Perspectives on Addiction

Workbook

by

Margaret Fetting
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INTRODUCTION
OVERVIEW

Addiction and substance use disorders are widespread problems in all cultures, especially in the United States. They now cut across all ages, genders, social classes, sexual orientations, and all cultural and ethnic groups. Our understandings of substance use, addiction, and treatment are some of the most rapidly evolving and also controversial areas of knowledge in the mental health and medical fields. This course is designed to cover the key content necessary for developing a comprehensive and reflective grasp of a complex body of knowledge that is filled with certainties and uncertainties, science and speculation, dogma and theory, as well as opinion and silence.

OUTLINE OF THE WORKBOOK

This workbook is divided into progressive chapters that were developed from twenty years of teaching semester-long graduate courses in Substance Dependence and Abuse in the School of Social Work at the University of Southern California. These chapters build upon each other and are designed to become the building blocks of your own knowledge base.

Addiction and its disorders are likely to touch us all. We each have more experience than we think, more knowledge than we use. This course invites the student to incorporate these into their learning process. The personal and professional knowledge base developed becomes the anchor for future learning, not only in this course but also for future professional development in this field. The content area covered (building blocks), moving from bottom to top, is diagrammed below.
Let’s walk through the knowledge base—some general special population statistics are presented and the reader is invited to consider the historical influences of his own culture. Social forces that influence addictive thinking and behavior are explored. Definitions of key concepts and ideas are also presented.

Perspectives on diagnosis, psychoactive substances, models of treatment, and psychoanalytic and self-medication theories are shared. The reader is introduced to an integrative model of treatment that infuses Stephanie Brown’s stage-driven approach to recovery with a psychoanalytic sensibility. Addiction treatment is deepened when a non-directive, reflective, analytic perspective and attitude is coupled with the more traditional and sometimes confrontational approaches of recovery treatment.

A reflective approach seems the necessary prerequisite for mastery of a complex, contradictory, and complicated field. A personally involved reader grasps and retains knowledge from a deep and meaningful perspective.
INTRODUCTORY COMMENTS

Many of us like the experience of being intoxicated, and that desire creates troubles for some of us. This course explores this desire and proposes a treatment path for these troubles.

We talk about addiction in peculiar and ineffective ways. We tend to whisper about whether someone’s actively addicted or getting over it; anxiously judge what’s going right or what’s going wrong; or gossip about whether someone is in a good place or a bad place with his using.

We don’t talk about this — What does all this drug and alcohol use mean to ourselves, our families, our nation, and other cultures? We don’t seem to have meaningful conversations about what’s behind this experience of desire and pleasure, this human need to “get high.”

We don’t really talk about:

- What’s behind a sizeable number of people salivating at 5 p.m. each day knowing that the day is over and that a beer, a glass of wine, a martini, or more will soon follow?
- Why do we start earlier than 5 p.m. on vacations and often continue drinking throughout the rest of these supposed stress-free days and evenings?
- What’s behind our teenagers’ furtive and focused plans to sneak out of their parents’ houses most nights and get high with a group of friends?
- Why are most social occasions and holiday celebrations organized around drinking/drugging?
- Why do we search for that bar as soon as we arrive at a party?
- Why are Super Bowl parties and charity and sporting events saturated with booze?
- Why do we notice non-drinkers? Why are some of us uncomfortable around them?
- Why are children’s birthday parties filled with drunken parents?
- Why is so much of our time filled with the help of alcohol and drugs?
- Why are we not more curious about our individual, cultural, and national preoccupation with alcohol and drugs?
Shouldn’t these questions be answered, these tendencies and preferences explored and not just intervened upon when they have crossed over to excess? Again, let’s not just focus on if we are in a good place or bad place with getting high; rather let’s focus on *what is the place* of getting high in each of us, our families, and societies. This requires intimate explorations, as well as valuing the importance of these continued and ongoing conversations. We seem to nervously rush past these “talks” either because we are ashamed of our desires or dismissive of our troubles with these pleasures. Since we are an alcohol- and drug-saturated nation, it helps to understand why.

**THE QUESTIONS CONTINUE.**

- Why, since humankind began, have we, all over the world, looked for a way to escape and expand consciousness?

- How do each of our cultures sanction or punish these urges and impulses?

- Why do some cultural practices protect this desire and others contribute to its abuse?

- Is it a hedonistic, dangerous, or a rightful pleasure? How often should we do it?

- What makes it a good and healthy experience?

- What makes it a destructive or dangerous one? Who decides?

**HOW DOES EVERY ONE OF US RESPOND TO THIS “DRIVE”?**

- Why do some love it instantaneously and need it repeatedly?

- Why do some start out fascinated and grow less interested over time?

- Why does it come and go in some people’s lives?

- What’s going on with people who are not interested in drinking at all?

- Why do some have a nonexistent relationship with alcohol and other drugs (AOD), some an indifferent one, some a destructive one, and some an amicable one?
Our society has hastened to educate, eradicate, and treat, but not meaningfully converse. If we don’t grapple with answers to these questions, we will never fully embrace this human drive; we will never have satisfactory conversations with our loved ones; we will never deeply understand what we are treating when pleasure turns into excess and we will never be able to reverse the relapse epidemic that arguably makes a mockery of the treatment industry today.

TERMS TO CONSIDER WHILE READING

- The words addiction and alcoholism, drinking and drugging, chemical dependency and substance dependency, substance use disorders, and addict and alcoholic are each used interchangeably to describe a disturbed or pathological relationship with AOD.

- AOD stands for alcohol and other drugs.

- Readers and students are referred to as “he.”

- A patient, addict, or alcoholic is referred to as “he.”

- Treatment providers, clinicians, and sponsors are referred to as “she.”

- An italicized word in the text emphasizes the importance of the content.

FACULTY

Margaret Fetting, Ph.D., LCSW, has twenty-two years of experience in this field. She is in private practice in Santa Monica and treats many substance abusing families and individuals. She is an adjunct professor at the School of Social Work at USC. In addition, she is on the teaching faculty for the Center on Child Welfare. Her doctoral dissertation was on an application of the Bowen Theory to the Child Abuse and Neglect System in Philadelphia from the University of Pennsylvania. She has done extensive management consulting in welfare and correctional facilities. Dr. Fetting’s book Perspective on Addiction was published by Sage Publications, Inc. in December 2011.
CHAPTER ONE

CULTURAL STATISTICS

AND STORIES
CULTURAL STATISTICS AND STORIES

This chapter encourages exploration of the influences of our individual ethnocultural histories on the seemingly universal human desire to escape and expand consciousness with the help of drugs and alcohol. Our cultural backgrounds shape our feelings, behaviors, and viewpoints. Our thinking about the uses and misuses of these substances, as well as our values and entitlements, denials and judgments about them runs deeper than we think. It is important to identify the historical and generational forces that drive our current drinking and drugging behaviors. It is personally helpful and clinically useful to recognize these covert and overt influences.

THIS CHAPTER:

- Identifies selected statistics that broadly contextualize AOD use, misuse, as well as treatment admissions among diverse populations

- Invites the student to read the short stories of many other students, as he begins to reflect into the influences of his own history

SPECIAL POPULATION STATISTICS

The three bar graphs presented below provide a very general sense of the comparative usage of AOD among diverse population groups. Comparative admissions to treatment among groups is also displayed. These statistics are presented to give the reader a general perspective on AOD usage among groups, as well as their treatment preferences. This will help contextualize the reading of the ethnocultural stories in this chapter and also help frame the student’s developing understanding of the influences of his own cultural history and background.
Table 1.1: Alcohol Use in Past Month by Ethnic Group in the United States—2005
Source: Inaba & Cohen, 2007, p. 244.

Table 1.2: Estimated Prevalence of Recent Illegal Drug Use by Race/Ethnicity: 1999–2000
ETHNOCULTURAL STORIES

Below are a collection of student stories generated from responses to these questions.

- How do you identify yourself ethnoculturally?
- In what ways does this identity shape your thinking about AOD?
- What’s the relationship between degrees of acculturation and AOD use?
- How have patterns of oppression and discrimination influenced your culture’s AOD habits?
- What are some of the relationships between communication skills and patterns, education, socioeconomic class, religion, age, family structure, and AOD use and misuse?
- What are the meanings of AOD in your culture?
- How have you internalized these—how have these shaped your own relationship with AOD?
• Has an individualistic or collectivist environment been influential here?

• Who partakes in the pleasures of AOD?

• In what ways?

• Who does not, and why?

• What if problems develop?

• How are they defined?

• How do people address them?

HOW DO YOUR CULTURAL PREJUDICES AND BIASES SHAPE YOUR NOTIONS ABOUT TREATMENT?

ARMENIAN AMERICAN AND AFRICAN AMERICAN, MID-20S

Both mentioned that drinking is everywhere. It starts with shots of cognac for colicky stomachs in infancy. “Our only form of treatment comes from elders. They counsel us, ‘We will help you learn to drink. Watch us and the way we drink. If you can’t drink, don’t.’”

HOMOSEXUAL AMERICAN SECULAR JEW

He never saw his parents drink or smoke. The message was, “Don’t do either, especially in the house.” “As a gay man, I live in a culture with a big alcohol and drug presence. It would really take a lot to get anybody into treatment. The biggest addiction in my community is cruising for sex, which includes use of methamphetamines.”

MEXICAN AMERICAN IN HER EARLY 20S

Both parents were born in Mexico. “There is more alcohol than kids at birthday parties.” Drinking is connected with gender. If girls drink, they get in trouble with their dad. The best decision for girls is to avoid “the situation completely.”
ASIAN WOMAN, MID-20S

“I think there’s a stigma attached to people who are addicts, a very negative stigma. The complexity of addiction is not taken into consideration, and instead people are judged for being weak and the issues of why they are using are overlooked or ignored. I’ve changed—if someone important in my life becomes addicted, I don’t think I would be able to stand and watch them destroy their lives. I’d ultimately have to confront or find ways to help them.”

CHRISTIAN CAUCASIAN HOME

“I grew up in a strict, rigid, and conservative Christian home. My father is a pastor, and we were taught that drinking is a sin. I was taught that addicts or users are sinners. Sin is bad, therefore they were bad and deserved to go to hell. When I got to college, I went through a partying phase where I abused alcohol. Believe me, I was quite aware I was sinning, and if God came, I’d go to hell.”

IRANIAN ITALIAN

First generation. Parents born in Italy and Iran. Prior to the revolution in Iran there was a lot of drinking, drugs, and prostitution. In her family, the men drink and do drugs freely in America; it is a rite of passage for cultural approval. “If you drink too much, it is not a problem. You get help only if mandated as a result of a DUI or assault charges.” Women should not be seen drinking. Women have eating disorders.

CAUCASIAN FEMALE

“American culture is one of overindulgence, which reinforces a gluttony that encourages people to shamelessly consume or pursue excessive pleasures/highs. This imprint lends itself to a level of use where many feel okay or even quite great about overindulgence. In Europe it’s different. Many see a glass of wine at dinner as a ritual, whereas in the U.S. it is an event in and of itself.”

EASTERN EUROPEAN

A mid-30s woman grew up watching everyone drink straight vodka. There was no age restriction for the purchase of alcohol. Since age 5, she recalls daily walking to the grocery store to pick up her grandfather’s vodka. She grew up believing drinking makes you more social. “Everyone does it, all the time.” She believes as a future clinician, she might normalize all drinking, even if it is a problem.
SALVADOR AMERICAN, MOTHER OF TWO

Young children start doing inhalants at age 7 or 8, and teenagers start drinking at 14 or 15. “Drinking is ingrained in everybody. We drink to avoid feelings and sharing emotions. I know my husband has a problem with alcohol. He drinks every night. He never talks or expresses emotions. I just let him be.”

LATINO

Drinking occurred every weekend. “I grew up in a family where you couldn’t get enough Coors and Bud Light through the back door. We never talked about all the drinking in our family, even the serious problems.” Her grandpa spent a month sweating it out in the back house, and her uncle moved to Atlanta and got sober. The family considers these two “cautionary tales.”

BIRACIAL, IVY LEAGUE STUDENT

“As a woman of color, I felt shameful and secretive about my father’s drug use. I connected this to the racism and classism in society’s attitudes—people of color are deviant and dangerous and should be locked up. So the lesson I learned was to keep using a secret. When I went away to college and interacted with the elite upper class, I was floored to hear many of them laugh or even boast about their parents’ drug use. It is clear culture forms our beliefs and behaviors about drugs and addiction.”
CHAPTER TWO

SOCIOCULTURAL ASPECTS
SOCIOCULTURAL ASPECTS

It is important not to over-pathologize troubled users. They live in a context, a society that in many ways invites and sustains widespread addiction. This chapter is about the influence of society and societal forces on addiction. I want to generate thinking and provoke a discussion that reflects an awareness that addiction, particularly in the United States, is not just the result of the increasing number of “biological predispositions” being passed on from generation to generation. Rather, widespread addiction, both with substances and behaviors, also reflects the pained and self-destructive responses of human beings, as they attempt to accommodate to the demands and pressures of the societal structure of America.

Over the years, I have used two books that attempt to look at the Western capitalistic forces that keep this addiction alive. This section reflects my interpretation and expansion of two authors’ points of view on the contribution of societal forces to contemporary addiction.

THIS CHAPTER:

- Encourages reflection of sociocultural influences on widespread addiction
- Suggests two addictive system profiles of contemporary addiction
- Connects the loss of developmental initiation rituals to contemporary addiction

WHEN SOCIETY BECOMES AN ADDICT BY ANNE WILSON SCHAEFF

The first book is written by writer, lecturer, and organizational consultant Anne Wilson Schaeff (1987). Dr. Schaeff trains healthcare professionals around the world on the influences of context and processes in daily living. Anne Wilson Schaeff suggests that we live in an addictive system (1987, p. 12). The addictive context is composed of societal institutions, laws and policies, and political, cultural, and economic forces that shape each of us.

