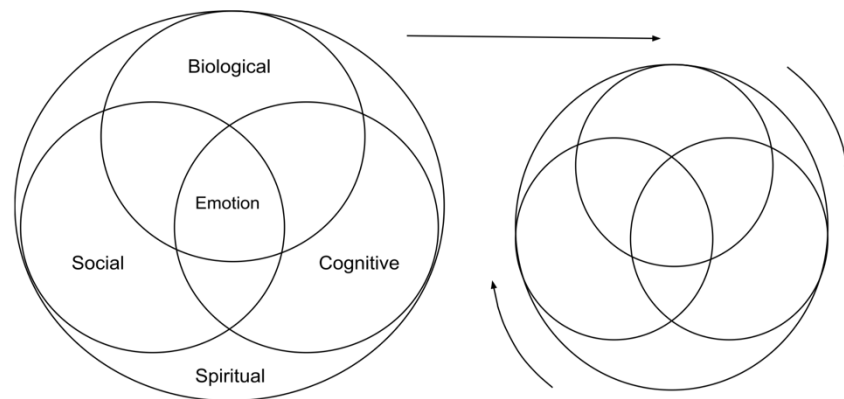


Figure 3. The Emotional Nexus Recovery Model Rotation

In clinical practice, ENR is used to demonstrate the unseen purpose of each emotion and its utility to survival. Much like our senses of sight, smell, and touch, which provide information to navigate daily life, our emotions do the same. In the ENR model, being human means using emotions to determine fundamental needs. For example, Sadness shows a person what has been lost and its subsequent value, or guilt points at an undesired result of our actions. When we create a link between emotion and a person's humanity and core functions, it can increase their self-compassion. Emotions are happening for us, not to us. In practical use, individuals gain autonomy and shift toward uncomfortable emotions associated with change because these emotions serve a greater purpose than suffering.

As described by Maté (2021), free choice comes from the ability to think about one's emotions and feel pain, without being motivated to suppress them through the use of addictive behaviours. By naming these emotions and allowing permission to feel them in their entirety, shame can be replaced with self-compassion. The ENR model argues that to do this, the individual must strive toward balance within the biological, cognitive, social, and spiritual domains of their life.

Central to the understanding of the ENR model of addiction is the emphasis on balance. If one were to focus only on their biological health, for example, by attending the gym multiple times a day, but did nothing to support their cognitive, social, or spiritual health, their recovery would not be holistic. This puts them in greater danger of relapse if something were to impact their ability to continue utilizing their one coping strategy, for example, an injury or illness that prevents them from working out. By focusing on all four domains, an individual is in a better position to face adversity and will have multiple mechanisms that they can use when they feel at risk. By seeing spirituality as all-encompassing, one may be even better able to manage hardships through an understanding that there is a greater purpose in life and find meaning in difficult situations. Adding arrows to the ENR model indicates forward motion, underscoring why balance is vital to a person's recovery (Figure 3). If one is lacking in a particular domain, they will need to work extra hard in the others to continue moving forward in their recovery journey. Imagine this as a tire with multiple air chambers biological, cognitive, social, and spiritual. If one of the areas becomes flat, the amount of energy required to push the tire forward would increase. A tire that is flat on one side easily creates an imbalance, needing more momentum

and energy to move the same distance. This extra torque creates stress on the wheel hub: our emotions.

Within the ENR model, there are multiple overlaps between domains. Many current therapeutic modalities for addiction would fall within one or two of the domains, while having little or no focus on the others. For example, CBT could be identified as primarily a cognitive approach to recovery, while DBT could fall within the overlap between cognitive and social domains, with the inclusion of groups. Mutual aid groups, such as Alcoholics Anonymous, focus on social and spiritual health, with some cognitive elements within the 12-steps, but do not overtly support biological well-being. Pharmacologically-assisted treatment, such as methadone or naltrexone support the biological aspects of withdrawal, but if used in isolation, neglect to consider the impact and importance of cognitive, social, and spiritual support. The intent of the ENR model is to encourage a recovery journey that incorporates all domains in order to develop a healthy emotional state, creating a full support system to mitigate relapse and improve overall well-being. With this is the understanding that each domain within the model has a direct impact upon the others, with emotions both impacting and being impacted by biological, cognitive, social, and spiritual factors.

Utilizing the ENR model, an individual can identify which areas of their life they feel they need additional support in to benefit their emotional wellbeing and recovery journey. Through assessing what is currently available to them within their biological, cognitive, social, and spiritual domains, they will be able to identify areas of potential growth. Additionally, by positioning emotions at the centre of the diagram, the importance of emotional health and overall quality of life remains the focus of recovery. It is important to note that emotional well-being is not the same as being happy, and that ultimate happiness is not the goal of recovery. Instead, emotional well-being is the ability to recognize, identify, and feel emotional experiences for what they are, without having to utilize psychoactive drugs to cope. Emotions can be utilized as a helpful guide to show someone what is important to them and what aspects of their life they feel are helpful or hurtful to their long-term recovery. By naming addiction as an adaptive strategy used to reduce overwhelming emotional experiences, shame can be reduced, and individuals can learn to practice self-compassion.

While the ENR model represents a promising framework for supporting individuals experiencing addictions, it has yet to be empirically evaluated to determine its effectiveness. Additionally, further reflection on the role of addictive behaviours needs to be

examined and may be warranted in future iterations of the model. Although the ENR framework positions emotional processes as the primary focus, with addictive behaviours identified as a secondary response, additional examination of how behaviours are represented within the model may enhance conceptual clarity. Finally, the application of the model across diverse cultural and socioeconomic contexts requires further exploration to ensure sensitivity and relevance.

A meaningful next step in establishing the effectiveness of the Emotional Nexus Recovery (ENR) model would involve a phased, mixed-methods research approach that reflects both its clinical complexity and its person-centred philosophy. Initial pilot studies could employ quasi-experimental designs in outpatient or recovery maintenance settings, comparing ENR-informed interventions with treatment as usual, with outcome measures including reductions in substance use, improvements in emotion regulation, and changes in shame and self-compassion. Building on these findings, randomized controlled trials (RCTs) would provide stronger empirical validation, ideally stratifying participants by severity and stage of change to assess differential impact. Given ENR's emphasis on emotional processing, validated psychometric tools such as measures of shame, affect regulation, and quality of life would be essential, alongside longitudinal follow-up to evaluate the sustainability of outcomes. Qualitative methodologies, including semi-structured interviews, should also be integrated to capture participants' lived experiences and the nuanced shifts in emotional awareness that may not be fully reflected in quantitative data. This combination of controlled trials and experiential data would allow for a comprehensive evaluation of ENR's effectiveness across diverse populations and treatment contexts, aligning with the model's holistic and integrative foundation.

6. Conclusion

The ENR model is proposed as an addition to the preexisting frameworks used to support individuals with addiction issues. It incorporates methodologies of empirically supported practices, primarily the BPSS and the emotion-focused therapy models, to provide a holistic understanding of the recovery process. The ENR model centres emotions as the root of both addiction and recovery, with the underlying philosophy that substance use is an adaptive survival strategy for overcoming life experiences. While identified as a helpful model for individuals, the ENR framework and its concepts can also be applied to family or group therapy settings. Future research needs to explore the clinical application of the ENR model across diverse treatment settings to refine its role within addiction recovery. In doing so, the model may contribute to a more holistic, responsive, and emotionally attuned approach to addiction care.

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