An Addictions Model Overview
with Implications for Dual-Diagnosis Clients

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This article is adapted and revised from a discussion paper which served to focus a dialogue on clinical services for dual-diagnosis clients in Western Massachusetts. The discussion was among members of a Steering Committee with representatives from an array of service provider organizations who have been collaborating on this effort since 1989, so the paper has a conversational tone which is preserved in this adaptation. The author has provided clinical consultation, training and supervision throughout the history of this collaboration, which has offered weekly LADA groups (Learning About Drugs and Addiction) for dual-diagnosis clients, sponsored by the various programs and agencies participating in the consortium.

Over time the appendices have grown – in particular appendix 2 – such that there are now more pages given over to appendices than to the original discussion paper itself.

Discussions of the subject of dual-diagnosis are hampered by a fuzziness regarding what, exactly, is referenced by the term "dual-diagnosis." Utilization of alternative terms, such as "co-morbidity," do not seem to appreciably resolve the fuzziness. The safe bet is that, where the term "dual-diagnosis" is used, there is a client with a mental health diagnosis, usually chronic, and also issues of alcohol and/or other drug involvement in their lives. If we assume that the mental health component of the dual-diagnosis is sound and unambiguous, we are left, then, with the question, "What is the other diagnostic component?" Sometimes this will be - or seem to be - fairly straightforward; an individual who is, by their own self-description, and in conformity with conventional diagnostic criteria, addicted to alcohol and/or other drugs. On many other occasions, though, there will be a pattern of substance involvement which is problematic - at least in the eyes of the service providers - but which may be more aptly named substance abuse, or problem use, rather than addiction. However, such distinctions are not systematically or coherently made.

Further, it is by now widely recognized that there are many addictions which do not involve substances. These can be every bit as crippling and life-compromising as the chemical addictions, but it is highly unlikely that a mental health client with an addiction to, say, scratch tickets, or television, or pornography, will be given the dual-diagnosis label, and offered services according to that diagnostic frame. It is my impression that most of this confusion and ambiguity emerges out of confusion regarding addiction itself. We have lengthy conversations wherein we talk about addiction, not acknowledging, or even recognizing, that there is not clarity or consensus around the most elemental questions regarding addicts; e.g, *Who are they? Why do they do it* (persist in the problematic behaviors)? and, *How can they be helped?* This article will delineate a perspective regarding addiction which will bear on these questions for addicts in general, and dual-diagnosis clients in particular.

To synopsize the ground of the confusion, we could say that, on the one hand, *there are numerous instances of substance abuse which are not a function of addiction.* And, on the other hand, *there are numerous instances of addiction which do not involve substance abuse.*[1] (This latter, by the way, can actually be good news, with respect to the therapeutic prospects for dual-diagnosed clients -- but we'll get to that idea further along.) Meanwhile -- why is it so important to stress that many instances of abuse do not involve addiction? Because the underlying predicaments associated with simple problem use[2] - and the appropriate remedies - are markedly distinct from those involved in cases of addiction. Thus, if you have an approach that is fitting for addiction, you will find yourself highly frustrated if you are trying to employ it with a non-addicted abuser -- and vice-versa.

The differences between these two situations can be characterized as follows, using drug involvement as the focus of this example: for the addict, the use of the drugs has provided them with a conspicuously successful existential solution - it helps them access a dramatically enhanced experience of self - at least in the beginning of their involvement with the drugs. For the problem user, while the use of the drugs provides them with more satisfactory affective states - it helps them access the kinds of feelings they prefer - the experience of an adequate and viable self is not hostage to the drugs. Thus, while the non-addicted abuser may become quite disappointed, agitated, etc. if they are frustrated in their attempts to use drugs, they do not experience the existential crisis which is the subjective signature of withdrawal in addiction[3] (See Appendix 1). This distinction is at the heart of the issue of powerlessness which is central to the twelve-step perspective on recovery from addiction. And this issue of powerlessness is at the heart of the question *Why do they do it?* -- so it's a good place to begin, because how we answer that question will substantially qualify how we think about who the addicts are, and how they can be helped.

Powerlessness

Let's start the discussion of powerlessness with an enquiry into the existential crisis mentioned in the last paragraph. In its most extreme manifestation the experience of this crisis can be compared to the following: imagine that someone has held your head under water for the last ninety seconds or so; what are you prepared to do now on behalf of being able to breathe? Well, of course -- almost *anything*! Because you are feeling that your survival - the continued viability of your elemental *self* - is at stake. This is the experience of the addict in advanced progression when confronted with the prospect of relinquishing their drugs -- or whatever instrument or technique their addiction has coalesced around: the experience of an adequate and viable self has become so completely hostage to the addictive technology that a false and compelling "center" usurps the exercise of will, sacrificing every other interest to maintaining the addiction. Of course,

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[1] Indeed, it was this recognition which prompted us to change the words associated with the acronym "LADA" from "Learning About Drugs and Alcohol" to "Learning About Drugs and Addiction" -- which not only broadened the scope to include the whole range of addictive plights, but also avoided colluding with the unfortunate and widespread misperception that alcohol is not a drug.

[2] The use of the word "simple" here refers to the underlying dynamic; not to the complexity or severity of the consequences of the abuse - which may be very great indeed.

[3] Note: in this discussion I am referring not to the narrow and straightforward event of physiological addiction, but rather that version of addiction which plagues and compels the addict long after any physical withdrawal has been accomplished.

progression evolves over time, and at earlier stages of progression the desperation provoked by the absence of the addictive “fix” will not be that absolute and acute, but will instead manifest as a state of pernicious discontent, resulting from a pervasive sense of what might be called “existential deprivation.” This state is at the heart of the plight known, in the world of alcoholism, as “dry drunk” -- the alcoholic is not drinking, but neither have they successfully invested in alternative routes to achieve existential adequacy (more on this later).

These two experiences then - the “dry drunk” syndrome, and the “drowning person” syndrome - bear on the first two of three aspects of the question of powerlessness. The first aspect of powerlessness in addiction, and the one most frequently envisaged when “powerlessness” is referred to, is the experience of watching behavior contradict intent. That is, the addict, in all earnestness, and with all the strength of purpose they can summon, determines that they will not go to the bar, for example; that they will, in fact, even go out of their way to avoid the bar, and plan to go somewhere else entirely. Then, two hours later, they find themselves, with their head in their hands and wet change piled in front of them, drunk on a stool at the bar -- *absolutely perplexed as to how this has happened.* This kind of situation, where the addict finds themselves unable to follow through on resolve, not because they have reconsidered and formed a new intent, but rather because some imperious command center seemingly *independent of their will* intervened to compel a behavior which they had consciously rejected, is the conventional image evoked by the term “powerless.” It conforms quite literally to the language of AA’s Step One, which declares, *“We admitted we were powerless over alcohol . . .”* And, when addiction has progressed to this point, it is the version of powerlessness which most immediately requires attention and redress. It is, however, neither the only, nor the most important, aspect of powerlessness.

The second aspect of powerlessness, referenced above with respect to the “dry drunk” syndrome, can be phrased as follows: “I am powerless to successfully solve the problem of alcohol in my life through control.” That is, although I may be able to decide whether or not to drink, at least some of the time, nonetheless I can’t managerially establish a relationship with alcohol - including non-use - which does not entail grievous disadvantages.[4]

There are many versions of this “dry-drunk” mode, but a very commonplace one is organized around some version of *compliance*. Clients can easily acquire the impression that the issue of use or non-use is primarily a function of their relationship with program personnel, or with “the system,” rather than their relationship with themselves; abstinence is about being “good” or “bad,” and recovery gets lost in the shuffle. There are other versions of the dry-drunk syndrome which are motivated not so much by compliance, as by, for example, the desire for *self-mastery* -- the “John Wayne” mode. And yet another mode is a function of striving for *reasonableness*. Any of these can be successful, so long as success is determined solely with respect to the fact and persistence of abstinence, without regard for the emotional, psychological, interpersonal and spiritual well-being of the party in question.