Schaeff suggests that each of us is susceptible to becoming attached to substances and compulsive processes in unhealthy ways in order to survive the pressures, demands, and exclusions of this contemporary societal context (1987, p. 19). The societal system calls forth these addictive behaviors, and the prevalence of addiction is often directly related to socio-environmental influences. Our universal need to get high is shaped by a historical and societal setting. Contextual forces greatly influence how we use AOD, make sense of our addictions, and how we address these problems.
ADDICTION OF INCLUSION AND EXCLUSION

I have identified two addictive system profiles. The first is addiction of inclusion. This addiction occurs among persons who are socioeconomically able to participate in the opportunities of our culture. This participation is increasingly coupled with much more pressure and stress. People self-medicate with AOD to relieve the tensions and anxieties they feel as they try to make it, fit in, or advance themselves in this addictive context.

The second addictive system profile is addiction of exclusion. This addiction occurs among persons who are marginalized from the playing field as a result of discrimination or high unemployment rates, poverty, or limited education. People self-medicate to numb feelings of inadequacy and rejection, isolation, and alienation.

ADDICTION OF INCLUSION COSTS ARE INCREASINGLY DESTRUCTIVE.

- Please consider your own individual addictive responses to everyday pressures and threats and their contributions to addictive living in America.
- We don’t have to participate in this pace and become its collateral damage.

ADDICTION OF EXCLUSION COSTS ARE INCREASINGLY DESTRUCTIVE AS WELL.

- The homeless and weary wander our streets and rural roads.
- They often live an aimless life of suffering and addiction.
- Many give up.

DRUGS, ADDICTION AND INITIATION: THE MODERN SEARCH FOR RITUAL  BY LUIGI ZOJA

Luigi Zoja (2000) is a depth psychologist and a student of Carl Jung. He compares pre-modern and modern society. His focus is on the absence of meaningful initiation rituals in our contemporary culture. His initiatory model proposes that widespread drug addiction reflects an unconscious search for what is missing (2000, pp. 8, 9).

- Initiatory rituals honor developmental rites of passage that occur when we outgrow one stage of development and embark on a new phase of growth and renewed purpose (2000, pp. 2, 6).
- Rites of passage satisfy the archetypal need for personal regeneration, to die and be reborn again throughout one’s lifetime.
- Something is missing without them.
• What is absent causes suffering and sends us on an unconscious, uncontrolled, and irrational search to satisfy this death/rebirth experience, wherever we can find it.

• According to Zoja, this ritualized world of intoxication is a perverted attempt to satisfy the loss of these death-rebirth moments, normally provided in initiatory rituals.

• The drug addict/alcoholic is a negative hero or heroine in search of transcendence, death, and rebirth in a culture that provides little or no meaningful opportunities for these (2000, p. 15). While heroic in their seeming search for ways to honor comings and goings, beginnings and endings, their intoxicated choices are ultimately negative ones. The inverted death-rebirth rituals provide relief before it is developmentally earned. They are empty of true growth and development, satisfaction and meaning.

• When the addict/alcoholic does eventually die to drug use, he is born into recovery. This path often includes participation in the world of Alcoholics Anonymous. This is a world filled with rituals and death-rebirth moments in many forms. There are ongoing celebrations honoring sober anniversaries. Birthday chips are given for thirty, sixty, ninety days, and every year thereafter.
CHAPTER THREE

DEFINITIONS
DEFINITIONS

Everyone has ideas about what *addiction* and *alcoholism* means to them. They have developed ideas from their own experiences and observations, their families, friends, the streets, and movies. Each experience leaves an impression, and most of the time, it’s not neutral. Addictions evoke emotions and these emotions often cloud thinking. People develop judgments and values, fears and prejudices, expectations and entitlements.

I have selected a range of definitions from many viewpoints. They come from a variety of reference points, including the medical model, science and biology, psychological suffering, attachment, spirituality, choices, family, recovery and treatment, and Alcoholics Anonymous.

These definitions are provocative, thought-provoking, and sometimes controversial. They are meant to be that way to invoke conversations, not only among students in the classroom but also among their families and friends as well.

THIS CHAPTER:

- Provides definitions of alcoholism and addiction
- Requires students to “reflect into and confront” their thinking about addiction

Please record your responses, reactions, and reflections to these definitions in the spaces provided.
ADDICTION:

- Is a dramatic conflict that avoids real conflict.

- Is a pathological love and trust relationship with an object that couldn’t care less about you as a person (Sager, Personal Communication, 2008).

- Is a substitute employed by those who cannot wait for time’s unfolding (Bion, 1992, p. 299).

- Is a brain injury rather than a brain disease as a result of repeated exposure to self-administered toxins. An addict’s brain is different from a non-addict’s brain as a result of neurochemical changes due to prolonged substance misuse. As with other injuries, healing can occur when the source of the injury has been eliminated (Thombs, 2006).

- Is a passive activity. Individuals take pills, powders, or liquids and wait for the desired effect—an alteration of their consciousness. The individual passively changes what he or she feels by using alcohol/drugs instead of facing and working through feelings of boredom, sadness, stress, and loneliness. Changing your mood by more active approaches involves more effort and motivation (Fields, 2010, p. 28).
- Involves conditions in which problems with regulating emotions, self-love, relationships, and self-care interact in varying degrees with each other and also with genetic vulnerability and the environment (Khantzian & Albanese, 2008, p. 19).

- Is the individual’s behavioral and cognitive preoccupation with a substance, and an overwhelming compulsion to have the substance (Brown, 1985, p. 71).

**ALCOHOLIC/ADDICT:**

- Over the course of nearly a half-century of clinical work with addicted individuals, I have yet to meet a person who became or remained addicted to drugs because of the pleasurable aspect of their use, or whose motives in initiating and using drugs was suicidal in nature (Khantzian 2011, p. 3).

- Addicts crave being high. Being high is the opposite of being deep. Being high is a substitute for being spiritually deep. Being high prevents one from going to the deeper places where the human heart resides (Zoja, 2000).

- Drugs can give people a sense of magical oneness with the world. The problem is that the drugs wear off, the feeling is only temporary. Addicts are driven to search for more. This hyper focus severely disturbs one’s sense of self, as well as intimate relationships with others. Sexual relationships are not needed anymore. The ego tragically surrenders itself to all that the drug world promises (Loose, 2002, p. 105).
ALCOHOLISM:

Perversion of social drinking into solitary excess (rotskoff, 2002, p. 74).

The peculiar charm of alcohol lies in the sense of careless well-being and bodily comfort that it creates. It unburdens the individual of his cares and fears. Under such conditions, it is easy to laugh or to weep, to love or to hate, not wisely but too well (emerson, 1932, p. 263).

Is defined as a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by periodic or continuous impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences and distortions of thinking, most notably denial. Each of these symptoms may be continuous or periodic (american society of addiction medicine, www.asam.org)

Saturates the lives of those it touches—their families, friends, and work associates; their decisions and plans; their aspirations and dreams; their identities and self-concepts; their very assumptions about what is real and possible (denzin, 1987).

Is a chronic, progressive, and potentially fatal disease characterized by tolerance and psychological and/or physical dependency. Is a disorder of intimacy. The alcoholic is extremely anxious over matters of
interpersonal closeness, involvement, and intimacy. He wants closeness, but it is safest to keep others at a distance. Pre-consciously and unconsciously the addicted individual equates interpersonal intimacy and closeness with annihilation, rejection, and potential destruction of one’s self. By drinking alcohol, and through the medium of intoxication, the alcoholic achieves a distorted or neurotic ability to be intimate (student).

Diagnostic and descriptive terms:

Tolerance occurs when the dependent or disordered user requires increasing or decreasing doses to achieve the original/desired effect. A change in the amount of the substance.

Physical dependency occurs when the body has been exposed to aod continuously for days/weeks and the addict has to maintain the dose/amount for the body to stay “physically balanced”.

Psychological dependency occurs when the psyche have been exposed to aod continuously for days/weeks and the addict has to maintain the dose/amount for the body to stay “psychologically balanced.”

Withdrawal occurs when dependent or disordered user stops using. The physical and psychological symptoms that occur when someone abruptly stops drinking or drugging.
CHAPTER FOUR

TWELVE PROFILES

OF

ADDICTION
DIAGNOSIS

The current DSM divides Substance-Related Disorders into two groups—the Substance Use Disorders (Substance Dependence and Substance Abuse) and the Substance Induced Disorders.

Clinicians who diagnose look to see whether someone’s maladaptive use of a substance is one of dependence or abuse. The treatment industry is anchored by these two categories and they surely help, but there is so much more. My sense is that individuals, families, and clinicians have over-relied on these categories and it has eclipsed our abilities to creatively see what is sitting across from us. Short- and long-term treatment is then compromised. Out of ignorance, exhaustion, or a desperate need to control an out-of-control situation, we have closed our detective storytelling eyes. The DSM and wider clinical community currently instruct us to pigeonhole people into one of these two categories. Nobody benefits from this narrow vision.

Over the years, I have found it helpful and useful to think expansively about diagnosis, not just limit assessment to abuse and dependence. I think in terms of descriptive profiles of using and addiction. I have created and share with my students twelve profiles that describe the stories behind the way we seem to involve ourselves with AOD. I have been struck with the idiosyncratic ways people attach themselves to these substances. This chapter is the spirit of this book and workbook.

THIS CHAPTER:

- Presents twelve working profiles of use, misuse, and addiction
- Encourages creative thinking about the complexities of assessment and diagnosis

PROFILES/CLINICAL DESCRIPTORS

USE

Since humankind began, we have always looked for a way to escape or expand consciousness. Sometimes it’s for spiritual ecstasy and other times for fun. We have taken plants and seeds from the earth. We now know the special place that alcohol assumed in early civilizations.

Ronald K. Siegel (2005) at UCLA proposes that this ancient desire is actually another human drive, similar to our need for food, water, and sex. He suggests that the urge to get high is among our basic motivations; he proposes that intoxication is the fourth drive, an acquired drive that is as powerful as an innate one (2005, p. 208). And like all drives,
desire varies. Some people have a high desire to escape consciousness, while others have medium or low drives.

VOLUNTARY NON-USE

This is a profile of people who early on and voluntarily make a decision not to include alcohol or drugs in their lives. They respond to this “drive” of human desire with a no, either emphatically from bad experiences, indifferently, or derived from a value. Some are influenced to make this choice as a result of what they have seen in their upbringing.

Many non-users acknowledge the pressures they experience from drinkers who want them to join in their partying. “Drinkers seem to feel guilty about their overdrinking, and don’t want someone sober watching them.” As one non-user observed, “It’s sad to see someone who is drunk reduced to a form of amusement, rather than a person.”

EXPERIMENTATION

“To experiment is to undertake; to discover something not yet known; to try out something; to find out whether or not it will be effective. To experiment is to test something out; to tentatively explore” (Webster’s New World Dictionary. World Publishing Company, 1968, p. 512).

We have made experimentation into something dreadful and foreboding. Testing an unknown is not a bad thing. Sharing our response to our experimentation is a good thing. Conversations encourage ongoing monitoring of the pleasures and dangers involved in our desires to escape and expand consciousness.

TAKE IT OR LEAVE IT USE

A number of people have a take it or leave it attitude toward AOD. It is not a pocket of meaning in their lives. That is, it is not a habit or activity that they invest with importance and repetition. They do not pay attention to AOD; it is not a big interest in their lives and, therefore, it is not part of their planning.

Take it or leave it people baffle many regular users of AOD. They generate envy in alcoholic or disordered users. “I watch people at a party or at a dinner and can’t understand how they leave a glass of wine half full, not drink as much as they can get their hands on, or voluntarily refuse a glass of wine and choose an iced tea instead. I really can’t fathom that.” The drive to get to high is so preoccupying to some and so incidental to others.
SOCIAL USE

These are people who enjoy a drink or two in the company of others. They look forward to a night out with the girls or the boys and anticipate a relaxing glass of wine, beer, or spirits during an intimate dinner or at a festive gathering. They enjoy getting high with other people; they relish the relaxing effects.

They imbibe to enhance a social event. They plan for a good time and gauge for any overindulgence. They usually do not want to lose control, ruin an evening, embarrass themselves, or feel any ill effects. They are gifted with an intuitive sense of moderation. They are fun-loving and responsible.

Every drinker wants to believe they belong in this category. They may, or they may not.

MISUSE

Sometimes we overindulge at a birthday lunch. We can later attend an evening event that same day and also drink too much. And we can do that on several occasions. Does that mean that we are on the road to alcoholism? Not necessarily. Check family history as well as the meaning behind the misuse of alcohol. Mishandling an attempt to satisfy a human desire does not justify hysterical and controlling responses.

Misusers are not afraid to acknowledge their mishaps, and talk about their drinking anxieties. They prefer to address these, not hide them. They are not ashamed of overdoing it; it feels normal, “It’s what all people do some of the time.” Misusers have the ability to reverse this infrequent, but bothersome, behavior.

ABUSE

The DSM-IV-TR identifies abuse as a maladaptive pattern of use leading to distress or impairment. To be diagnosed with abuse, one or more of the following symptoms must occur within a 12-month period (DSM-IV-TR, 2000, p. 199).

Abusive use . . .

- Results in a failure to fulfill everyday role obligations
- Involves physical or psychological hazard
- Begets legal problems
- Produces health, relationship, work, family, and other problems
- Has not met the criteria for dependence
If you are abusing substances, chances are that the motivations for using are becoming more psychologically complex. Often it’s no longer just about having fun or escaping. All too often, drinking occasions turn into unpredictable events followed by the abuser discounting what happened and why. Increased abuse brings worry and guilt, and an increasingly private monologue with yourself about behavior that you can’t seem to control.

PROBLEMATIC USE AT A PROBLEMATIC TIME

Stressful periods of life invite stressed responses—including drinking/using to excess. Behavior at problematic times in one’s life can mimic more drastic diagnostic categories and seduce one into thinking of more draconian treatment responses. We sometimes can reverse short-lived unhealthy drinking patterns by exploring history, the current contextual demands, as well as noticing the considerable motivational strengths of each person. What “looks and smells” like alcoholism is often problematic use at a problematic time. This profile requires sensitive assessment.

PROBLEM USE

According to NIAAA and other independent researchers, there are four times as many problem drinkers as alcoholics in this country (Moderation Management). This suggests that the highest percentages of people with issues with alcohol are not alcoholics. They are problem drinkers who experience ongoing problems but do not have a severe physical dependence on alcohol (Institute of Medicine, 1990). We offer the least amount of services for their nightly or weekend heavy drinking, their blackouts or brownouts, and/or their periodic or regular binge episodes.

Problem drinkers are usually drinking not just for fun but also to cope. Life has gotten away from them, demands are overwhelming, and over time drinking has gotten sloppy. Difficulties mount in both the financial and legal areas as well as with physical and mental health, marital relationships or partnerships, children, and work. Honest discussions about these problems and difficulties stop working, and angry accusations abound.

SHADOW USE

Doctors Ratey and Johnson identify shadow syndromes as mild or subtle forms of otherwise serious mental disorders (1997, p. 36). These syndromes serve as shadow expressions of some of the diagnostic categories delineated in the DSM-IV-TR, including substance dependence and abuse.
This profile identifies persons whose lives are going relatively well. They have jobs, friends, children, and homes. They pay their bills, and they show up for life. They also drink or drug nearly 365 days of the year. They never miss a beat and AOD on the surface seems under control.

Over time, some underlying tensions may emerge. Increasingly, the user is less interested in participating in family activities, or if he does, he is always under the influence. Nights of drinking or drugging are never missed, conversations among family members decrease, and the distance between and among family members slowly increases. Traveling becomes problematic and cumbersome. The first stop after arrival is a liquor store or a dealer. While all seems okay on the surface, this once benign intruder is now robbing family members of vitality and spontaneity.

Not all shadow syndrome users are able to arrest or reverse the insidious creeping destructive potential of this profile of using. Not all are able to reverse these troubling patterns. Some escalate into deeper trouble.

**PSYCHOLOGICAL DEPENDENCY THAT IS NOT YET PHYSICAL**

Alcohol, opiates, and sedative hypnotics have the potential to produce physical and psychological dependency. Increased use disturbs, disrupts, and resets both the mind’s and body’s homeostatic balance or resting point. The problem user becomes dependent on maintaining this new normal.

In this profile, physical addiction is being held at desperate bay. Just enough of the drug is used to stave off the symptoms of physical withdrawal, and to quiet the escalating terror and despair from the increased recognition of psychological dependency. The user senses that total loss of control is looming. Family and friends are both frantic and silenced.

**DEPENDENCE**

The *DSM-IV-TR* identifies dependence as a maladaptive pattern of using, leading to distress or impairment. To be diagnosed with dependence, one demonstrates three or more of the following symptoms, occurring at any time, in the same 12-month period (*DSM-IV-TR*, 2000, pp. 197–198):

**Dependent use . . .**

- Produces tolerance—change in amount
- Results in withdrawal and its self-medication
• Involves using larger amounts over longer periods of time than intended
• Results in failed attempts to reduce or control usage
• Begets an increased preoccupation—the substance becomes the central organizing principle in the addict’s life
• Results in a failure to fulfill role obligations
• Produces problems

The person in this profile is using AOD 24/7. His psychological and physical dependency requires this. He is often waking up, having a swig or a hit before or in his coffee. He continues nipping throughout the day and evening. This continues into weeks, months, and, for some, into years. Concerned pleas are ignored or angrily responded to, and friends feel alienated and exhausted. Family talks are often met with the addict’s hardened desire to continue using. The dependent person feels fated to his existence; he imagines that he will use, and live this way, for the rest of his life.

To avoid over- or under-diagnosing in this profile, I have designed three additional criteria to add to the DSM list of dependent symptoms. These terms are described below; a clinical question is posed and their application is demonstrated in a clinical case:

The Mess Factor (Is it high, medium, or low?): Truly dependent individuals don’t have problems due to using; they have messes. They live in a world of financial, health, family, physical, and work disasters. A work mess collides with a financial one. A health mess collides with a family one. Life is about dodging these messes and figuring out a way to stay high.

A high mess factor suggests that wanting and needing drugs and alcohol so much has severely incapacitated any kind of judgment. The addict is tragically unable to anticipate and address life’s responsibilities and difficulties. Feeding his physical and psychological dependency is paramount, staving off the consequences of withdrawal and his messes a mainstay. The addict’s collapse is his final mess. Abstinence is needed to reverse this destructive trend.

The Length of the Moratorium (Is it long, medium, or short?): Leon Wurmser (1978), a psychoanalytic addiction psychiatrist, proposes that all addiction is about a moratorium on the development of age-appropriate skills. During this developmental stalemate, the addict repeatedly uses AOD to solve problems. This overreliance on an external substance results in a severe deficiency in the establishment of psychological and behavioral coping skills. Users are unable to face everyday distress and are incapacitated by their incapacities.
The length of the moratorium measures the years people have used AOD to address or avoid emotional difficulties and everyday problems. During this time, alcohol and drugs have resided in the addict’s back pocket, always available and ready to be pulled out and used in times of upset or stress. The constant return to this choice prevents the development of necessary life skills. A medium or long moratorium begs for abstinence. Without it, it is too tempting to rely on that back pocket again and again to repeatedly dodge facing reality. Abstinence forces the alcoholic and addict to draw on his own internal and external resources in ways never used before. Psychic capacity is then built, and new problem solving skills are developed.

**Pockets of Meaning (Are they decreasing? Is there only one left?):** This lovely term, very loosely adapted from Jay Effran’s work, is also diagnostic (Effran, Lukens, & Lukens, 1990, p. xv). I have previously defined pockets of meaning as passions that are invested with importance. These are the things that are valuable in a person’s life, the things people pocket and protect. These may include family, friends, hobbies, religion, work, or children. There is only one pocket of meaning in the world of the dependent alcoholic or addict. Life is about survival, and the substance is perceived as the only thing that can ensure that. Other pockets of meaning have long since been discarded. This loss or lack of interest in protecting ongoing pockets of meaning or discovering new ones strongly suggests that people are paying attention to AOD too much, and for the wrong reasons. Courageously letting go of this perceived pocket of survival allows abstinence to become the primary pocket of meaning. Sobriety delivers time and, with it, the discovery of new meanings and passions.
CHAPTER FIVE

ELEVEN CLASSES OF PSYCHOACTIVES
ELEVEN CLASSES OF PSYCHOACTIVE SUBSTANCES

This chapter introduces the reader to the eleven classes or types of psychoactive drugs that we ignore or enjoy, abuse or misuse, become destructively dependent upon and then, if fortunate, refrain from using. Oftentimes the eleven psychoactive substances are clustered into categories, such as depressants, stimulants, or analgesics. This chapter considers each individual psychoactive as identified in DSM-IV-TR.

THIS CHAPTER:

- Introduces the reader to some basic neuroscience
- Includes easy-to-read reference charts
- Identifies drug behaviors and visual cues

SOME BASIC NEUROSCIENCE

In 1970, it was discovered that the neurotransmitters endorphins and enkephalins produce the same effects as opioid drugs. This finally gave an understanding of how psychoactive drugs work in the body. A discussion about naturally occurring chemicals and biologic processes began. Over the next 40 years, researchers correlated the relationships among psychoactive drugs and the neurotransmitters directly affected by their use.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Neurotransmitter or Amino Acids (aa) Directly Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>GABA (aa), Glutamate (aa)</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>GABA (aa)</td>
</tr>
<tr>
<td>Marijuana</td>
<td>Endocannabinoids</td>
</tr>
<tr>
<td>Opioids</td>
<td>Endorphins</td>
</tr>
<tr>
<td>Hallucinogens (LSD, PCP)</td>
<td>Serotonin</td>
</tr>
<tr>
<td>Cocaine and Amphetamines</td>
<td>Norepinephrine, acetylcholine</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>Serotonin, dopamine, adrenaline</td>
</tr>
<tr>
<td>Inhalants</td>
<td>Dopamine, GABA (aa), glutamate (aa)</td>
</tr>
<tr>
<td>Nicotine</td>
<td>Acetylcholine, serotonin, dopamine, norepinephrine, epinephrine</td>
</tr>
<tr>
<td>Caffeine</td>
<td>Dopamine, norepinephrine, GABA (aa)</td>
</tr>
</tbody>
</table>

Table 5.1: The Relationship Between AOD and Neurotransmitter Systems


Virtually any psychoactive drug works because it mimics or disrupts naturally occurring chemicals in the body that have specific receptor sites. This means that psychoactive drugs cannot create sensations or feelings that don’t have a natural counterpart. It implies that human beings can naturally create virtually all of the sensations and feelings we try to get.
through drugs. There are four big differences: (1) the drug or alcohol experience is a more intense one; (2) the timing of their impact is more predictable; (3) drug or alcohol effects weaken with repeated use; and finally, (4) drugs or alcohol carry deleterious side effects (Inaba et al., 2007, p. 61).

Neurotransmitter research seems to indicate that some people are drawn to certain drugs because of a neurotransmitter imbalance in their brain. Drugs repair this deficiency, and the person feels normal, satisfied, and in control.

**REFERENCE CHARTS**

The charts on the following pages are quick, easy, and useful reference guides. They are designed to include some of the key content necessary for understanding the basic essentials of each of the psychoactives listed in the *DSM-IV-TR*. The material has been gleaned from multiple sources—reading and studying technical texts on chemical dependency, teaching and listening to student stories over decades, as well as listening and learning from my patients. The historical and factual materials have been gleaned from the texts identified in the Further Study section in the book’s chapter. The number of featured categories are intended to neither overwhelm nor underwhelm the reader with AOD facts. This selective grouping is a concise guideline for the delivery of treatment.

The categories are described below.

- *Italics*: A factoid of historical interest

- Group: Examples of the pills, powders, or liquids in each psychoactive class and their effects on the mind and body

- Pattern of Use: Method of administration

- Natural History: The likely number of years and patterns of using AOD (Vaillant, 1983, pp. 107–180)

- Potential for Dependence: Physical and psychological dependence potential—high, medium, or low

- Withdrawal: Short- and long-term physical and psychological symptoms that appear after a dependent user stops using

- Points to Ponder: Selective clinical considerations and salient features
(1) ALCOHOL

A part of human culture since the beginning of recorded history. Understanding alcohol’s place in human culture engenders avoidance and conflict.

Group
Beer, wine, liquor—These are central nervous system depressants.

Pattern of Use
Oral

Natural History
25 years to a lifetime of dependent use
15 years of problematic use
1–5 years of poly drug use and experimentation

Potential for Dependence
Physical—High
Psychological—High

Withdrawal
Initial acute withdrawal of 24–96 hours includes the following symptoms: hyperarousal, anxiety, irritability, insomnia, tachycardia, delirium tremors, agitation, sweating, vertigo, alcohol hallucinations, muscle weakness, excessive fatigue, irritability, incontinence

Alcohol has a 2-year protracted withdrawal period with decreasing severity and frequency of symptoms.

Points to Ponder
- Alcohol is the most popular psychoactive pleasure in the world. It isn’t easy for people to learn how to enjoy, not exceed, this central nervous system relaxant.
- Campral is a new medication that restores chemical imbalances from severe alcohol dependency.
- Alcohol recovery always involves the working through of anxieties about interpersonal closeness and intimacy.
(2) AMPHETAMINES

Scientists have discovered ephedra plants thought to be 60,000 years old. The Chinese used ephedra for medicinal purposes 5,000 years ago.

Group
Methamphetamine, dextroamphetamine, Ritalin, diet pills, Ecstasy—These are central nervous system stimulants and provide a sense of well-being.

Pattern of Use
Oral, intravenous, intramuscular, nasal inhalation, and smoking

Natural History
25 years to a lifetime of dependent use
15 years of episodic and binge using
1–5 years of poly drug use and experimentation

Potential for Dependence
Physical—Debated in the literature
Psychological—High

Withdrawal
Symptoms include irritability, agitation, aggressiveness, restlessness, insomnia, fatigue, depression, and anhedonia.

Points to Ponder
- It is estimated that 60–80% of amphetamine users simultaneously drink alcohol (Schuckit, 2010, p. 140).
- Repeated use can temporarily decrease the number of dopamine receptor sites and severely damage the brain’s pleasure centers. There is some evidence of reversal after long-term abstinence.
- Substances acting like amphetamines are found in many over-the-counter energy boosters.
The industrial, medical, and recreational use of the cannabis plant has a long history, beginning in 8000 B.C.

Group
Marijuana—unprocessed leaves, dried flowers, seeds, and stems of the plant
Hashish—processed from the resin of the plant
THC—the most psychoactive compound found in the plant and produces most of the high
Cannabis produces variable effects. It can act as a stimulant, relaxant, anti-anxiety, or depressant.

Pattern of Use
Smoked in a pipe
Eaten in food
Drunk in tea
Ingested from a pill

Natural History
25 years to a lifetime of dependent use
15 years of a pattern of on and off use—on during the weekend or nighttime, off during the week or daytime
1–5 years of poly drug use and experimentation

Potential for Dependence
Physical—Low
Psychological—High

Withdrawal
Symptoms include irritability, restlessness, mental confusion, anxiety, depression, cravings, insomnia, agitation

Points to Ponder
- Marijuana is the most commonly consumed illicit drug, with 200 to 300 million users worldwide (Earleywine, 2002, p. 47).
- The experience of marijuana is influenced by one’s mindset and one’s physical and emotional setting; it is referred to as a set/setting drug.
- Marijuana has many established medicinal purposes—from serious medical problems to mild ailments.
COCAINE

Derived from the pulped leaf of the South American coca plant.

Group
Coca leaves, coca paste, cocaine hydrochloride powder, cocaine alkaloid—These are central nervous system stimulants.