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[4] I am reminded of the W.C. Fields quote to the effect that “I understand that the effects of whiskey are many and varied; I have found, however that it is the effects of the *absence* of whiskey which are most unfortunate.”

But there is a third version of powerlessness, which is the most fundamental, and at the same time the most elusive, in large part because of a bedrock misunderstanding which inheres throughout the very fabric of our cultural and social mores and institutions -- including the mental health treatment system. In the trainings I do I often assert that addiction teaches us two lies. The first of these is the idea that "'X' technology will allow us to manage our feelings and our identity states most successfully." This proposition, of course, while compellingly credible during the onset of addiction, ultimately reveals itself to be utterly, and catastrophically, false. But the second lie is much more insidious, and resistant to revelation, precisely because it is so ingrained in our cultural mind-set, and that is *the very notion that feelings and identity states ought to be managed.* In fact, feelings and identity states are to be *lived*, consciously and responsibly; not managed. It is my observation that this mistaken orientation is at the heart of much that we find problematic in the world today.[5]

The most adequate and generic representation of step one, then, could read, *"I am powerless to achieve fulfillment through control."* In this rendering I am assuming, as suggested in Appendix 1, that it is through striving for the fulfillment of longings that we consolidate identity and establish meaning within our lives and our communities. Thus, if our efforts on behalf of these fulfillments are fundamentally misguided, our personal and cultural experiences of identity, meaning and community will suffer gravely.

So what has all this to do with the problems of our dual-diagnosed clients? Well, a great deal. For one thing, they, like we, are embedded in this culture which urges a control-based perspective on them -- and many of these clients are particularly susceptible to these enticements, and, indeed, incorporate features of these cultural aberrations into the fabric of their delusional and dysfunctional personal mythologies and epistemologies.

But - and here we come to one of the centermost treasures in the whole dual-diagnosis field, in my opinion - *for mental health clients to encounter and appropriately engage with the addictive issues and dilemmas in their lives reconnects them with their essential humanity, and therefore with the larger human community.* One of my favorite quotes goes like this: Addiction is *acute and chronic human nature.*[6] Similarly, I found myself saying, in the promotional flyer for a workshop I gave a few years ago, that *"Addiction is a likely outcome of the intersection of human nature and technology."*[7] This notion is premised on the realization that the heart of addiction is a misapprehension of the merits and proper role of control in our lives. Since exponentially burgeoning technological capabilities offer us possibilities for control to a degree, and in ways, unprecedented in human history, it is no surprise that addiction, in a multitude of forms, is a pandemic, almost species-wide phenomena today. While this is an ominous plight that both includes and threatens us all, it also invites - indeed, urges - all of us to come to terms with the limitations of control; in brief it invites and urges us to reconcile ourselves with our essential mortality, individually and within our widening circles of family and community. And no conscious and responsive person - including those with mental health diagnoses - is excluded from

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[5] Several years ago I wrote a paper entitled "Self-Will Run Riot: The Earth as an Alcoholic." This paper details some of my concerns regarding the addictive consciousness in our society, culture and politics.

[6] The more playful rendering of this idea goes, "Addicts are just like everybody else -- only more so."

[7] The word "technology" in this usage refers to any systematic method of manipulation -- not just hardware. Thus, there are, for example, technologies of the mind, technologies of relationship, etc.

the challenges of these dilemmas -- or the profound life-enhancements to be derived through seeking their resolution.

This, then, is the point I alluded to earlier, when I said that

> "there are numerous instances of addiction which do not involve substance abuse. *This . . . can actually be good news, with respect to the therapeutic prospects for dual-diagnosed clients.*" (Italics reversed)

On numerous occasions during LADA supervision we have concluded, with respect to a particular client, that their relationship with substance use, while problematic, is probably not addictive, based on the criteria discussed above. However, we will often - even usually - find that there is an area of their life where some other version of addiction is, you might say, "alive and unwell." How does this constitute the possibility of therapeutic advantage? Because, for the substance abuser who is not an addict, the client's equation governing use of or abstinence from drugs is very straightforward: "Do the payoffs I experience in using these drugs exceed the costs?" So long as their subjective experience sums up to a "yes" answer, our only prospects for modifying the behaviour are: 1) reason with them to try to persuade them to reconsider and re-calculate to arrive at the opposite conclusion (unlikely); 2) entice them with the prospect of rewards, which sometimes muchly resemble bribes -- (bigger carrots); or, 3) goad them through interventions that restrict their options, which often resemble punishments -- (bigger sticks). With any of these approaches - or with none, whereby we stand by and watch the situation persist or even worsen in frustrated helplessness - the entire enterprise is essentially strategic and custodial. These situations are often unavoidable, due to the formal mandates of our programs, and/or the simple mandates of compassion. They are, however, not the sort of involvements with clients which facilitate transformative healing; at best, they prevent further deterioration. So we must look elsewhere if we wish to facilitate transformative healing. And the best prospect is frequently an area wherein they *do* experience an addictive dilemma.

Because this section is addressing the core issue of powerlessness, it would exceed that agenda to try to describe in detail the various manifestations of addiction our clients encounter. Some of them are, of course, commonly observed and recognized: addictions to food, to gambling, to television, to sexual behaviours and distractions -- etc. There is an overview wherein these multitudes of particular addictive patterns are summed up and made coherent which has informed our discussions in the LADA clinical supervision over the last ten years; those interested in exploring these ideas to some extent are referred to Appendix 2. Meanwhile, I hope I have sufficiently set the stage to distinguish between the version of powerlessness that is central to the plight of, and recovery from, addiction, and the more conventional definition of powerlessness, which refers to the helplessness of the addict while still in the grip of their addiction -- and as well the helplessness which is often such an intimate and dreadful aspect of the lives of our clients. These two paradoxical aspects of powerlessness - the inability to be effective on one hand, and the seed-crystal for transformation on the other - converge in the moment that we call "hitting bottom," which deserves our attention next.

Hitting Bottom

Firstly, what hitting bottom is *not*: it is not a state of dire circumstantial misfortune, nor a state of sufficiently acute personal anguish or dismay -- although any or all of these can contribute to or accompany the hitting bottom event. For a summation of what hitting bottom *is*, I'll excerpt from the "Self-Will Run Riot" paper I mentioned in footnote [5]:

> The following formulations describe the experiential perspective of an individual addict. As you read, bear in mind that the hitting bottom event is not a function of objective circumstances, but of consciousness; of the subjective *interpretation and experience* of circumstances and events. These characterizations are complementary; they are different angles on the hologram.
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> Hitting bottom is:
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>][An occasion where *pain* intersects with *understanding.*
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> It is important to recognize that the understanding may be incorrect. People often hit bottom resoundingly, and take action informed by understandings which are plausible and persuasive -- but quite mistaken. If the understanding is *fundamentally* incorrect (e.g., flawed *vis-a-vis* the control issue), recovery cannot follow from this particular hitting bottom event.
>
>][The *ownership of powerlessness.*
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> Powerlessness manifests in different ways at different stages of recovery. Allowing for this, and appreciating the vast array of technologies which are potential seed-crystals for addiction, perhaps the most adequate generic definition of powerlessness in this context might read: *"I am powerless to achieve fulfillment through the exercise of control"* (as discussed earlier).
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>][An occasion where one is *no longer willing to live with the person they have become.*
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> This is, for me, the most viscerally satisfactory characterization of hitting bottom, because it alludes to the existential emergency at the heart of the event, and thus indicates the arena wherein healing must take place, if the problem is to be, not merely managed, but *resolved.*

I find that all three of these characterizations shed light on the hitting bottom event from different angles, and thus illuminate the event more adequately together than any of them can alone. Nonetheless, I most frequently refer to the last, for the reasons noted in the paragraph above. It suggested itself to me during the seven years that I worked in Detox centers, and tried to reconcile the seeming illogic of who hit bottom, and who didn't. There were, on a weekly basis, dozens of alcoholics in the most dire circumstances along any axis you would care to name, objective and/or subjective, who seized the earliest opportunity (sometimes simply the return of

consciousness) to sign out against medical advice in order to resume their catastrophic drinking -- occasionally with fatal results. Then there would be the individuals who would enter the detox, and whose lives seemed more intact than mine, in some cases - health essentially sound; marriages intact; job secure and productive; no legal difficulties; finances uncompromised - and they were unmistakably hitting bottom! In reflecting on their essential *state of being* I identified that key quality: the internal experience of no longer being willing to live with the person they had become.

There is great promise, and great danger, in this state of being. It can, and does, catalyze suicide. And it can provoke psychotic breaks, for those so predisposed. It is perilous, wrenching, deeply disruptive, life threatening -- and, profound. Indeed, it is precisely because this state of being is so unsparing - it leaves no wriggle room - that it also offers access to transformations which are otherwise inaccessible. When one encounters the hitting bottom experience, one is fully, completely immersed in an essential truth regarding their life; a culmination of a mode of being which has bankrupted. As therapeutic allies, it is vital for us to appreciate these aspects of hitting bottom -- and to position and conduct ourselves with respect to these powerful events to the best possible advantage of the client.

Enabling

Ah, yes. It is an eminently logical segue that takes us from the subject of hitting bottom to the issue of enabling. Frequently, in agency and institutional settings, we are mandated to insure that people in our programs have their basic physical needs met, and we may fear that we are therefore enabling people to maintain drug and alcohol addictions. Count on it. One program administrator remarked that "We must not allow the concept of enabling to become a rationale for withholding contact, food, shelter, or emotional support since this simply reinforces clients' sense of worthlessness that has been associated with their having a mental illness." This is a tricky proposition, with many nuances and complexities, so perhaps my major complaint about that sentence is the inclusion of the word "simply" (". . . since this *simply* reinforces clients' sense of worthlessness . . ."). A great deal is potentially happening when a person collides with the consequences of their addictive choices; the presence of diminished self-respect may well be part of the personal ecology in that moment -- and quite possibly in an essential way, as we've been discussing in the section just above. So let's try to tease out some of the various issues, postulates, and concerns that converge here.

First of all, there is, I would like to imagine, some interpretive latitude around the question of "withholding contact, food, shelter, or emotional support." Indeed, when we establish Rep Payees we are engaging in an act of withholding -- as innumerable clients will indignantly remind us (although this is not food, shelter, or, necessarily, emotional support). And a situation presents itself routinely, which is resolved variously: "What to do when the client repeatedly hocks the furniture, spends the food money on drugs or other addictive wherewithal, trashes their apartment in a drug-induced rampage, etc.?" What are the perimeters and parameters of the formal mandates which constrain us from allowing the clients to encounter the logical real-world consequences of their addictive behaviours? Which constraints would remain as a function of discerning compassion, even absent the formal mandates? And, to flesh out the list and foreshadow the next section; which constraints flow out of codependent perspectives and impulses on the part of program leadership and staff -- at all levels of the human services system?

The answers to these questions are often not simple. However, I believe that the process of searching for these answers would be usefully informed by the perspective on hitting bottom described in the last section. Here is a deliberately provocative framework for the discussion: *there are worse fates than death; one of these may be, to live life bereft of meaning or dignity.* I submit that, in our dedication to custodial supervision of our clients, we often contribute to the latter outcome. Certainly this is not through lack of caring or compassion; usually it is quite the opposite. And it may indeed turn out that, to a large extent, we are required by our institutional mandates to stave off hitting bottom experiences for our clients. I know that was true in the detox centers where I worked -- we were providing a medical service in a custodial setting which, unmistakably, enabled many careers of alcoholism to be prolonged, often for years on end.

What is to be done, then? The guiding principle is summed up in one word: *honesty*. Firstly, honesty with ourselves. It is my personal conviction that much that we are required to do ostensibly on behalf of our clients actually serves our clients to a deep and profound disadvantage -- undermines their prospects for recovery, and the qualities of life which are embedded therein (see Appendix 3). That is not pleasing for me; I would rather be an unambiguous agent for life enhancement, but this is often not the case. And much of the ambiguity is unavoidable, either by virtue of inescapable incongruities that life presents us with, or because of institutional, legal, or other formal constraints referenced above.

So, when I have my bearings, I share this understanding with my clients, in all its fullness. That is, I avoid enabling wherever possible, as clients careen down the road of addictive behaviour -- sharing my perceptions, understandings, sympathies, and recommendations all the while in order to convey support, and promote consciousness on their part. Then, when one of the external mandates requires that I intervene in a way that seems likely to enable the continuation of addictive behaviour, I name the situation for what it is, lay it out in detail with the client, express my regret for having unavoidably become a part of the problem, and empathically lament their plight. There can be a critically useful power and influence in adopting that role -- not the least of which is to model a mature relationship with my own powerlessness.

However, if I am, instead, trying to insist that my every interaction with the client - including those that enable their addictions - is unfailingly "for their own good," I engender two sets of problems: first, I diminish the client's confidence in me. The clients were not, as they say, born yesterday; they recognize on some level that there is enabling going on -- even if they are not actively playing a manipulative "game." So if we are not explicitly acknowledging this enabling aspect, a certain ingenuousness enters the relationship, and the prospect for therapeutic intimacy is reduced. And the second problem arising from adopting a pose of unequivocal helpfulness is that I diminish my own credibility with myself -- albeit often unconsciously. Part of me knows there's some bogus stuff going on, and then I become susceptible to some version of defensiveness; subtle, or not so subtle. Although my relationship with the client is usually sturdy enough to survive this misfortune, neither myself nor the client are at our best advantage in that situation, and a whole realm of therapeutic possibilities is going unrealized. *There is no resource that we can bring to our relationships with clients more valuable than personal authenticity;* we compromise that at considerable cost in clinical efficacy -- and personal fulfillment. And, "meaning well," no matter how intensely felt and expressed, is not an equivalent of, or substitute for, personal authenticity.

The condensed formula regarding enabling, then, might read like this: Do it as little as possible, and, when it is unavoidable, do it consciously and candidly, using the situation as a therapeutic instrument. Why don't we readily and consistently do this? Frequently, the answer to that question implicates the role of . . .

Codependency

In a footnote in Appendix 2, at the bottom of page 18, I repeat a story a friend of mine tells about herself which exemplifies an instance of how codependent process plays itself out in our lives. I mention this by way of noting that I can't, offhand, think of anyone I know in the field of human services who does not have some significant degree of codependency to deal with – certainly myself included. And let us, as readily as possible, dispose of the caricature that claims that all this talk of "codependency" is simply the stigmatification of caring and compassion. Codependency is one of the family of addictive dilemmas, and as such is contaminated with narcissism -- even while it may wear all the trappings of altruism on behalf of others. In fact, it compromises our ability to be authentically involved with others, to the extent that it is prominent in our constitution at a given time. Further, to the extent that we are unconscious of this element within our own makeup, we are severely handicapped in our abilities to recognize and understand it in others. And it is, assuredly, epidemic in our client population, as it is in the wider society.