Pattern of Use
Coca leaves are chewed
Coca paste is smoked
Cocaine hydrochloride powder is snorted or injected
Cocaine alkaloid is smoked or injected

Natural History
1–2 years of daily, dependent, and dangerous use
5–10 years of a mix of daily use, episodic use, and binge use
1–5 years of poly drug use and experimentation

Potential for Dependence
Physical—Debated in the literature
Psychological—High

Withdrawal
Acute withdrawal of 36 hours includes symptoms of anhedonia, paranoia, agitation, fatigue, chills, nausea, headache, vomiting, and muscle tremors.
Post-acute withdrawal of 7–10 days includes symptoms of fatigue and flu-like symptoms.

Points to Ponder
- Crack—cocaine mixed with baking soda and water over a hot flame. The substance, which is 90% pure cocaine, is then dried. The soapy looking substance that results can be broken up into rocks and smoked. These rocks are about five times as strong as cocaine. Crack gets its name from the popping noises it makes when it is smoked. One puff of a pebble-sized rock gives a high for about 20 minutes. The user can usually get 3–4 hits off the rock before it is used up (Doweiko, 2009, p. 137; Hanson et al., 2009, pp. 268–269).
- Free Base—produces a stronger high, and the process eliminates cutting agents. It is made with Cocaine Hydrochloride (street market cocaine). It is dissolved in water, and a solvent (usually petroleum ether or ammonia) is added to release cocaine alkaloid from the salt and other adulterants. A stronger base (baby laxatives) is then added to neutralize the acid content. The solvent rises to the top, where it can be filtered or drawn off. As the solvent evaporates, the cocaine salt oxidizes and what is left is cocaine base. Free-base cocaine is water soluble and can be smoked or injected. These methods get rid of all possible cuts in cocaine (Doweiko, 2009, p. 137; Hanson et al., 2009, pp. 268–269).
(5) INHALANTS

Inhaled substances altering perceptions of reality can be traced to ancient Greece.

Group
Volatiles solvent and sprays—glue, paint, paint thinners, stimulant drug, euphoric
Volatiles nitrites—amyl nitrate, butyl nitrite
Anesthetics—nitrous oxide, ether
This group produces intoxicating, stupefying effects on the central nervous system, as well as euphoric giddiness, loss of inhibitions.

Pattern of Use
Inhale from a container, rag, or canister (“huffing” or “bagging”)

Natural History
5–8 years of mixed use, including periods of daily using, interspersed with periods of episodic and binge using
1–5 years of poly drug use and experimentation

Potential for Dependence
Physical—Low
Psychological—Low

Withdrawal
Symptoms include mental confusion, disorientation, ringing in the ear, headache, fatigue, and muscle weakness.

Points to Ponder
- Inhalants are breathable chemicals that were never meant to be used as recreational drugs.
- One-time using of inhalants can result in sudden sniffing death syndrome. Learning disability symptoms develop with increased inhalant use.
- Children who regularly sniff solvents develop tolerance to them. This sniffing habit can be difficult to break.
HALLUCINOGENS

Hallucinogenic plants have been used long before recorded history.

**Group**
LSD, Salvia, psilocybin mushrooms, Peyote Cactus, Ecstasy, DMT ("the business man’s LSD")—This group alters perceptions and alters consciousness.

**Pattern of Use**
- Oral—sugar cubes, capsules, tablets
- IV—rare (LSD)
- Smoked
- DMT—injected, sniffed, or smoked

**Natural History**
- 25 years to a lifetime of episodic or ritualistic use
- 15 years of planned hedonism
- 1–5 years of poly drug use and experimentation

**Potential for Dependence**
- Physical—Low
- Psychological—Low
- May be the lowest potential for abuse and dependence

**Withdrawal**
Flu-like symptoms, depression, fatigue, and anxiety

**Points to Ponder**
- Drug seekers search for sensual experimentation and ritualistic use.
- Hallucinogens are set and setting drugs; the mindset and one’s setting greatly influence outcome. Predictability is reduced, thus long-term interest decreases.
OPIATES/OPIOIDS

Used in religious rituals and cultivated as a crop as early as ten thousand years ago. “Narkoticos”—the Greek word for numbing or deadening.

Group
Natural—morphine, codeine, opium
Semisynthetic—heroin, Vicodin, Percodan, Dilaudid
Synthetic—Demerol, Darvon, methadone
These drugs are analgesics and reduce physical and emotional pain. They provide a euphoric rush, lower anxiety, and increase an overall sense of well-being.

Pattern of Use
Oral
IV, IM, skin popping—under surface of the skin
Snort, smoke
Mucous membranes of mouth, nose, or rectum when vomiting, unconscious, or can’t swallow

Natural History
25 years to a lifetime of dependent use
15 years of chipping and episodic use
1–5 years of poly drug use and experimentation

Potential for Dependence
Physical—High
Psychological—High

Withdrawal
Initial acute withdrawal of 48–72 hours of withdrawal includes symptoms of nausea, vomiting, gooseflesh, intestinal spasms, abdominal pain, kicking movements, diarrhea, irritability, violent yarning, sneezing and runny nose, restlessness, and increased heart rate and blood pressure.

The opiates have a 2-year protracted withdrawal period with decreasing severity and frequency of symptoms.

Points to Ponder
- Prescription pain relievers all too often become drugs of dependence and abuse.
- Beware of the opiates’ daily seductions as mother’s or father’s “little helper.”
- Buprenorphine (Suboxone, Subutex) has been approved by the FDA and seems to have replaced methadone as the treatment for opioid dependence. It is unique because its therapeutic effect plateaus at certain levels; addicts are less likely to get high (Erickson, 2007, p. 237).
- Chippers—occasional users of heroin.
(8) PHENCYCLIDINE (PCP)


Group

PCP, TCP, Ketamine, or Ketalar—These are dissociative anesthetics, separating mind/body experiences.

Pattern of Use

Oral
IV
IM
Smoked
Snorted

Natural History

5–8 years of mixed use, including periods of daily use interspersed with episodic or binge using

Potential for Dependence

Physical—Low
Psychological—Low to Moderate

Withdrawal

Mixed evidence of a withdrawal symptom

Points to Ponder

- PeaCe Pill is the street name for PCP.
- As a drug of abuse in the United States, its popularity waxes and wanes. PCP is considered a set/setting drug; mindset and setting greatly determines outcome.
- Levels of intoxication range from mild to induced psychosis.
SEDATIVES, HYPNOTICS, AND ANXIOLYTICS

In 1960, a new class of anti-anxiety drugs replaced reliance on the barbiturates. Benzodiazepine (BZs) are the most prescribed psychotropic medications in the world.

Group
Barbituates—Seconal, Nembutal, Amytal
Benzodiazepine—Librium, Xanax, Ativan, Klonopin, Restoril, Rohypnol
Other sedatives-hypnotics—quaalude, GHB, miltown
This class of drugs reduces anxiety and induces relaxation. They can also promote sleep and a sense of well-being.

Pattern of Use
Oral
IV

Natural History
25 years to a lifetime of daily use
15 years of periods of daily use
1–5 years of poly drug use and experimentation

Potential for Dependence
Physical—High
Psychological—High

Withdrawal
Initial acute withdrawal of 24 to 72 hours includes symptoms of apprehension, anxiety, insomnia, stomach cramps, sweating, fainting, nausea, restlessness, and agitation.

The benzodiazepines have a 2-year protracted period with increasing severity and frequency of symptoms.

Points to Ponder

- These medications are thought to increase function of GABA and suppress unnecessary anxiety and insomnia.
- Sudden cessation will produce withdrawal symptoms. Tapering of dependent use is strongly recommended.
- Be wary of alcoholism-sedativism. The effects of daily heavy drinking are mitigated with nightly benzodiazepine use.
- Watch for increased daily usage as antidote to fast-paced anxious society.
(10) NICOTINE

References to nicotine are etched into Mayan stone carvings from 600 A.D.

**Group**
Cigarettes, tobacco, snuff, nicotine gum, nicotine skin patch, cigars, pipe tobacco, and salves
This class of drug decreases anxiety, calms, and decreases appetite.

**Pattern of Use**
Smoked
Chewed

**Natural History**
25 years to a lifetime of dependent use
25 years to a lifetime of chipping or episodic use
1–5 years of experimentation

**Potential for Dependence**
Physical—High
Psychological—High

**Withdrawal**
Symptoms begin within hours and peak on days 2–4, and last up to a month.

Symptoms include increased craving, increased appetite, irritability, anxiety, difficulty concentrating, and restlessness.

**Points to Ponder**
- In the 1960s, 40% of U.S. adults were smokers. Today, it is down to 21% (Kuhn et al., 2008, p. 174).
- Eighty percent of men and women who are alcohol dependent currently smoke (Schuckit, 2010, p. 211).
- There are two sources of smoke from cigarette smokers; the smoke they exhale (secondhand) and the smoke rising off the lit cigarette (sidestream). Sidestream smoke has a higher concentration of carcinogens than either secondhand smoke or the smoke taken into the lungs through a cigarette filter (Kuhn et al., 2008, p. 181).
(11) XANTHINES (CAFFEINE)

Coffee was first cultivated in Yemen in the sixth century.

**Group**

Coffee, tea, chocolate, soft drinks, energy drinks, over-the-counter pain relievers, stimulants and medications
This class of drugs enhance concentration, alertness and attention, calms, and decreases fatigue.

**Pattern of Use**

Oral

**Natural History**

25 years to a lifetime of dependent use
25 years to a lifetime of episodic use
1–5 years of experimentation

**Potential for Dependence**

Physical—High
Psychological—High

**Withdrawal**

Symptoms develop between 12 and 24 hours after the last dose of caffeine.
Symptoms include headache, fatigue, yawning, and nausea.
Non-prescription pain relievers to relieve headaches are used during withdrawal.

**Points to Ponder**

- It is estimated that more than 50% of Americans drink coffee every day.
- Prenatal and postnatal effects include reduced chances for pregnancy and lower birth weights (Kuhn et al., 2008, p. 69).
- Caffeine disturbs, stresses, or interrupts functioning in the heart, eyes, kidneys, digestive, reproductive, and respiratory systems.
- Caffeine causes constriction of blood vessels, and this is a likely reason why it is effective for migraine headaches (Kuhn et al., 2008, p. 71).
- Overall, caffeine is fairly safe if a healthy person takes it in moderate amount.
AOD BEHAVIOR AND CUES

AMPHETAMINES

GENERAL BEHAVIOR:
Overall hyperactive behavior; restless, nervous, talkative

There is no set pattern of behavior or exact physical characteristics that will positively identify amphetamine abusers short of laboratory tests. However, there are several common signs to look for. These include:

- Hyperactivity, often accompanied by intense anxiety, nervousness, talkativeness, irritability, and short temper
- Dilated pupils
- Bad breath, sometimes accompanied by raw, cracked lips
- Sores or lesions caused by picking and scratching imaginary bugs
- Nose rubbing—amphetamines cause the mucous membranes to dry out and itch
- Needle marks and scars

COCAINE

GENERAL BEHAVIOR:
Excitable, restless behavior

Cocaine is a powerful and dangerous drug. As with other drugs, the reaction of one individual to cocaine may vary substantially from that of another, which makes it extremely difficult to spot the signs of cocaine abuse with any certainty. However, there are a number of symptoms and behavioral traits that may indicate cocaine abuse, particularly if the symptoms are severe. These include:

- Extreme excitability and hyperactivity
- Excessive restlessness and anxiety
- Visual and auditory hallucinations
- Open sores and/or scabs caused by picking and scratching imaginary bugs under the skin/face
- Damage to nasal mucous membranes
- Dilated pupils
- Talkativeness
Paranoid fears
- Hostile and belligerent

**DEPRESSANTS**
(INCLUDING ALCOHOL)

**GENERAL BEHAVIOR:**
*Stumbling, staggering, disoriented, “drunken” behavior*

Generally the signs of depressants and alcoholic intoxication are similar with one important difference. Depressant users will not have the odor of alcohol on their breath or clothing. The abusers’ thought processes are muddled. They neglect their personal appearance. Some conditions to look for when trying to determine if a person may be a depressant abuser are:

- General incoherence
- Disorientation
- Staggering and stumbling
- Drowsiness—abuser may be in a complete stupor
- Constricted pupils (dilation may occur in overdoses)
- Slurred speech
- Irritability and restlessness
- Belligerence
- Depressed reflexes
- Slow, shallow respiration
- Odor of alcohol
- Swollen, blotched face

**HALLUCINOGENS**

**GENERAL BEHAVIOR:**
*Appears to be in trance or state of panic*

There is no specific sign or mode of behavior that definitely indicates a person is under the influence of a hallucinogenic drug. The associated physical behavioral signs vary widely. The following have been observed:

- Dilated pupils
- Rambling, incoherent speech
- Complaints of visual and auditory hallucinations, ranging from pleasant to terrifying
- Distortion and changes in sense of time, smell, hearing, and touch
- Nausea, chills, flashes, trembling hands
- Increased sweating
- Euphoria
- Trance-like behavior
- Anxiety, panic, and terror

**HEROIN**

**GENERAL BEHAVIOR:**

- Overall unkept condition, physically run down, lethargic, and stuporous
- Seemingly normal appearance
- Short of laboratory tests, there is no way of telling whether or not a person is using heroin or any other narcotic. There are a number of signs that may indicate heroin abuse, including:
  - General rundown physical appearance. Heroin abusers frequently ignore their personal hygiene and nutritional needs.
  - The presence of narcotics paraphernalia, such as needles, syringes, cookers, strings or cords used as tourniquets, capsules, envelopes or paper and foil packages with traces of white powder
  - Cigarette-burned fingers. Abusers frequently are in a semi-comatose condition and suffer from diminished perception of pain.
  - Constricted or “pinned” pupils of the eyes that fail to respond to light
  - Scars (tracks) or discolorations over the veins, caused by repeated intravenous injections
  - Early signs of withdrawal, such as a runny nose, sweating and/or anxiety, restlessness, and dry mouth
  - Abscesses caused by injected needles
  - Sores on the face
  - Stuporous, lethargic behavior
MARIJUANA

GENERAL BEHAVIOR:

- Sluggish, intoxicated, may precipitate panic or other irrational behavior
- A little too happy or perky about life, when used as a stimulant

There are few tell-tale signs that help identify a person under the influence of marijuana. Some indications include:

- Intoxicated or disturbed behavior. While under the influence of marijuana, users may exhibit symptoms of alcohol intoxication. The odor of alcohol will be missing. Sometimes marijuana use may precipitate panic, hallucinations, and irrational behavior.
- The odor of burning marijuana. When smoked, marijuana gives off a strong characteristic odor, similar to that of burning hemp.
- Odor of incense or room deodorants. Users will sometimes burn incense to mask the strong marijuana odor.
- Inflamed or redden ed eyes often accompany use of marijuana.
- Possession of marijuana cigarettes or paraphernalia

REFLECTIONS

Before leaving this chapter, make sure you have grasped:

- Some basic neuroscience about how AOD work in our body.
- The differences between each of the eleven psychoactives that we can use misuse or become addicted to.
- The importance of further study of scientific or medical discoveries about each of the psychoactives.