It is also, unfortunately, a cumbersome term which almost invites ridicule, with a sort of meandering etymological derivation, and - as is the case pretty much throughout the field of addiction - a conspicuous lack of widespread agreement about its exact meaning. If you are interested in some of the history of the term, see Appendix 4. Meanwhile, here is a paraphrase of the definition of codependency you will find therein:

> *An individual is codependent to the extent that their experience of personal adequacy and viability is contingent on their being in certain kinds of relationship with another person or persons.*[8]

In the literature, and in the popular impression of codependency, these relationships are envisioned as "people-pleasing," caretaking, victimized, and/or romantic/sexual dependencies. This perception fails to appreciate the numerous codependent roles and plights where the codependent stance is more robust; for example, in the battering syndrome, almost invariably *both* parties are codependent; are addicted to the relationship. But, typically, only the "victim" role will be described as codependent. Similarly, people can be addicted to being bosses, objects of

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[8] This is a matter of some delicacy, and deserves careful differentiation. I am not saying that we have no needs for human recognition and relationship; indeed we do. I am referring rather to those experiences wherein the essential *integrity of the experience of self* feels like it is at stake. By way of example, let us imagine that I am in a successful and fulfilling marriage -- as, happily, I am. Should I lose my partner through some tragedy, my grief would be enormous; but *there would be a whole person grieving.* I am familiar, personally and professionally, with the alternative experience, wherein the loss of the partner feels like the fundamental integrity of self has been fractured -- intolerably compromised. In those instances the relationship itself is a kind of a "fix," and there is a persistent unease - a thread of neediness - permeating the relationship even at the best of times. As well, I should mention here, as in Appendix 5, that in most of our relationships there is a codependent constituent woven in amongst whatever other elements of love and convenience may hold the parties together. So when I used my marriage as an example earlier in this footnote and represented it as absolutely non-codependent, for the sake of illustration, that was a misrepresentation. In my life, as in most peoples', codependency waxes and wanes. In this, as in so much else, self-honesty, consciousness, and humility are invaluable resources.

applause, etc. -- *and will manifest withdrawal when they are unable to sustain those roles.* So, once again, we see that the event of addiction is not a function of a particular technology - in this case a technology of relationship - but rather of the association between the use of the technology, and existential adequacy. Among our clients we will find, essentially, the same general array of codependent patterns and entanglements that are distributed throughout the general population.

Among ourselves, however - the human services provider population - we are quite likely to enter into the field bearing a sizable dose of the caretaking version of codependency along with us. I hope this doesn't scandalize or offend; I don't make this claim polemically or indignantly -- it just happens to be the case (excepting those of us who do direct service with the chronic mental health population in order to reap the astronomical financial remuneration typically offered for such positions). For me the question is not: "Am I codependent?", but rather, "What do I do about my codependency?" Of course, those who insist they are exempt from codependency spare themselves the need to address it -- usually at some more or less considerable cost to themselves, their colleagues, and above all, their clients.

(Incidentally, this last phrase " . . . at some more or less considerable cost . . ." implies one of the more important elements of the perspective we've adopted in the LADA supervisions regarding addiction: that addiction does not occur in our lives as all-or-nothing, you are or you aren't, yes or no phenomena, but rather, on a continuum of severity. That is, that one can be very codependent, somewhat codependent, or a little codependent -- and that this applies to other addictive dilemmas as well.[9])

For those who do come to terms with their codependency, and effectively invest in recovery, one of two results will occur: 1) - they become superior clinicians/administrators, or 2) - relieved of the caretaking imperative, they find themselves free to leave the field of human services. Both of these are felicitous outcomes; the greater misfortune is when 1) - talented clinicians/administrators perform their roles compromised by codependent dynamics, or 2) - people not well-suited to the human services as a profession nevertheless cling to their positions in fealty to an unrelenting codependent mandate. For elaboration on how investing in recovery in relation to codependency enhances one's clinical efficacy, see Appendix 5.

Spirituality & Twelve-Step Groups

In any discussion of addiction which includes the twelve-step perspective, the subjects of "powerlessness," and of "surrender," or "relinquishing control," will be prominent. These terms are provocative and, potentially, ambiguous in the best of cases. When the discussion involves the

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[9] To elaborate on this a bit, it's worth noting that there is a comment which circulates in AA - a response to someone proposing that they might be "a little bit" alcoholic - to the effect that that's like being a little bit pregnant. Although the thrust of the remark typically is to dismiss the idea of there being wriggle room in the matter - either you're pregnant or your aren't - in fact the analogy is very apt. Just ask someone in their ninth month of pregnancy whether or not there's a difference between being a little bit pregnant, or a lot pregnant. We can evoke the continuum of severity by asking the question: "to what extent does the addictive plight sum up the person?" There are some people about whom you could say, for example, "They are an alcoholic," and it would be a truth, and an important truth, about that person, but it would not sum them up; there would be much more about them that needs to be included to evoke the wholeness of their life situation. But there are other individuals - typically those in advanced progression - who will, indeed, be substantially summed up by the statement, "they are an alcoholic." Whatever else has been, or might be, true about that person is pretty much swallowed up in the all-encompassing and overshadowing fact of their alcoholism.

dual-diagnosis population it can become especially charged and tricky.[10] The paradoxical remedy for powerlessness is, indeed, to relinquish control. This is so counter-intuitive, for Western thinking, anyway, that it gives us a bad case of "The Willies," as they say in the DSM IV.[11] And this proposition, which seems to violate common sense in general, seems even more preposterous when contemplating the situation of the person with a history of chronic mental illness: surely this individual needs to find ways to *augment* control; not relinquish it.

Further, regarding spirituality, mental health workers often witness clients mired in florid delusional states wherein God is ostensibly commanding them to perform destructive behaviours, or who are otherwise entangled in mystical/religious turmoil of one kind or another. Given these issues, and the considerable volatility and/or confusion which so often accompanies these kinds of symptoms, clinicians will often approach subjects of religion and spirituality with a great deal of caution. Yet, the twelve-step perspective locates spirituality very much at its center. In the remarks which follow I will try to defuse some of the alarms which these subjects often trigger.

The essence of the idea of control is to be able to predict results. And it is precisely this promise that lies at the heart of the addictive seduction: *"eat me, drink me, use me -- and I will enable you to control results where it matters the most; in your subjective experiences of feelings and identity."* In brief, this invites and cultivates hubris; the assumption of powers and prerogatives which turn out to be neither fitting for, nor sustainable by, mortal humans. So, as a counter to this seductive and ultimately catastrophic enticement, the addict, be they dual-diagnosed or otherwise, is encouraged to relinquish control -- to *abandon the strategy of trying to achieve fulfillment through willful insistence joined to systematic manipulation.*

This consideration is addressed toward the end of Appendix 5 thusly:

> *[When we relinquish control, we liberate ourselves from] inappropriate responsibilities; specifically we are relieved of the responsibility of assuring a certain outcome, and our mental and emotional energies are thereby released to attend conscientiously to the integrity of our intent, and of our effort. These areas, intent and effort, are the legitimate - and exclusive - domains of our responsibility.*

It is worth noting that, informed by this perspective, we are spared the confusion often voiced by people first contemplating relinquishing control: the idea that surrendering control is equivalent to passivity; to becoming a doormat, as it were, for the world to walk on. In fact, while we cannot control outcome, we *can* effect, or influence, outcome -- and, indeed, *we cannot avoid effecting outcome, in any matter in which we play a role.* Experience teaches us that the person who accepts responsibility for the inevitable fact of their influence in a situation, rather than being preoccupied with the idea of insisting on a certain outcome, tends to be 1) - more effective overall, and 2) - much more balanced and fulfilled in general.

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[10] Or, for that matter, any population which is disadvantaged within the society.

[11] The *Diagnostic and Statistical Manual, Fourth Edition*, of the American Psychiatric Association. This is, I confess, a fictional tongue-in-cheek reference.

To do this is challenging for all of us; indeed, it is, arguably, the central challenge of life; the challenge of developing maturity, wisdom and character. While it may seem unrealistic and therefore unreasonable to propose such a striving for people handicapped by mental illness, in fact it is not only feasible for them to make appreciable progress along this path; it is their best hope for finding meaning, intimacy, and dignity within their lives -- as it is for the rest of us. Is it more challenging for a person with a mental illness? Of course; but it is also, arguably, even more urgent for them, for the cumulative effects of their symptoms, their psychotropic meds, their embeddedness in a custodial system, and the stigma of mental illness conspire to relegate them to a relentlessly marginal existence. In order to transcend these constraints they - and we, as their institutional allies - need have recourse to . . .

. . . yup, you guessed it: a power greater than ourselves. And the two essential instances of such a power are embedded in: personal spiritual experience, and human community. Each of these spheres is fraught with challenges. Regarding spiritual experience, it is challenging to not succumb to personal grandiosity (including that version of grandiosity which invests in self-mortification); it is challenging to not mistake dogma and doctrine for sound spiritual principals and guidelines; to not confuse religious chauvinism with spiritual community, or oppressive proselytizing with spiritual sharing; it is challenging to distinguish those voices within ourselves whose origins are fear and doubt from the voices of intuition and authentic spiritual inspiration and guidance. Are these challenges more acute for the person with mental illness? Usually. Are they therefore more dispensable? *Au contraire.*

One of my all-time favorite stories regarding spirituality comes from the 50th AA International Conference in Denver some fifteen or so years ago. One of the speakers there reported that for many years in his recovery he had thought of himself as a human being striving to become a spiritual being -- and that recently it had dawned on him that he was a spiritual being striving to become a human being. For me this is an exquisitely poignant summation of what spirituality is about; the unfolding realization - making real - and ongoing celebration of who we actually *are* -- not the attempt to become something different and "better." Nowhere is this distinction more aptly poignant than for those struggling to be their human selves and simultaneously cope with the distortions, disablements and provocations of a mental illness.

The other relevant instance of a power greater than ourselves resides in the community of humanity, wherein the actualities of spiritual principals have their laboratory, as we all strive to achieve authenticity, integrity, and fulfillment._ God knows, this is a messy process! And the messiness is seemingly compounded in the venue of AA, and the other twelve-step fellowships, where there is a singular and quite intentional absence of any organizational imperatives to constrain or control the actions and expressions of the members. This lack of structure, in the conventional sense, is what distinguishes the twelve-step groups from treatment modalities; there is no accountability in the sense that there are no parties identified as the treatment providers. This is because AA, *et al*, are not organizations, in the formal sense; they are best understood as ecologies.

An analogy: it may be that an MD will recommend that a patient should move to Arizona, because their condition is more likely to improve in that ecology. Should the patient fail to improve, though, it will not make sense for us to try to hold Arizona accountable for this disappointing outcome. But it may well turn out that the failure resulted from *how the patient situated themselves* within the large and complex ecology of Arizona; it may be that, if there is a "guide" available to the patient who is knowledgeable about both the patient's health problems, and the range of ecological niches in Arizona, they can instruct the patient about how to conduct and position themselves so as to maximize the advantages to be gained.

This is our role -- to act as guides for our clients so that they can avail themselves of the phenomenal benefits that the twelve-step community has to offer, and avoid, as much as possible, the various, and sometimes considerable, pitfalls that are elements of that ecology as well.[12] Obviously, though, we cannot do this job well if we are not ourselves familiar with the ecology. "Yes, but I read about it in a book," or "I went to a workshop on Arizona landscapes and climate." Uh-uh. That wouldn't satisfy me if I were the patient in Arizona -- some guy from Vermont who read about Arizona in a book is gonna be my guide . . . *There is <u>nothing</u> we can do on behalf of our clients who struggle with addictive dilemmas - i.e., most of them - that will begin to be as valuable as developing a well-rounded, first-hand twelve-step literacy for ourselves.* Yet, we are much more likely to travel many miles and invest a great many hours and dollars in attending clinical workshops, than we are to go to, say, a dozen twelve-step meetings conveniently located within 20 minutes of our homes -- for free.

Why? Well, the reasons are, of course, varied, but I suspect that prominent among them, for many of us, is that we've gotten close enough to the twelve-step environs to feel that we don't want to get any closer -- and that our reluctance has to do with the messy humanness of it all, which disconcerts us for one or both of these two reasons: 1) It doesn't conform to the theoretical frames of treatment, with their hierarchies and explanatory schemata within which we feel oriented and reassured -- perhaps in large part because these frameworks clearly distinguish *us*, the competent service providers, from *them*, the needful persons at a pathological disadvantage; and 2) We may unconsciously picture ourselves bumping up against areas in which we are not fully reconciled with certain features of our own mortal frailties. I am not, by the way, saying that clinicians exploring the twelve-step groups would encounter their own unacknowledged and/or unaddressed addictions -- although that happens often enough, to be sure. But my point is that the twelve steps, and the assorted fellowships coalescing around them, are keenly and poignantly relevant - and revelatory - for everyone; anyone possessing a modest degree of self-knowledge, and a reasonably open mind, will find themselves variously drawn to, and challenged by, what they find in those rooms.

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[12] I often tell clients that AA meetings are like bars; they all serve the same thing, but vary enormously in social makeup, ambience, protocol, etc. A friend of mine, sober in AA for over twenty years, remarked, "There are some AA meetings that, if I went to them on a regular basis, would drive me to drink. But there are people attending those meetings who are obviously well served by them -- and who might despise the meetings I love. Go figure."

Dual-Diagnosis - the Future

Several years ago I was asked to participate in a discussion of dual-diagnosis concerns. Toward the end of this discussion, the facilitator asked us each to formulate our hopes for the status of dual-diagnosis efforts in five years, then ten years, then twenty years. I found myself saying that I hoped that, in five years, there would be much more widespread recognition of the issue of dual-diagnosis and its prevalence; that in ten years I hoped there would be a greatly expanded body of treatment resources available for the dual-diagnosis population -- and that in twenty years I hoped that there would be no such designation as dual-diagnosis. My mental process in that instance, which generated the apparent incongruity between the third wish and the two preceding it, is the need to, as the Buddhist nun Pema Chödrön says, "Start where you are." And where we are - where we have to start from - is a situation where the prevailing mind-set regarding the presence of addiction in peoples' lives is based on the notion of pathological predisposition; the idea that people become addicts as a result of some congenital and/or acquired pathological disadvantage. As is evident throughout this paper, I represent an alternative perspective, based on the idea that addiction is a dilemma which emerges out of "the convergence of human nature and technology" -- with the term "technology" representing, again, "any systematic method of manipulation." While relief from symptoms of pathology can integrate into the ensemble of rewards provided by the technology, the presence of pathology is not an essential feature of the onset of addiction, in my view.

But, we are where we are; my view is not widespread at the present time, and the presumption of pathological etiology is deeply embedded in the common view of addiction, among professionals and the lay public alike. Hence I advocate for greater awareness of what we now call the dual-diagnosis population, and enhanced and augmented treatment modalities and resources for this populace, even while I work to promote a perspective on addiction which sees the addictive plight as a dilemma of the whole person, rather than as an aberration somehow ancillary to other features or aspects of a person's life. Without going into a more elaborate critique at this point, it is my hope that eventually the term "dual-diagnosis" will fall from usage because there will be a recognition that this designation obscures and misleads more than it clarifies.

Conclusion

It is sometimes the case that situations which are particularly grave and dire engender new developments - evolutionary breakthroughs - which are exceptionally fortunate and beneficial. This cosmic irony, if you will, replays itself, as if for the first time, again and again in the lives of individuals who survive the hitting bottom experience discussed earlier in this paper (pp. 6-7), and, through grace, courage and persistence, dramatically reconstrue the basic tenets of their lives such that they give birth to a whole new set of life-possibilities. This is a miracle and a blessing every time it happens for any person; it is even more remarkable when it happens in the lives of people who are challenged by persistent and confounding mental/emotional disorders. It is remarkable for two reasons: firstly, such a person has extraordinary - literally, extra-ordinary - hurdles to overcome in order to show up for the disciplines and trepidations which necessarily attend the recovery process. But, secondly, these individuals, without fail in our experience, enjoy marked and often dramatic improvement not only with respect to their addictive dilemmas, but

also with regard to the coterie of symptoms which have plagued them for years, often decades, and which were at best managed, but essentially unresolved, through pharmaceuticals and other treatment efforts.