FURTHER STUDY


CHAPTER SIX

TEN MODELS

OF

TREATMENT
TEN MODELS OF TREATMENT

This chapter was originally developed from the article, “Treatment Implications of Chemical Dependency Models: An Integrative Approach,” written in the Journal of Substance Abuse Treatment in 1989 by Brower, Blow, and Beresford. The article identifies basic (single-focused) and integrative (multi-focused) models of chemical dependency treatment. Etiological assumptions, addictive identities, treatment goals, strategies, and caveats, as well as advantages and disadvantages of each model, are suggested.

This article delivers a classic contribution to the field; the presentation of models is comprehensive and also concisely organized and cogently delivered. The features and uses, strengths and vulnerabilities of each model are freely shared with the reader. These ten pages provide a very useful overview of the most widely used treatment models, as well as the details necessary for clinical application. The treatment provider is encouraged to mix and match models and model parts with their clinical style, as well as with the needs, wishes, and beliefs of the addict and alcoholic.

THIS CHAPTER:

- Introduces the reader to the field of treatment and further his understanding of different approaches to recovery

- Provides the beginning content necessary to develop a workable and reflective grasp of treatment modalities in the field

- Furnishes some pertinent information about each model with the least amount of unnecessary complexity or redundancy

There are five basic or single-focused models and five integrative or multi-focused models. Hopefully, what follows will help the readers identify and clarify their treatment approach of choice.
A moral model suggests that chemical dependency occurs as a result of moral weakness. The chemically dependent person has an evil, weak, or bad character. This weakness of will and character results in a person who is unable or unwilling to stop destructive and hedonistic use of substances. Treatment for this “condition” includes spirituality, religion, or the military. God or a strong arm is the only solution. Both inspire the willpower needed to resist the evil temptations of the substances.

The learning model suggests that chemical dependency arises from the learning of both maladaptive behaviors and faulty cognitions.

The chemically dependent person is a tabula rasa or a blank slate. Unhealthy habits and thinking patterns, behaviorally and cognitively imprinted, drive destruction. A decision to drink or drug every night is a remembrance of the numbing rituals of childhood. This learning and repeating goes on without reflection for years and decades. This blank slate of a person is not bad; he is woefully misdirected by poor parental or family modeling.
Learning model approaches hold people responsible. Treatment encourages the development of new cognitions and behaviors, better coping responses, as well as healthy lifestyle adjustments. Education is stressed. Moderation Management (MM; Kosok, 2006) and Self-Management and Recovery Training (SMART) are examples of learning models (Horvath & Velten, 2000). Weekly groups identify specific goals, provide support, and attempt to hold people accountable.

**THE DISEASE OR MEDICAL MODEL**

Simply put, the disease model states that alcoholism is a chronic, progressive, incurable disease characterized by an irreversible loss of control over alcohol (American Society of Addiction Medicine).

The alcoholic is sick with an illness and needs treatment and care. A lifetime of abstinence is the recommended course of recovery. In the current zeitgeist, this is by far the most dominant model of treatment in the field. It is entrenched and established, endorsed and embraced by the majority, funded for treatment and research, and politically correct. The disease of addiction is considered progressive and its evolution is displayed below.

![Diagram of Disease Model](image)

**The Self-Medication Model**

The self-medication model says that addictions arise from untreated psychological suffering.

Dr. Khantzian, in his classic paper on the Self-Medication Theory in 1985, suggested that addicts attempt self-medication for a range of psychiatric problems. They use drugs and alcohol to help alleviate the unresolved pain of their histories; to relieve the symptoms of another primary mental disorder such as depression, anxiety, or schizophrenia; or to compensate for psychological incapacity. They self-medicate for intense suffering; they are not morally weak, driven by a disease, or recipients of poor parental modeling. They have psychological problems, have found a solution in AOD, and need psychological help. The goal of treatment is to improve mental health. The strategies include psychotherapy and psychopharmacology.
THE SOCIAL MODEL

A social model of addiction links the stresses of social living to addictive consumption.

Social distresses that drive chemical dependency include discrimination and economic anxiety, drug availability and peer pressure, a sense of urgency pulsating in big cities and the sense of despair languishing in our rural towns, family chaos and dysfunction, work pressures and exhaustions, as well as living beyond our means and greed. These disturbing social influences are vast.

Treatments support social adjustments—recognizing and altering destructive forces in one’s environment, as well as identifying and improving coping responses for the daily stresses of living in contemporary culture.

MULTI-FOCUSED MODELS

THE ALCOHOLICS ANONYMOUS (AA) MODEL

This model contains aspects of the moral, learning, and disease models.

AA embraces and incorporates each of these single-focused models. A spiritual path to recovery is encouraged. Acknowledging powerlessness over the disease of addiction is strongly suggested. This paves the way to abstinence. Meetings, 12-step work, moral inventories, service to others, fellowship, apprentice learning, being sponsored and later sponsoring combine to support long-term sobriety. AA meetings are available around the world and 24 hours a day. Alcoholics Anonymous has believers and doubters. Many people in the field have written about its utility and effectiveness, as well as its stranglehold and serious limitations (Rotskoff, 2002).

AA was founded in 1935. Somewhere, I read this joke: A man asks another man, “How does AA work?” The response, “It works very well, thank you.”

THE DUAL DIAGNOSIS MODEL

This model contains aspects of the disease model and the self-medication model.

The dual diagnosis model of treatment has reverence for two disorders. One is the disease of addiction and the other is a mental health disorder, such as depression or schizophrenia, generalized anxiety, or a personality disorder. Both need diagnosis and attention. Both are considered primary, and both exacerbate each other. Both involve denial and an element of loss of control. Both can be life-threatening, and recovery usually involves lifelong attention.
Treatment options include AA, support groups, psychotherapy, outpatient or inpatient programs, as well as medications.

**THE BIOPSYCHOSOCIAL MODEL**

This model contains aspects of the disease, self-medication, and social models.

Treatment for the biology may include abstinence and AA, or moderation and psychotherapy. Treatment for the psychological suffering is likely to include pharmacology and psychotherapy. Social recovery strategies may include group support, AA meetings, improved coping responses, and adjustment or alterations in the environment.

**THE HARM REDUCTION MODEL**

This model contains aspects of the learning, disease, self-medication, and social models.

Harm reduction begins with recognizing the validity of the patient’s own preferences and strengths. Treatment options and decisions are designed within the treatment relationship. Harm reduction does not hold abstinence as a necessary precondition for recovery. Rather, problem users may become more responsible users if given the chance to do so. Strategies are varied. Any reduction in harm is considered a step in the right direction. Allan Marlatt calls harm reduction Compassionate Pragmatism (1998, pp. 56–58).

This model believes that treating a problematic user, addict, or alcoholic with respect and dignity pays off. Compassion invites a collaborative treatment relationship, which may eventually encourage the adoption of abstinence, if harm reduction approaches have failed.

**THE MULTIVARIANT MODEL**

This model embraces features of all the basic and integrative models of treatment.

A multivariant treatment provider values the components of both single-focused and multi-focused models. She believes in the sensibilities and sensitivities of the addict. She tends to study each model and appreciates the idiosyncrasies of each. She continually searches for a good treatment fit.
CHAPTER SEVEN

SELF-MEDICATION

PSYCHOANALYTIC

AND

PSYCHODYNAMIC THEORIES
SELF-MEDICATION THEORISTS

During the 1970s and 1980s, Dr. Ed Khantzian did much to humanize addiction.

He and others debunked the popular and prevailing notions that addiction resulted from hedonism, escapism, self-destruction, or pleasure. Dr. Khantzian, in his classic paper on the Self-Medication Theory in 1985, suggested that addicts attempt to self-medicate for a range of psychiatric problems and intense emotional states. Addicts psychologically suffer like all of us, but they seem to suffer more intensely and with greater difficulty. In many cases, this has led them to discover that the short-term effects of their drug of choice greatly helps them cope. Continued use gets them in a lot of trouble. Psychological treatment can be helpful here. This chapter is the heart of this book and workbook.

THIS CHAPTER:

- Provides a self-selected collection of addiction and psychoanalytic writers who value connecting psychological and emotional vulnerabilities to the development of addiction
- Attempts to synopsize, bracket, and discuss the most salient features of each of the theorists in the next pages
- Uses both discipline and imagination in my interpretations of their work

LANCE DODES: Lance Dodes (2002) is a psychiatrist from Harvard. He has worked in the field of addiction for more than twenty years. He proposes that true addiction or the “heart of addiction” is fundamentally psychological in nature. Addiction exists when there is a psychological need to perform the addictive behavior (2002, p. 74). Dodes straightforwardly highlights the transient nature of physical addiction and urges us not to confuse its consequences and complications with the problem of addiction in general. He sharply suggests that “physical addiction is surprisingly incidental to the real nature of addiction” (2002, p. 76). These symptoms are largely a medical problem attended to during the early hours of withdrawal. Most people can be safely detoxed in a matter of days or weeks. His emphasis is on addiction’s psychological nature, not its physical complications (2002, pp. 3–9).

CONTEXT OF ADDICTION: People often feel trapped in a problem or dilemma. This results in feelings of helplessness and powerlessness.

DRIVE BEHIND ADDICTION: Being and feeling trapped creates rage. The rage at feelings of helplessness is the irresistible force that drives addiction.

PURPOSE OF ADDICTION: To reverse feelings of helplessness and powerlessness. Addiction provides a false sense of empowerment, seducing the addict into believing that he is in control of his emotional experience, as well as his life.
**ADDICTION AS A SUBSTITUTE ACTION:** All addiction is a substitute action because another, more direct response to one’s helplessness does not seem possible or permissible.

**ED KHANTZIAN:** Ed Khantzi (1999, 2008, 2011) is the founder of the self-medication theory of addiction. His early theories in the 1970s and 1980s challenged the prevailing notions that addicts were weak-willed and thus doomed to forever capitulate to hedonistic desires. For decades, he has been moved to look at the psychological suffering of addicts. One of his earliest theories looked at the relationship between an individual’s emotional suffering and his choice of drugs (Khantzian, 1999, pp. 69, 117–119).

**MOTIVATION TO USE:** Not self-destruction, sociopathy, or euphoria

**PURPOSE OF ADDICTION:** To turn uncontrolled or passive suffering into controlled or active suffering

**ADDICTS:** Are sitting on an affective storm of chaotic emotions. People live with the sense that something is wrong but are at a loss on how to explore this. This is passive suffering.

**CHOICE OF DRUGS IS NOT RANDOM:** People choose a specific drug because it predictably and reliably works on their internal storm. It quiets or animates the storm. Returning to this relief again and again results in addiction. This is active suffering.

**ED KHANTZIAN with JOHN MACK:** A hallmark contribution of Ed Khantzian with John Mack (1999) is the discovery that addicts self-medicate because they are unable to self-care. Self-care functions are ego functions developed through the process of internalization. Responding to a child’s needs and fostering healthy dependency builds his ego capacities and skills. These are necessary to live well. Self-care ego functions serve to warn, guide, and protect individuals from hazardous or dangerous involvements and behaviors including drug addiction and alcoholism, unhealthy and violent relationships, impulsive choices, and destructive situations. Khantzian looks at self-care deficiencies as a way to explain a range of troubled human behaviors (1999, pp. 335–355).

**ADDICTION IS ABOUT TWO THINGS:** Problems of Control and Psychological Suffering in four areas

**PROBLEMS OF CONTROL:** Addictions are troubled and destructive behaviors. People have lost choice and lost control. Addicts are unable and thus unwilling to make healthier choices.

**PSYCHOLOGICAL SUFFERING IN FOUR AREAS:**
1. A chaotic affect from the experience of qualities and quantities of feelings that are either too intense or too vague, nameless, or confusing
2. A pained sense of self with little or no confidence
3. A wish to make contact and have relationships with others, but it is a wish filled with a sense of hazard and impossibility
4. An inability to desire self-care for oneself

SELF-CARE FUNCTIONS: Early and responsive caregiving results in self-care functions that produce:

An energized sense of one’s value and worth. A feeling that one is worthy of care and protection either from self or others.
An ability to listen to anxiety that says trouble is approaching, with the desire and ability to anticipate, as well as attend, to the danger
An ability to control impulses and renounce pleasures whose consequences are harmful
An enjoyment of appropriate levels of risk, in which dangers are realistically measured
An accurate and real knowledge about the outside world and oneself sufficient for survival
The ability to be self-assertive or aggressive to care for and protect oneself
Important relationship skills, especially the ability to choose friends and loved ones whom ideally enhance one’s sense of value and worth and encourage one’s self-care and protection.
The ability to rebuff and avoid people who interfere with and jeopardize one’s sense of value, self-care, and protection.