If we view the dilemma of addiction as emerging out of our strivings to fulfill those very longings and yearnings which inspire in us our most lofty achievements and transcendent states - and as well our darkest deeds and corruptions - then the enterprise of recovery takes on a whole new meaning and resonance. Rather than being recuperation or rehabilitation in the conventional sense, it entails an encounter with the core issues of what it means to be human -- what are the fundamental limitations; what are the astounding potentialities. This undertaking - which we call recovery for want of a better term[13] - is both ennobling and humbling; both exalting and democratizing -- according to the idiosyncratic and evolving needs of each individual. Recovery is so highly individualized because the central event of recovery is that the *experience* of transformation of self, originally contrived through the addictive technology, resolves to the *fact* of transformation of self. When authentic self-transformation is involved, it necessarily leads to enhanced individuation; to the greater realization of the unique potential of each person.[14]

We are well advised, though, to avoid romanticizing the process; while it is punctuated with transcendent moments, and yields remarkable growth and accomplishments over time, the day-to-day unfolding of recovery is gritty and very much down to earth. And often very frightening; the kinds of encounters with one's own limitations - and potential - which characterize the recovery experience can be deeply unsettling. It can also, of course, be aborted at any stage -- either obviously, through a resumption of the original addictive behaviour, or through the adoption of new, and perhaps more "sophisticated," addictive patterns (control modalities).[15]

Now, as a closing exercise, I invite the reader to review the preceding two paragraphs with the idea that we could be talking about those who *provide*, rather than *receive* treatment; that we could be, even, talking about the treatment system itself, as embodying a consciousness which can be more or less healthy -- more or less incorporating principles and precepts conducive to well-being. In this instance - the need to come to terms with the denial of mortal limitation which is at the heart of addictive process - the injunction, "Doctor, heal thyself," may be the single most useful intervention we "doctors" can make on behalf of our "patients," over the long run.

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[13] In fact, the term itself - recovery - is misleading, in that it suggests reacquiring something which one previously had -- as in recovering stolen property, or returning to the state of health one had before becoming ill. A more satisfactory expression, for me, in place of *recovery from* addiction, would be *resolution of* addiction -- because this is what happens; addiction offers one solution to a set of urgent interests having to do with transforming the experience of self -- then it goes bankrupt. The appropriate and adequate recourse is to *re-solve* the problem of transformation of self, in ways which are authentic and trustworthy. However, the term "recovery" is so widespread and ingrained that it will almost certainly prevail in our language.

[14] Ed McCaffrey, a former colleague of mine, and an astute commentator on addiction and recovery, observes that the longer an addict invests in addictive process, the more predictable they become; and, conversely, the longer they invest in recovery, the more unpredictable they become -- simply because more and more of their uniqueness and creative potential finds expression in the conduct of their lives.

[15] -- A recourse which has been likened to the strategy of changing seats on the Titanic.

Appendix 1

In The Beginning

The seeds of addictions are first planted in our lives when we make certain *great discoveries*. Often these times of discovery are brief and powerful - hardly more than moments - but moments etched deeply into our consciousness; indeed, into our very being, as we shall see. Sometimes, however, these discoveries gather themselves over years, or even decades, and the etching is more subtle, gradual and cumulative - not the sort of thing which can be attributed to a particular time, or experience. However these discoveries may accrue, abruptly or gradually, what makes them *great* discoveries is that they provide conspicuously superior solutions to two crucial problems we all encounter in our lives.

The first of these problems can be stated: How can I manage my feelings most successfully? It is a central feature of our daily lives that we search for ways to experience certain emotions, and avoid others. Naturally, different people value different feeling states. Some people, for example, find that feelings of *safety* are very important to them, because they have lived so much with feeling at risk, while others will prioritize more adventurous experiences. Also, of course, the same person will value different feelings at different times. Whatever our particular emotional priorities may be, when we discover a *technology* - a systematic method - that offers us the ability to access those desirable feelings with dramatically enhanced exactness and consistency, we can reasonably call that a *good* discovery, and we are likely to employ that behavior with some regularity, so that it becomes a *habit*.

However, when we discover a technology which allows us not only to manage our feelings more successfully, but also routinely allows us to have a more satisfactory and adequate experience of our very *identity*, we have made a *great* discovery. Although this usually involves an experience of an improved identity - a self that feels more successfully integrated, perhaps, or having more wit, charm or courage - what is sometimes most remarkable about the experience is simply the sense of *having* an identity. Often people will talk about how they went through life *pretending to be someone*, until the use of some technology - drinking, work, food, sex, whatever - “filled an emptiness that I felt, right where the center of my *self* should have been.”

This latter experience, of feeling a realness about oneself which may have been missing as far back as memory can reach, is sometimes so appealing that a person is willing to accept even a less attractive personal identity - one that is less approved and welcomed in the world - in exchange for the feeling that this identity, however objectionable it may be, is *authentic.*

Spiritual Animals

The two problems solved by an addictive technology,[16] then, are summarized in the following pair of questions: *How can I manage my feelings most successfully?* and, *Who am I?* You might say that the first of these questions, about feelings, goes to the heart of our animal nature; and the second question - "Who am I?" - goes to the heart of our spiritual being. Our wholeness - our humanness - dwells in the pool of longings, desires and appetites where these two aspects of our being converge. Obviously, we are playing for high stakes here. So when we discover a way of fulfilling these longings which works much better than anything else we've tried, we do the logical thing -- we use it again.

And again. And again, and again, and again . . .

And over time - a short time or a longer time - we find that the experience of being ourselves is *most satisfactory and complete* when we are using this technology we have discovered.

Inverted, this statement reads: "when we are *not* using this technology, the experience of being ourselves is *less satisfactory* and *less complete.*" And this situation becomes more acute over time. The rule of thumb is this: as addictions progress, experiences of emotional well-being, and existential adequacy, become increasingly *hostage* to the use of the addictive technology. When we are deprived, by our own choice or otherwise, of the use of the technology around which our addiction is organized, not only do we feel less adequate in managing our feelings, we also experience, as the quote above suggests, an intolerable emptiness, and/or lack of viability, exactly where the center of our self should be.

It is by virtue of this process that an addiction acquires the credentials to overrule common sense, and gradually consolidates into a center of being within the addict which can finally commandeer the life so absolutely that the original, authentic self is dumb and mute before the imperative requirements of the addictive self.

[16] It is important to understand right from the beginning that no technology is *intrinsically* addictive; addictiveness is a function of the meanings the technology acquires in the addict's life.

Appendix Two

On the Adult Child Dilemma & the Borderline Personality Disorder

Three Modes of Addiction

While it would be impossible to list every conceivable addiction, it is possible to step back and recognize that every particular addictive situation can be seen to fit within one (or more) of three modes.[17] The three modes, with summary characterizations, are:

> *Autonomous Addict* - A person who is preoccupied with issues of control mediated through a *solitary* technology.[18]
>
> *Codependent* - A person who is preoccupied with issues of control mediated through a technology of *relationship*.
>
> *Adult Child* - A person who is preoccupied with issues of control -- *period*.

The adult child syndrome is typically known as "Adult Children of Alcoholic Parents," or variations on this. However, it turns out to be much more widely generalizable, as we will see further along. I should note right off that I've never met anyone who fit within only one of these modes -- although at a given time one might be so preponderant as to effectively overwhelm the others; for example, an alcoholic (autonomous addict) in late-stage progression. While that person may have adult child and codependent issues, even of great magnitude, the severity and drama of the alcoholic plight is likely to distract attention from the other addictive modalities. Should that person effectively address their alcoholism and embark on the journey of sobriety, they are likely to begin to encounter, and have to deal with (or suffer from not dealing with), the ways in which other addictive modes are present in their makeup My impression is that each of these modes is, to some extent, present for virtually all of us.[19]

The Purest and the Saddest

The adult child mode is, among the three, both the purest, and the saddest. I say "purest" because every addiction is, at its heart, a preoccupation with control which has usurped, to a significant extent, the seat of selfhood. The adult child mode, then, unencumbered by any

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[17] There is a great deal more to say about these three modes than will appear in this paper; the purpose of introducing them here is to locate the adult child plight within the framework of these distinctions.

[18] That is, a technology which can be managed, or operated, without needing to involve others -- such as drinking, eating, exercise, masturbation, TV, etc.

[19] A friend of mine was asked to speak once at an Alanon meeting on the occasion of their anniversary. They were including speakers from three different programs, and she was invited as the AA speaker. She began by saying that she could actually have spoken as either an alcoholic, adult child, or codependent, since she deals with all three predicaments. "In fact," she reported, "when I was asked to speak, I was told each of us would have about twelve minutes to talk. In my head I heard my alcoholic self say, 'Who the hell are they to tell me how long I can talk?' But my codependent self replied, 'Well, whatever makes them happy . . .' Then my adult child self concluded, 'It doesn't really matter how *long* I talk, as long as I don't make *any mistakes.'"*

mediating technology, manifests the problematic core of addiction, *sans* the obfuscations and distractions generated by the innumerable technologies around which addictions organize.

I say that the adult child dilemma is the "saddest" of the three modes because the adult child never gets any relief. At least the other participants in the system - the autonomous or codependent addicts - get to have an initial period where their addictive technology gives them a positive payoff. Whether it's booze, drugs, romance, caretaking, gambling, sex, or whatever, at least there is an interlude, usually of some considerable duration, where they get a substantial piece of their heart's desire -- whatever that may, in their case, be. Of course, this interlude is simply the seed-crystal for their germinating addiction, and the bill will, to be sure, arrive eventually. But even then - down the road perhaps a great distance, when the addictive technology delivers only an anemic and degenerated version of its once bountiful payoff - even then there is at least the memory of those earlier, auspicious times. The adult child doesn't have even that retrospective solace -- that remembrance of a time when they were either relieved of their adult child imperative of unfailing control, or presented with the means to, apparently, pull it off.

You can see this distinction manifest in virtually any ACOA[20] meeting you might attend. There will be, almost invariably, some members of the group who are also alcoholics in recovery in AA, and these folks typically have a markedly higher level of self-assertiveness, and a sort of irreverent humor that pokes fun at the sacred cows -- whether within their own make-up, within the program, or in life in general. This emerges out of their having had that interlude of self-sufficiency, while their addiction was working at its best, promoting a rather grandiose and narcissistic stance. (Conversely, by the way, you can see in virtually any AA meeting you might attend, those members whose adult child history has been particularly formidable, and, for the most part, unresolved. They are the ones who are likely to invest in the enterprise of recovery with a kind of grim, or terribly earnest, seriousness;[21] they are particularly prone to making categorical error number two.[22])

So there's the picture. The adult child, unless moderated by an intervening addiction, or opting for the under-responsible strategy we will examine below, is on guard against anything that might compromise their ability to maintain control within and around themselves -- and trying to accommodate and account for the profound sadness generated by this titrated engagement with life. It is not a happy way to be in the world, though this will not always be immediately apparent, since for many adult children the high premium placed on appearances often makes smiling an imperative. Then, of course, there is the terrible sense of incongruence between the inner experience of pain, and the outer demeanor of resolute cheeriness.

How does this dreadful adult child predicament enter into human lives?

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20 ACOA - Adult Child of Alcoholics meetings -- typically but not always twelve-step based.

21 There is a fairly trustworthy correlation between humor and sobriety in relation to the adult child dilemma, by the way. I say "fairly" trustworthy, though, because certain people learn early on to integrate humor into their control repertory. For these folks it becomes a more subtle issue -- but still, the factor of genuine *lightheartedness* is a viable index.

22 There are, it turns out, two large scale categorical errors one can make with respect to work of sobriety, which embrace the innumerable *particular* errors one can make. These are: 1) - Neglecting to do it (and you can go to daily twelve-step meetings and still be neglecting your work); and 2) - Subscribing to the mistaken belief that sobriety is about following the *right set of rules.*

The Principles

There are two simple organizing principles constituting the adult child "inheritance."

1) You can't trust *anything.*
2) It's not okay to be you.

The first rule - "You can't trust *anything*" - emerges out of the experience, gathered from early childhood on, that you cannot confidently expect that things will turn out to be the way they're represented to you. This may be because people outright lie to you, but often enough it's more subtle, and more insidious, than that. In trainings I do for mental health professionals I soometimes offer the example of two fathers, both alcoholics, approached by their toddler children for attention while they are reading the paper. In the first case, the child finds that on one occasion dad may be welcoming and affectionate, but, for no discernible reason, on another he may react with impatience and anger -- even perhaps violence.

In the second instance, though, the father conducts himself with unfailing consistency -- on every occasion he puts aside the paper, picks up the child, and asserts that the youngster is his "little angel." So what's wrong with this last picture? Simply this: kids, prior to being socialized otherwise, have an uncanny ability to see the truth, and when the child in this last case looks into dad's eyes, he can see that, for all the commendable language being spoken, there's an emptiness behind the eyes -- there's *nobody home.* Ah.

The question I put to the trainees, then, is: *which child is worse off?* It is challenging to generalize about the wide range of forms these wounds can take. I can report, though, that the *latter* plight tends to make for much tougher sledding in therapy, because of the amorphous history at the heart of the injury.[23]

So what about the second rule -- "It's not okay to be you"? To do justice to this, I need to digress, and offer my generic characterization of the adult child plight. I say "generic" because it has become a commonplace that the constellation of features and symptoms associated with children growing up in alcoholic families, is: 1) - not limited to families where there is alcoholism,[24] but 2) - not so broad spectrum as to apply to any and all dysfunctional families; there are many ways for families to be unhealthy, and they don't all engender the adult child predicament. So here is my modest offering, the acronym for which would be the unmellifluous non-word, ACOFI, pronounced, perhaps, "a-coffee."

Adult
Child
Of
Flawed
Immortals

[23] That is, the second child, lacking an unambiguous history of abuse, is much more likely than the first to distrust their own feelings, and incline toward blaming *themselves* for whatever dismay, discontent or disturbance they may experience.

[24] Indeed, in the example of the two fathers just above, the detail of their being alcoholic is not essential for the point it makes -- I specify that feature as sort of a conceptual convenience, because people are familiar with that particular model.

If it strikes you that this must be tongue-in-cheek, I don't blame you. But it refers to something serious enough -- the plight of growing up in a family where one or both of the parents have a description of perfection which they require of themselves. This description will be, in different cases, as diverse as you can imagine, ranging from *Thou shalt always follow the rules of Emily Post,* to *Thou shalt always be politically correct,*[25] to the truck driver in Detroit whose description of perfection is, simply, *You don't never feel* <u>*nothin'*</u>*.* In this discussion the important feature of these descriptions is not their particulars, but the absoluteness -- the requirement of perfection, along whatever lines. It is, in effect, a mandate denying mortality, for the essence of mortality is not so much the particular fact of eventual death - of limited longevity - as it is the fact of limitedness in general, along any axis you may define.

But, of course, these poor folks find that they fall short of the unsparing requirements they make of themselves, so they are consequently *flawed* immortals. The message generated by this example - this modeling of *how to be in the world* - establishes the second of the two adult child organizing principles: *it's not okay to be a limited, mortal human,* which, because kids personalize everything, is then translated into the poignant interior conclusion: *it's not okay to be* <u>*me*</u>*.*

These two organizing principles, in turn, converge in their implications to constitute what might be called the adult child mandate, as follows: *Thou shalt be in complete control at all times.* And the two responses to this mandate are either to embrace it - the over-responsible option - or, to flee from it, making repeated demonstrations that you are not to be counted on -- the under-responsible course.[26] Some adult children will do pretty much one strategy or the other quite consistently, but many oscillate between the two, striving without lasting success to find relief from the harsh austerity of that *be in control at all times* mandate. However you slice it, it ends up pretty crazy making.