DONALD RINSLEY: Donald Rinsley, a psychiatrist who wrote in the 1970s, focused on what is missing in the psychological structure of someone with a borderline personality disorder. He was struck by their inability to self-soothe. Addicts lack the same capacity (Rinsley, 1988, pp. 1–7).

SOOTHING INTROJECT: An element of psychological structure that allows one to identify, monitor, and modulate the emotional shifts that occur throughout a day. It is missing in addicts. They are unable to soothe feelings of frustration and helplessness.

REASON ADDICTS USE DRUGS: To self-medicate as a coping mechanism for this deficit in psychological structure

KAREN WALANT: Karen Walant (1995) is a social worker from Katonah, New York. For decades, she has been interested in attachment and addiction. Walant suggests that a denial and devaluation of merger moments throughout the life cycle has increased the likelihood of addiction. She proposes that premature autonomy and independence have been encouraged at the expense of attachment needs. She applied this interest to her own version of the theory of self-medication and addiction (1995, p. 2).

MERGER MOMENTS: Transformative experiences between a parent and dependent child that result in the child developing a cohesive sense of self

NORMATIVE ABUSE: When parents and caretakers do not honor a child’s healthy dependency needs, but instead honor the cultural norm of independence and separation
NORMATIVE ABUSE RESULTS IN: A child, later adolescent and adult, who is disconnected from his needs and desires, and lacks a cohesive sense of self

AT THE HEART OF ADDICTION: A detached, alienated person looking for pseudo-merger with AOD

HEINZ KOHUT in JEROME LEVIN: Jerome Levin (2001) is a major contributor to the field of addiction theory and treatment. His work includes Heinz Kohut’s psychoanalytic theory of self-psychology. Kohut sees narcissistic or self-disturbances as central to the psychopathology of the addict. Internally, the addict feels empty, fragmented, and unorganized. Alcoholic drinking is the pathological compromise that attempts to make up for this depleted sense of self. Therapeutic relationships that foster a sense of self-cohesion are essential in recovery. Addiction doesn’t inhabit individuals with a sense of self-cohesion and life purpose (Kohut in Levin, 2001, pp. 71–97).

SELFOBJECT: Important others in the life of a child that are experienced as part of the self or in the service of the self

SELFOBJECT NEEDS: Specific, empathic responses that the child needs in the areas of grandiosity, idealization, and likeness

SELFOBJECT EXPERIENCES: Occurs when parents provide needed responses to the child. These parental responses assist in the building of his self-structure. We seek similar experiences throughout our lifetime.

TRANSMUTING INTERNALIZATION: This occurs when needed aspects of important selfobjects are internalized. Functions of the parents are taken in and transmuted into the child’s sense of self and self-worth.

THE EXPERIENCE OF THE ADDICT: An inner emptiness is felt as a result of an absence of an internal self-structure. This is experienced as a void that addicts try to fill with AOD. It cannot be done. This effort is “futilitarian.”

MOTIVATION TO USE: All human beings strive toward health no matter how disturbing their behavior. AOD are attempts to preserve and protect a fragile and fragmented sense of self.

THE NEED DURING RECOVERY: A relationship with a person or persons that can build and replace deficient and missing selfobject capacities in the areas of tension regulation, self-soothing, and self-esteem regulation.
WILFRED BION: Dr. Wilfred Bion (1967), a British psychoanalyst who wrote in the 1950s, made a major contribution to our understanding of how we as a people learn how to think.

Bion considers tolerance of frustration an innate factor of our personality (1967, pp. 110–119). In other words, we can face frustration if our mother (caretaker) helps us. When she accepts, contains, and modifies these overwhelming and upsetting feelings, she turns them into what Bion calls our apparatus for thinking thoughts. She acts as a soothing container for difficult emotions. We learn, from her, how to face life’s upsets. We learn the pleasures of thinking, and thus, we don’t need the gratuitous satisfaction that comes from AOD (Fetting, 2009, p. 7).

DEFICIENCY IN THE ADDICT: The apparatus of thinking thoughts

CAUSES OF DEFICIENCY: Lack of reverie from his caretaker. Reverie is maternal containment of a child’s frustrations. It provides repeated experiences of transforming painful sensations into tolerable states of being, via the mother’s thinking and soothing functions.

MOTIVATION TO USE: To avoid dealing with frustration. Frustration is repeatedly felt as an overwhelming emotion that needs to be evacuated at all costs. This frustration and upset is discharged during repetitive addictive behaviors. It brings temporary satisfaction.

ADDICT’S NEED: A relationship with someone who has the capacity for reverie. The recovering addict can then internalize this person’s capacity to think through and soothe frustrations. He is then less likely to act them out in addictions.

CHRISTOPHER BOLLAS: Christopher Bollas (1989) is a British psychoanalyst and writer. He has written on many topics including free association and unconscious communication. He also has drawn on the classical notions of fate and destiny, as well as D. W. Winnicott’s ideas about the true self and the false self. Together, these notions are helpful in understanding some of the deeper self-medicaive purposes behind addiction (1989, p. 8).

ADDICT’S VULNERABILITY: The addict’s object world (parents, caretakers) did not provide the right conditions for the child to evolve and articulate his idiom. This person feels tragically fated and unable to experience life as conducive to the fulfillment of his destiny.

PURPOSE OF ADDICTION: To remove the suffering that comes from living the fated and reactive life of a false self. To self-medicate the suffering that comes from feeling unable to achieve one’s true destiny.

THE NEED DURING RECOVERY: A relationship with a person who hears the faint murmurs of a true self with its desire to express its idiom through its destiny.
IDIOM: The unique nucleus or defining essence of each individual

SENSE OF FATE: A person who feels fated has not experienced reality as conducive to the fulfillment of his inner idiom. Such a person is frustrated at the very core of his being. A false self becomes his guide through life.

SENSE OF DESTINY: Refers to the urge within each person to articulate and elaborate his idiom. A form of a life instinct in which the person seeks to come into his own true being through “an experiencing” that releases his potential.

LISA DIRECTOR: Lisa Director (2005) looks at omnipotence in the psychoanalysis of substance users. Living in a state of omnipotence suggests that one desires a sense of complete control or influence over the self, an object, or others in the outside world. Dr. Director describes elements of omnipotence that are present in drug use. These include a dominant wish, a focused drivenness with an insistence on pleasure (2005, pp. 567–587).

ADDICT’S VULNERABILITY: Addicts live with a pervasive and disturbing sense that one’s needs cannot be met by self or others. This sets into play an aggressive and destructive search to meet them through AOD.

INSTRUMENT OF OMNIPOTENCE: Drugs, alcohol, and the world of ritualized addiction provide the addict with a sense of omnipotent control. The use of drugs and alcohol promises that needs will always be met.

THE NEED DURING RECOVERY: A relationship with a person who has the capacity to hold and contain the addict’s defensive feelings of omnipotence. The function of this state of mind can then be more easily explored and discussed.
CHAPTER EIGHT

STEPHANIE BROWN

AND

AN INTEGRATIVE

TREATMENT MODEL
INTRODUCTION

Dr. Stephanie Brown is a major contributor to the field of addiction. She co-founded the Stanford Alcohol Clinic in 1977. She has published in the areas of addiction psychotherapy and the process of recovery, including individual and family treatment. Dr. Brown was intrigued by the question, “What happens to adults when they stop drinking?” This led to the creation of her developmental model of treatment that heralds the importance of the addict’s construction of a new identity, highlights the evolving needs and processes of each “timeless” stage of recovery, and identifies the deeper work required for the achievement and maintenance of a sober identity and the evolution of a healthy lifestyle. I have valued, studied, practiced, and taught this model for more than twenty years. Students, addicts, and their families seem to value it as well.

This chapter provides an overview of Dr. Brown’s stage-driven developmental model of alcoholism recovery. This overview is followed by four chapters that highlight some of the work of each of her stages of treatment, the tasks of therapist and addict, and proposes other avenues of growth and development for both members of the therapeutic dyad. This chapter is the meat of this book and workbook.

Dr. Brown’s substantial body of work is cogently and selectively presented. Her writings reflect her allegiance to the disease model of addiction. She has created an abstinence-based developmental model of recovery that is quite structured and also invitingly flexible. Over the years, I have discovered that her model welcomes and easily incorporates other treatment theories and strategies. As an assimilative thinker, I have included writers, psychoanalysts, social workers, psychologists, addiction specialists, and educators to support the work of each of her stages.
OVERVIEW OF BROWN’S DYNAMIC MODEL OF ALCOHOLISM RECOVERY WITH AN INTRODUCTION TO AN INTEGRATIVE TREATMENT MODEL

ASSUMPTION

Alcoholism recovery is a process of construction and reconstruction of a person’s fundamental identity and view of the world.

MODEL:

- Three major components of alcoholism operating in a passage of time.

<table>
<thead>
<tr>
<th>4 Stages</th>
<th>3 Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking/Using</td>
<td>Alcohol Axis—Represents individual’s focus on alcohol</td>
</tr>
<tr>
<td>Transition</td>
<td>Environmental Interactions—Interplay between individual and factors other than alcohol</td>
</tr>
<tr>
<td>Early Recovery</td>
<td>Interpretation of Self and Others—View of self and world</td>
</tr>
<tr>
<td>Ongoing Recovery</td>
<td></td>
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</tbody>
</table>

The relative importance and pattern of interaction of these components, coupled with stages of recovery, define the task of therapy.

Each component operates in each stage of alcoholism recovery, but operates differently (e.g., alcohol focus before abstinence is a dominant, negative focus narrowing cognition and emotions; after abstinence alcohol focus is dominant but positive in that it generates new development).

KEY FEATURES OF THE INTEGRATIVE TREATMENT MODEL:

Identity Reconstruction

Stephanie Brown’s model of treatment can be explained in one sentence: Recovery is about an identity reconstruction, nurtured over four stages of development. The emphasis on an identity reconstruction is absolutely essential for the achievement of abstinence but also applicable for any of the Profiles of Addiction discussed in Chapter 4.
A focus on an identity shift is imperative, and to grasp this profound task is to have reverence and respect for anyone who attempts recovery. Most simply, recovery involves what Michael White, the recently deceased Australian social worker, calls the migration of an identity—actively moving away from how one has known oneself and the world (the drinking or false self), with a desire to experience self and the world from a new and different place (the recovery or true self). This involves moving away from “I am not an addict, it’s not that bad, everyone is out to get me, and who cares anyway?” and moving toward “I see that my difficulties with living are related to using, people are caring and not controlling, and I care and want to do something about this” (White, 1995, p. 99).

**Nurturing Interest and the Prevention of Relapse**

The British psychoanalyst Adam Phillips (1998) suggests that passionate living is dependent upon an energized interest in one’s true self. Fundamentally, recovery is about engaging in a more authentic relationship with yourself and your world, and keeping this interest ever-present.

The proposed treatment model suggests that relapse occurs because people stop taking their new sense of self seriously. They grow weary and lose interest in staying connected to the reawakening of their true self, including their fragile recovering identity (Phillips, 1998, pp. 3–36). One patient announced, “I’m so tired because I’m recovering from my life, you know.”

Nurturing, sustaining, and maintaining the return of a child-like curiosity, with its unbridled interest in self, is the key to long-term recovery. Relapse will occur otherwise. And, relapse has made a mockery of a treatment industry that has not conveyed this message to the recovering consumers and their families, and the public in general.

**Four Stages of Development**

Brown’s developmental model of recovery includes four stages. The stages begin while one is actively drinking or using and move through transition, early recovery, and ongoing recovery.

Her model provides a progressive mix of ingredients, including characteristics and features of each the stages, identity tasks for the alcoholic or addict, as well as recovery responsibilities for the treatment provider. These together essentially define the work of recovery and treatment.

Return to the figure on page xxx. It diagrams the addict’s journey through the four developmental stages of recovery. Growth is not linear; thus, the arrows move back and
forth between stages. Some parts of the self move forward into a new stage while other parts remain in or return to a previous stage. Integration of these selves takes time. A conflicted or non-integrated identity sometimes invites relapse; “The addict forgot who he was.” Please keep this in your mind as you learn about the work of each stage.
CHAPTER NINE

INTEGRATIVE

TREATMENT MODEL

THE DRINKING

AND

USING STAGE
THE DRINKING AND USING STAGE

INTRODUCTION

The using (drinking, drugging) phase of treatment is about establishing a meaningful relationship with a person in trouble with drugs and alcohol, not conquering an addict or alcoholic. There is nothing more to do than create this relationship, and doing this is doing so much. The field, as well as its addictive families, too often becomes obsessed and preoccupied with a campaign or conquest, not with a connection. We are lost and misguided without the establishment of a relationship that is receptive to the alcoholic’s way of being and point of view. Many of our “difficulties” working with alcoholics and addicts are because of this relational confusion. We need a meaningful connection, not a victorious conquest.

Establishing a working relationship means making contact with the user’s identity, the ways in which the addict is thinking and feeling about his relationship with drugs and alcohol. During this stage, his thinking and feeling are both confused and intense. The clinician needs assessment and treatment skills in cognitive therapy, as well as capacities to work dynamically with many contradictory emotions.

USING’S PRIMARY TASKS ARE:

- **Establishing a relationship** with a using identity that feels persecuted and omnipotent, anxious and misunderstood, terrified and hopeful, desperate for help and fiercely protective of his relationship with drugs and alcohol.

- **Comprehending** the dual nature of addiction. It is a thinking or cognitive disorder as well as a doing or behavioral disorder.

- **Incorporating clinical concepts** such as identity reconstruction, discounting, blind eye, natural history, reverie, totalization of identity, de-totalization of identity, ambivalence, and registering impacts.

Identity Reconstruction

As stated in Chapter 8, recovery involves an identity migration over four stages of treatment. The using identity is composed of a mix of self-states. Two contradictory ones frequently appear: One is fiercely protective of its drinking/drugging and fiercely private about its worries. Another state is dreaming about a better solution to one’s life and can’t imagine this possibility.
Discounting

Addicts discount in four ways. They discount the very existence of their addictive behavior. Many actually live with little or no conscious connection to their AOD problem. Many also discount the significance of their problem. Addicts are often unable to make a causal connection between their pained life and their problematic using.

Alcoholics, equally, cannot bear to take responsibility for the impact their using has on the lives of their loved ones. This is either aggressively defended, excused away, or dismissively justified. Finally, most addicts live in the problem and only dream of a solution. This causes them to discount their capacity to repair anything at all about their using.

A Blind Eye

Persons in trouble with AOD often feel stymied and stuck between knowing that they have a problem and defending and protecting its continuation. This paradoxical bind of knowing and not knowing, sensing trouble but not wanting to address it, often called turning a blind eye, leads to immobilization (Steiner, 1993, p. 129). The person is unable to imagine a change that would make a dent of any kind.

Natural History

A cold has a natural history of five to seven days. You can make it better or worse, everyone has a choice.

George Vaillant (1983) is one of the most respected longitudinal researchers in the field of addiction. He looks at the natural history of alcoholism, that is, the path or course of one’s distinct relationship with AOD, as well as one’s path or course of recovery (pp. 107–180). Everyone’s natural history is unique and it’s imperative that each is understood. One of the first things I do in the using phase is get a sense of the patient’s “location” in his natural history. Where is he in accepting this dual identity of sickness and healing? It is important to both embrace and challenge their place. Addicts feel respected by this effort.

Identifying a patient’s natural history aligns a clinician with the rhythm of the addict’s current relationship with AOD. To understand this is to grasp his readiness to acknowledge some difficulties, or his preference to pretend them away. Does the addict recognize his “cold,” and know some adjustments in living will further natural healing? Does the person ignore all the telltale signs with a wish that by looking the other way, the cold will spontaneously disappear? Or, does someone attack the cold with an infusion of homegrown remedies, and stubbornly keep on going anyway?
Natural History One

There are two natural histories that appear during the using phase of addiction. The first involves people who are paying increasing amounts of attention to AOD. They are beginning to get into some troubles and tensions with self, work, family and friends, or health. Things haven’t spun out of control, and there is a hope and belief that they will not.

Natural History Two

People are paying much more attention to AOD in the second natural history of this stage. The using has dangerously escalated; chaos and unpredictability are the norm, families are terrorized by bad decisions, and physical and mental health are seriously deteriorating. Time is running out and life is threatened. This natural history can end with devastation or with opportunity. Interventions are more action-based, unlike the more cognitive and reflective interventions of Natural History One.

REVERIE

Wilfred Bion, the eminent psychoanalyst, describes this maternal state of caregiving with an infant. The caregiver takes in and on his child’s frustrations and fears, pondering what and how to respond to them. Reverie is a receptive, not prematurely active state, fueled by emotional availability and fierce maternal instincts. The mother functions as a thinking container for the infant’s desires and frustrations, and transforms hunger into satisfaction, pain into pleasure, and loneliness into company. Therapists are encouraged to inhabit this state as well. We take in and on what our patients present or “give” to us, and we “dream” a response. It is a difficult state of uncertainty, but staying with and in it usually brings good results (Bion in Grinberg et al., 1975, p. 39).

Totalization of Identity and De-Totalization of Identity

Michael White (1995) makes a valuable contribution here. He believes we are tragically obsessed with labels in America. White suggests this is a shaming cultural practice. We call people alcoholic and addict, bulimic and anorexic, or shopaholic. He continues that these labels totalize one’s sense of self or identity. The alcoholic often feels morally weak, behaviorally bad, or mysteriously flawed. Pathological feelings totally dominate the addict’s sense of self (1995, pp. 43–59).

White continues that this totalization of one’s identity is particularly harmful. This hyper-focus on a label dismisses so many parts of the self that are not at all “contaminated” by the symptom of drinking and drugging. Yes, an alcoholic under the influence can be self-destructive and frightening, defensive and hostile. And, yes, an alcoholic may also be
thoughtful, caring, gentle, hardworking, devoted, creative, and passionate when not in a state of excess.

It is imperative to be curious about, make contact with, and explore all facets of a user’s identity. This is most important work during the drinking stage. Addicts and alcoholics need to be de-totalized. They need to feel that people are interested in other parts of their being, and value all aspects of their personality. They need to know, like all of us, that we are more than our problems. This interest goes a long way in softening defensiveness about their addiction. The safety necessary for attachment is fostered and relationships between therapist, family members, and users are increasingly tolerated.

**AMBIVALENCE**

An aspect of Miller and Rollnick’s (2002) seminal work on motivational interviewing is helpful here. They remind us that an addict is not a liar, manipulative, resistant, or in denial. Rather, if you tickle or scratch an addict’s psyche, you will find it is filled with worry. Scratch or tickle another part, and you will find that it doesn’t want to stop. Addicts’ hearts and minds are filled with ambivalence (2002, pp. 13–19). They love and they hate their relationship with drugs and alcohol. It’s been a best friend and now it’s becoming an enemy; it’s been trustworthy and now it’s no longer reliable; it’s saved a person from utter despair and now it brings about disgrace, humiliation, guilt, worry, and tension; it’s prevented them from suicide and now it’s causing thoughts of suicide; it’s had some predictability and now it has almost none.

**Registering Impacts**

Michael Eigen (1998), the renowned psychoanalyst and writer, repeatedly encourages us to register the impacts of both our everyday relationships and ongoing life experiences (pp. 61–79). In intimate and therapeutic relationships, interactions feel energized and focused if we allow the impact of our beings to receptively wash over each other: “I take in what it feels like to be connected to you, and you take in what it feels like to be connected to me.” These impacts can feel good and invite self-expansion or feel bad and invite self-restriction. Eigen reminds us that we live with the “shock” of these relational and experiential impacts all day long, and it is important to take these into account. Registering them helps us understand what is going on inside of us, as well as what is going on between us. Eigen suggests, “One gets a little better at working over impacts and letting impacts work on one, so that one gets something more out of living” (2004, p. 142).

Being open to impacts is essential when working with someone in the desperate stage of using. An addict’s intense ambivalence is cloaked in many unattractive emotions. These
impacts often overwhelm, and the confusion is difficult to register. Clinicians shut down in defensive protection. Addicts bear the brunt of our inability. We tune them out, talk over them, and attempt to coerce them and tell them what to do. This is not an exchange that invites connection. Rather, it encourages resistance. They tune us out, withdraw, and become angry, and then we lose them. They often relapse as well.
CHAPTER TEN

INTEGRATIVE

TREATMENT MODEL

THE

TRANSITION

STAGE
INTRODUCTION

No addict wants to stop using. Acknowledging his behavioral folly and facing what is underneath seems utterly incomprehensible. There is no ability and no will. So many addicts and alcoholics use until they have damaged themselves and most good things in their lives. They use until they have run out of most forms of currency—spiritual and emotional, relational and financial, and physical and psychological. They use until their bankruptcy forecloses around them. Addicts then do the unfathomable—they stop, or they reconsider. They enter the transition stage of recovery.

Transition marks a change in the addict’s relationship with drugs and alcohol. It begins with an unconscious wish, followed by a conscious desire. Next are cognitive reconsiderations and changes in behavior. Much needs to take place.

The addict’s ambivalence, for the first time, tips toward not using. A crisis forces him to stop, or the threat of a crisis forces him to reconsider. This crisis has to be subjectively experienced by the addict. Nothing changes otherwise. There is a freedom for the using identity that surrenders. There is entrapment for the using identity that remains in conflict. Either way, things will never be the same again. This chapter is about the straight and crooked path of a developing transition identity.

TRANSITION’S PRIMARY TASKS ARE TWO-FOLD:

- **Fostering** a sober identity and **nurturing** interest in the interests of the true self
- **Incorporating clinical concepts** such as *transition’s identity reconstruction, transition’s time, the transition moment, transition moments revisited, interventions during transition, authoritative versus authoritarian hints, hovering and hinting rather than possessing and ordering, the interests of transition, and families in transition.*

OTHER TASKS INCLUDE:

- **Co-developing** the design of the addict’s recovery program
- **Supporting** the management of the messes of addiction—legal, relational, work, health, emotional, and financial
- **Attending** to relapse
- **Exploring** considerations of using again
- **Including** clinical concepts and treatment interventions from Chapter 9
Transition’s Identity Reconstruction

Transition for an addict is based on a deconstruction of an identity. This involves an unconscious and conscious wish to shed the using sense of self that was unwilling to know its own trouble and isolated in slow disintegration instead. It also involves shedding an identity that felt that using drugs and alcohol was the only and best answer to life.

Transition is also based on constructing a new identity—an identity that wants to be free from the intoxicating highs and quick fixes that made life seem easy. This new identity is forged from a desire to face things, no matter how painful.

Transition’s Time

Transition is a time of fits and starts, focus and exhaustion, distractions and detours, gains and reversals.

Time, for the addict, has been about using, recovering from using, or preparing to use again. This urgent “use” of time has not allowed for an openness to other experiences or opportunities with people, nor for thinking and reflecting. Wilfred Bion identifies an addict’s difficulty with time when he states that drugs and alcohol are substitutes employed by those who cannot wait for time’s unfolding (1992, p. 299). The question of what to do with time is a critical undertaking during this stage in recovery. Transition’s time is best reflected in a quote from Michael Eigen (1996, pp. 193–194):

“Time is God’s most precious gift;  
God’s most pervasive filter.  

To do away with time is to do away with life.  

The psyche needs time to work,  
the mind needs time to think,  
the soul needs time to feel,  
and life needs time to evolve.”

This time is now available to be discovered, to be used for experiencing, learning, problem-solving, and healing. Therapeutic holding is imperative during the addict’s struggle to make sense of its newfound dimensions.
The Transition Moment

Transition begins with a bang or a whimper. It is the most critical stage of treatment. It is also the most tender. The addict needs chutzpah for the critical and grace for the tender. Arriving at transition has been both treacherous and exhausting. Its first hours and days bring agitated relief and numbing terror. The addict momentarily possesses a startlingly clear sense that the drinking and drugging behaviors have to change. This revelation is often grasped from an emergency room gurney, a rehab bed, in a family intervention circle, or on a therapist’s couch.

This transition moment is terrifying. The addict meets this moment in those first hours and is challenged by its reappearance throughout this stage of recovery. The transition moment is a question for the addict: “Will my identity grow forward into my recovery, will I languish and lose some vigor along the way, or will I move backward into using?”

A deep and calming resignation that the fight is over and defeat is victory brings forward movement; a half-hearted acquiescence suggesting that the fight continues and defeat is only temporary begets hesitant movement; overwhelming emotions and feelings of extreme alienation from others often invite a return to destruction. The path of transition is often shaped during this period of early awakening. Does the addict embrace a transition identity based on a knowing that it’s time to let go? (Move forward.) Does he hold on to a using identity based on fantasizing that by cooperating now, he can quietly resume drinking or drugging later? (Hesitate.) Does he flatly refuse to enter transition’s gates? (Move backward.) These responses determine the direction and momentum of transition’s early development and movement.

TRANSITION’S MOMENTS REVISITED—IDENTITY FORWARD, RESTING, OR BACKWARD

Transition’s beginnings are unique to each individual. For some, the path feels a glorious propelling into the wondrous unknown. There is excitement, hope, and relief. This journey is open to possibilities. For others, the path is entangled by doubts and hesitancies, refusals and reversals. Conflicts ensnare possibilities. There is often begrudging or destructive movement. On any of these paths, the recovering addict will revisit transition moments again and again. These are critical forks met along the way. Every transition moment begs a challenge: Will the addict venture into recovery’s infinity? Will his growth plateau in uncertainty? Or, will he resubmit to addiction’s authority? These moments arise again and again during transition.

Sometimes, transition moments invite practical, everyday questions: Will I listen to myself? Will I take the time to hear my struggles? Can I handle what is next? How will this undertaking affect my recovery? Should I take it on? Or, does it feel too much? Am I
overwhelming myself? Do I need to reach out to others, to support systems? Does something feel right or wrong? Can I start to trust my gut?

**INTERVENTIONS DURING TRANSITION, AUTHORITATIVE VERSUS AUTHORITARIAN HINTS, HOVERING AND HINTING RATHER THAN POSSESSING AND ORDERING**

As has been suggested, a psychoanalytic attitude can enhance addiction treatment. It provides a way of listening and relating that is both unintrusive and empowering. It encourages a self-experience that values psychological reflection and thinking. It allows the addict to wait for time’s unfolding (Bion, 1992, p. 299). It adds merit to a field that tends to be over-controlling, possessive, too directive, and prematurely reassuring. It has its place in the four stages of recovery. Its use, however, requires judicious discernment. Sometimes, it operates in the forefront, and sometimes it needs to be waiting in the background.

Some tasks of transition require more active and direct interventions. These save a life, resolve a crisis, and redirect momentum. These are necessary interventions for persons overfamiliar with survival through the use of drugs and alcohol, and under-familiar with the use of clear thinking and healthy day-to-day coping strategies.

Adam Phillips’s work on hinting is extremely useful in both the development and delivery of transition interventions (1998, pp. 75–117). Psychoanalytic practitioners listen through attentive hovering. Hovering suggests one lingers or waits close by in an uncertain condition, or stays suspended or fluttering in the air near one place (Guralnik & Friend, 1968, p. 705). Hinting after hovering provides the transition addict with some helpful guidance as he learns to make decisions based on his own truth.

Phillips differentiates between authoritative and authoritarian interpretations or hints. An authoritative hint delivered after hovering allows for two possibilities: it gives the addict room to make something of his own of it, and it also gives him space to dream something up from it (Molino, 1997, p. 128). The clinician who uses her authority with an authoritative hint honors the addict’s authority as well.

An order is the opposite of a hint. An order is authoritarian. Its message is confining; there is no room for dreaming. The addiction field is dominated by orders. These invite retaliation or compliance. Neither reaction is useful for the urgencies of this stage, nor for the evolution of the real self.

**The Interests of Transition**

Adam Phillips (1998) isn’t a specialist in the field of addiction. His profound writings on childhood interest and curiosity, however, endow us with a deep understanding of addiction’s etiologies, as well as powerful propositions about what is necessary for addiction’s recoveries. He sheds light on the dual concerns of the transition stage of recovery—the
securing of a sobering identity that eventually invites the return of the addict’s interests in his real self. Listening for an addict’s interests and encouraging their further exploration is a key task of transition. It also secures long-term recovery.

The transition addict is very interested in his experience of life without AOD. At first, he may sense how frightened and scared he is, later notice how little and small he feels, as well as how big and overwhelming the world seems. Watching what others are doing and saying, connecting with others in recovery, and discovering his own feelings and preferences are filled with childlike wonder. These early interests and curiosities are overwhelmingly frightening and threatening. They haven’t been listened to for years; they feel foreign and odd. There is a chilling fear that they are unimportant and irrelevant, and certainly not critical to the tasks of transition. It takes time to realize that interest in one’s true self needs to become a lifelong interest.

Transition addicts need someone behind them. They need to be in a relationship with someone who listens for and helps keep alive their discovery of their real interests. This may be a sponsor, a therapist, a psychoanalyst, or a member of AA or another support group. Without this champion, disinterest reappears, and relapse will surely follow. Relapse occurs when one ignores the nuances of need in those early, bewildering days of transition.

**FAMILIES IN TRANSITION**

Family members often feel left out and confused, ignored and silenced during transition’s early days. They are often baffled by the addict’s recovery. They are bewildered by his transition path. They do not comprehend the limitations of a person who just months ago managed events and activities without a glitch. They forget that drugs and alcohol fueled his smooth sailing. Nor do they understand the necessity for temporary withdrawal periods that foster identity restoration. These feel eerily reminiscent of drug using isolation; it takes time to trust that these retreats are healthy. Families feel held hostage by the addict, even in recovery.

Transition’s immediate goal is to prevent the addict’s relapse, as well as soothe overwhelming family confusion. The long-term goal is the sustaining of recovery for each family member.

Transition is not the time for normalcy. Rather, it is a focused and persistent time of rebuilding. This often brings a deep disappointment and resentment for family members who have endured so much and just want to move on. Moving on is a recipe for disaster.
CHAPTER ELEVEN

INTEGRATIVE

TREATMENT MODEL

THE

EARLY RECOVERY STAGE
INTRODUCTION

The entrance into this stage is subtle. Early recovery moments often slip past conscious awareness for both patient and clinician.

The fit of the environment is examined, and the state of the addict’s mind is explored during early recovery. The addict struggles through the reorganization of his internal world and the reconstruction of his external life. This is the treatment work of early recovery.

Landscape of the Environment

The lives of recovering addicts are no longer organized around not using. Life is more than sobriety. Gone is the chaos of the using stage, the turbulence of transition. Gone are constant cravings and pervasive temptations. The addict’s rituals of sobriety and moderation are supported by a new lifestyle. His identity feels solid and confidence in his recovering style has developed. There is either an increase or decrease in attendance at AA meetings, an increase or decrease in therapy, and an increase or decrease in medications. The addict relies on his styles and choices and these are now increasingly trusted by his family, friends, and coworkers.

There are many satisfying developments. There is life without daily drinking episodes, dinners and weekends, parties and holidays without drunken destruction, increasing household stability, more consistency in work performance, and the development of new intimacies in relationships.

These satisfying developments also bring challenges. A welcoming of a new life includes a departure from the old. The recovering addict puts his world under scrutiny—how he parented, what he does, how he enjoys, and who he spends time with are all up for grabs. There is a reorganization of so many aspects of his life. His relationships with his partner, family, friends, and work are examined. Some existing bonds are intensified and deepened; others are weakened and disrupted. There is so much going on within and between everyone in the addict’s world. It is important to make room for feeling and thinking through these impact changes. The addict struggles to make sense of his longing for the familiar, excitement for new possibilities, and apprehension about the future.

LANDSCAPE OF THE MIND OF THE ADDICT

The mind of the addict is saturated with AOD during using. It is preoccupied with its perpetuation. The mind of the addict is busy crafting constant adjustments during transition. It is occupied with staying afloat. The mind of the addict in early recovery is neither preoccupied nor occupied. It is free to feel and then learn to think. The primary therapeutic task of the early recovery period is to listen for this mind and, on hearing it, begin to explore and investigate its operations. What does this mind do with itself without AOD? How does this mind process everyday thoughts and feelings? More specifically, how does the newly “natural” mind experience and work with pain? It is a mind over-primed to escape suffering; it is a mind under-primed to live with discomfort and uncertainty. The ways it has responded
to pain are visible for the first time in years. Attention to this activity is a primary early recovery task. This chapter proposes a lens for viewing this critical function.

**EARLY RECOVERY’S PRIMARY TASKS ARE TWO-FOLD:**

- **Exploring** the fit between a sober identity and a sober world, and **determining** if a psychic retreat is the dominant response to pain
- **Incorporating clinical concepts** such as *an overview of psychic retreats, structure, and treatment*

**OTHER IMPORTANT TASKS INCLUDE:**

- **Reinforcing** methods for achieving sobriety or maintaining moderation agreements
- **Assessing** dual diagnoses, as well as establishing and adjusting psychopharmacological supports
- **Conducting** family work as needed
- **Including** the cohort of clinical concepts and treatment interventions from Chapters 9 and 10

**An Overview of Psychic Retreats**

Addicts in early recovery go through periods of evading real connection. Protection is more important than contact. Changes feel overwhelming, growth pain feels unbearable, and moving through it all seems impossible. The work of recovery can start to feel stale. Many addicts in treatment decide to stop the work. The therapeutic dyad starts to feel stuck. Steiner’s work on psychic retreats is useful here.

Psychic retreats beckon as a protective response. These are well-worn internal structures of the mind that were organized and deployed during an addict’s infancy and childhood (Steiner, 1993, p. 105). These were the mind’s way of offering shelter during early overwhelming trauma and neglect (1993, p. 8). Retreats both camouflaged suffering and caused suffering during adolescence and early adulthood. AOD provided ongoing relief. Many retreat-prone individuals develop addiction problems.

The addict, in the early recovery stage, often starts to rely again on this sober psychic haven after transition’s busy days of early abstinence.

**Structure**

All people psychically retreat at times. Not everyone repeatedly relies on a psychic retreat as a pathological form of survival. Psychic retreats, as states of mind, are highly structured systems of primitive defenses, including projective identification and splitting (Steiner, 1993, p. 2). The former gets rid of unwanted emotions; the latter keeps difficult ones apart. In either case, emotions remain inaccessible. Retreats are also tightly organized networks of object relations that seduce parts of the personality (1993, p. 13).
Dependent and destructive parts of the self are projected onto a group of internal objects (Steiner, 1993, pp. 4, 54). This “organization” of internal objects has a character or “feel” (1993, pp. 47, 53). Retreaters describe it as a mafia gang, a choir of young boys, a table of statisticians, a group of leprechauns, military commanders, an island, a glass room, a force that powers through, a light bulb, Charlie and the Chocolate Factory’s great glass elevator, a cave, a warm humming sound, or a fortress. The individual mind determines if these objects protect with vengeance or shelter with warmth (1993, p. 8).

A Faustian deal is entertained. This organization of the mind hates human weakness and vulnerability, truth and growth. The individual or recovering addict is afraid of these. The organization offers a promise, “We will take away your fears, if you honor our hatred of truth and don’t listen to yours.” The individual signs on, “I will give you omnipotent power over me, if you protect me from my fear of vulnerability and provide a shelter that prevents exposure of this.” A family business is born.

Retreats provide an area of the mind where reality does not have to be faced, where fantasy and omnipotence can exist unchecked, and where growth and development is sacrificed (1993, p. 5). They are alternately felt as a refuge of relief and resignation, or a site of defiance and triumph (1993, p. 2). They are unconsciously recalled during overwhelmingly painful moments.

**Treatment**

Clinicians are at a real loss without the watchful sense that retreats may become the pathological organization of choice during early recovery. They are stymied without understanding the omnipotence and perversion these seductive structures provide retreat-prone addicts. The immediate safety and security they furnish obstruct contact with reality, connection with others, and ongoingness in the therapeutic dyad (1993, p. 5). Patients visit and depart these “sites” or dwell and become entrapped by them.

During this stage, the dependent part of the addict is no longer saturated with AOD’s protection. Reality, avoided for years and sometimes decades, presents unbearable challenges to the addict’s newly sober psyche. Early recovery addicts lack experience with conflict and its resolution with the help of people. Reliance on others feels wordlessly untenable.
CHAPTER TWELVE

INTEGRATIVE

TREATMENT MODEL

THE ONGOING

RECOVERY STAGE
INTRODUCTION

Ongoing recovery is the last formal stage in addiction treatment. The migration of an identity is nearly complete. Sobriety or moderation seem secure on a conscious and unconscious level, wobbly legs are now sturdy, and a thinking mind feels better than a retreating mind. Adjustments and alterations in the environment feel familiar.

A solidsly sober identity is able to work through historical traumas that were held in abeyance during earlier stages of recovery. The working through of these conflicts brings emotional relief. What was repressed is released; some energy is now available. New ways of experiencing one’s self encourage more risk-taking; tolerance of more intense feeling states promote relational changes; and new psychological capacities permit reflecting on “unthought known,” or the dispositional knowledge of the true self that has yet been thought (Bollas, 1989, p. 10).

Many in this stage of treatment begin to question what they thought they would never question and consider doing things that they thought they would never consider.

**Ongoing recovery’s primary tasks are two-fold:**

- **Listening** for the addict’s idiomatic or unique expressions and **fostering** the development of his destiny or future

- **Incorporating clinical concepts** such as the context of destiny, true self, destiny, idiom, village of living objects, ruthless usage, the context of fate and the false self

**Other important tasks include:**

- **Deepening** of psychodynamic or psychoanalytic therapy

- **Exploring** choices and meanings of intimacy, sexuality, and gender identity

- **Including** clinical concepts and treatment interventions from Chapter 9, Chapter 10, and Chapter 11

**The Context of Destiny, True Self, Destiny, Idiom, Village of Living Objects, and Ruthless Usage**

An infant marches forward into his destiny if he believes his true self or inner essence is seen and nourished by important people in his world. Bollas, citing D. W. Winnicott, defines the infant’s true self as his inherited potential that exists only in experiencing (Bollas, 1989, pp. 8, 213).
Ongoing contact with an attentive and intuitive mother enables him to have ongoing contact with his real essence. If all goes well, the child, and later adolescent, continues to experience his caretakers as regularly responsive to his true personality and its potential. This back and forth feels validating and brings forth more spontaneity. He feels he is steering his own life. A destiny drive is born. Bollas refers to this as the urge within each person to articulate and elaborate his idiom through the selection and use of caretakers (objects) in his environment (1989, pp. 8, 41, 211).

The idiom of a person refers to the unique nucleus of each individual (Bollas, 1989, p. 24). This brand of uniqueness needs favorable environmental conditions to evolve and thrive. The child of his destiny innocently, unknowingly believes the world is there to support his defining essence.

The young idiomic resides within a village of living objects that have the potential to further his future (Bollas, 1989, p. 9). These may include coaches and teachers, preachers or therapists, mentors or advisors, as well as books, music, films, Internet, sport, religion, and the like (p. 18). All of these help to establish a young personality that feels real and alive (p. 34).

Bollas identifies the essential ruthlessness of a child of his destiny (1989, p. 42). The child feels free to assert his needs and aggressively express his wishes. He uses members of his living village for satisfaction and fulfillment of these.

People of destiny are people we all know who are passionate about what they are doing in life, and how they relate to others.

**The Context of Fate and False Self**

If all does not go so well, an infant, child, and later adolescent lives in a different kind of caretaking world. Spontaneous expressions of his true self are rejected or ignored. He does not feel safe to be, or safe to explore his essence and his world. Family moods and practices dictate an acceptable way of being instead (Bollas, 1989, p. 214).

The child, then adolescent, raised in this environment lives in a world of commandments. These are experienced as drastic demands dictated by his caretaker. These commands most often have nothing to do with his true self or inner essence. These declarations feel topsy-turvy to his sense of self, but he feels fated to follow them anyway (Bollas, 1989, p. 45). A person who feels fated does not experience reality as conducive to the fulfillment of his idiom (p. 33).
A false sense of self develops, organized around the wishes, defenses, and dictates of others. The fated false self lives with a tension that feels excruciating and unreachable. The child doesn’t know how to talk about his distress.

Drugs and alcohol provide much comfort for the fated individual. He “ruthlessly” and repeatedly selects these as a reliable source of soothing and reprieve for his nameless dread (Bion, 1967, p. 116). The alcohol or drugs persuasively quiet his longing for true self-expressions in his real life.

**Implications for Treatment**

Clinicians and the recovery treatment world are at a loss without a sense of Bollas’s work, particularly in ongoing recovery. He provides a framework of infant and childhood development that is aligned with the development of an ongoing recovering identity. Eigen’s elaborations on the true self and false self are both simpatico and complementary to Bollas’s work.

The therapist gently hovers around an individual who barely believes he has a life beyond his fated sense of duty, endurance, and survival. The ongoing recovery addict needs to believe that his wishes are worth expressing. Therapeutic hovering encourages their articulation.

The pace and rhythm of ongoing recovery treatment develops some buoyancy. A sober confidence yearns for fanciful exploration of dreams and fantasies. If listening occurs, the formerly fated child, later masquerading as an adult with the elixir’s false protections, soon begins to explore an unimaginable life of his wishes. It requires the fortune of staying drug-free, as well as focused determination, and a long, steady road of very difficult and confusing recovery work. It also requires some healthy assertion and aggression to get what you need, and certainly attempt to take what you want (Bollas, 1989, p. 31).