Adult Child *In Extremis*

And speaking of crazy making . . . a number of unfortunate and persistent predicaments which are typically defined as mental illnesses can usefully be regarded through the lens of understanding addictive process. One of these, which has proven especially problematic to address through conventional therapies, is called the "borderline personality disorder" (BPD); it has proven helpful and illuminating in my practice to consider the person diagnosed with BPD as an example of the Adult Child dilemma, as characterized above, in particularly exaggerated manifestations. Here are the diagnostic criteria for the BPD diagnosis:

> A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

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[25] One of the more challenging cases in my private practice involved two sisters who were third-generation pacifists. "No rest," you might say, "for the righteous."

[26] This "over-responsible / under-responsible" theme is addressed in much of the literature on adult children. One excellent offering is a book called *The Responsibility Trap,* by Claudia Bepko and Joanne Krestan. These two also authored a second book of considerable merit, focusing on the plight of women adult children in particular, wonderfully titled *Too Good for her Own Good.*

1. *frantic efforts to avoid real or imagined abandonment.*
2. *a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation*
3. *identity disturbance: markedly and persistently unstable self-image or sense of self*
4. *impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).*
5. *recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior*
6. *affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)*
7. *chronic feelings of emptiness*
8. *inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)*
9. *transient, stress-related paranoid ideation or severe dissociative symptoms*

These criteria are from the fourth edition of the Diagnostic and Statistical Manual (DSM IV) of the American Psychiatric Association. If you hold these descriptions of characteristics and behavior in your mind, they will, as an ensemble, tend to evoke the plight of the “borderline” individual. However, below are brief excerpts from a couple of other texts, to help convey a more adequate feel for this inherently elusive designation.

> . . . a "personality disorder" marked by various features of "borderline" personality organization, such as instability, impulsiveness, intense or poorly controlled anger, inability to tolerate being alone, and chronic feelings of emptiness. Individuals with this disorder sometimes seem to be on the borderline of psychosis and are highly unstable in mood, behavior, self-image, and affect.
>
> None of the features of borderline personality are constant. The behavior of such personalities is highly unpredictable and they seldom achieve their full potential. Their interpersonal relationships are often stormy because of their shifts in attitude and tendency toward idealizing, devaluing, or manipulating others. Suicidal gestures and self-mutilation may occur. *(Miller-Keane Medical Dictionary)*
>
> *<u>Causes and Risks</u>:*
>
> The exact cause of borderline personality disorder is not known. The person with a borderline personality is impulsive in areas that have a potential for self-destruction. Relationships with others are intense and unstable. The person will go through frantic efforts to avoid real or imagined abandonment by others, and express mood instability and inappropriate anger. There may also be identity uncertainty concerning self-image, long-term goals or career choice, sexual orientation, choice of friends, and values.
>
> People with this disorder tend to see things in terms of extremes, either all good or all bad. They view themselves as victims of circumstances and take little responsibility for themselves or for their problems. Risk factors include abandonment issues in childhood or adolescence, sexual abuse, disruptive family life, and poor communication within the family.

> This personality disorder is often associated with schizotypal, histrionic, narcissistic, and antisocial personality disorders . . .
>
> *Prevention:*
>
> Unknown
>
> *Treatment:*
>
> People with borderline personality disorder tend not to be compliant with treatment. However, the following therapy may be helpful in some cases.
>
> Self-destructive behavior may be modified through peer relationships in social and therapeutic environments. Peer reinforcement of appropriate behavior may be successful because difficulties with authority often impede learning. Group therapy can be helpful in modifying specific impulsive behaviors, as peer pressure in the group may restrain rash behavior . . .
>
> *Prognosis:*
>
> Borderline personality disorder has a poor prognosis . . . as noncompliance with treatment is common. However, people with this disorder who make it through their 30's and maintain sobriety, may begin to improve. *(HealthCentral: Online Medical Dictionary)*

Here is the thinking which leads me to understand the "borderline" person as manifesting the adult child dilemma *in extremis*. The adult child is informed and mobilized (or immobilized) by the irreconcilable intersection of the conditions and demands of the adult child inheritance on the one hand, and their fundamental human longings on the other. The adult child inheritance, remember, is founded on the interlocking premises that 1) the universe in which they find themselves is not to be trusted, and 2) they themselves are intrinsically lacking in viability and worthiness. These organizing principles converge to constitute the Adult Child imperative, which reads: *"thou shalt be in complete control at all times."* As described above, the two possible responses to this imperative are, simply, "yes," or "no." The tragedy of the adult child life unfolds as it is revealed that neither answer brings lasting relief from a pernicious and unforgiving sense of existential flaw. Furthermore, adult children are more than just their plight; they are, originally and ultimately, human, yearning for those deep fulfillments which enrich our lives, and feed our souls.

The "irreconcilable intersection of the principles of the adult child inheritance on the one hand, and their fundamental human longings" mentioned at the beginning of the last paragraph plays out as follows, then: adult children feel that they need to be . . .

1) intimately connected on the one hand -- but disengaged and invulnerable on the other;

to be . . .

2) omnipotent on the one hand -- but entirely helpless and unaccountable on the other.

Regarding 1): when you are a person that it's not okay to be, in a universe which is not to be trusted, you long for someone to find you worthy and viable after all, and stand with you, so you aren't facing that dreadful universe all by yourself. But, of course, since you experience yourself as *not* viable and worthy, you must make sure that no one comes to know the true you. So the option of intimacy ("in-to-me-see," as I've seen it rendered) is out of the question. And regarding 2): the only way to succeed in fulfilling that adult child imperative about "being in complete control at all times" is to be omnipotent. However, to define yourself as such means, simply, that anytime anything goes wrong -- *you* are to blame. Not surprising, then, that we observe very few adult children who derive lasing comfort from either the compliant, over-responsible role, or the non-compliant, under-responsible reaction.

The adult child predicament, like all addictive plights, occurs in human lives to greater and lesser degrees. Because every form of addiction is essentially a dilemma - that is, composed of features which seem both compelling, and incompatible - when any addictive plight manifests in its most severe and extreme versions, the irreconcilable interests clamor, not for their turn, but for perpetual ascendancy.[27] In these life-modes, the core *unreasonableness* of addiction, always present to the knowledgeable observer, becomes overwhelming and inescapable. It is my observation and understanding that the "Borderline Personality Disorder" diagnosis refers to a person who is at the mercy of that predicament so unrelentingly that they don't even have the luxury of oscillation; they feel that they must be connected to others - and unconnected - *simultaneously*; that they must be *simultaneously* in complete control -- and absolutely out of control.

The Road to Borderline

Now -- how might one find themselves in such a dreadful, exaggerated version of the adult child plight? By way of introduction I need to share a characterization I offer of the experience, or the event, of loving / being loved, to the effect that loving consists of unconditionally *accepting, embracing, and celebrating* that which is loved. (Note that acceptance, embrace and celebration are not to be confused with agreement, approval and/or acquiescence.) So to be loved means to feel accepted, embraced and celebrated *for who you really are.* Obviously, this last phrase is crucial; a particularly poignant misfortune occurs when a person finds themselves receiving all these evidences of love -- but only so long as they follow a certain script. It doesn't even really help if that script closely conforms to the lines of that persons authentic makeup; it still registers, on some level of consciousness, that the love is being awarded, as it were, for *fealty to* a standard independent of the core self, rather than evoked in response to a *recognition and appreciation of* that authentic core self. This difference is all the difference in the world, and in fact takes us back to the genesis of the parental component of the adult child predicament in the first place; it helps explain how such a mandated description of perfection might become established in a person's life in the first place.

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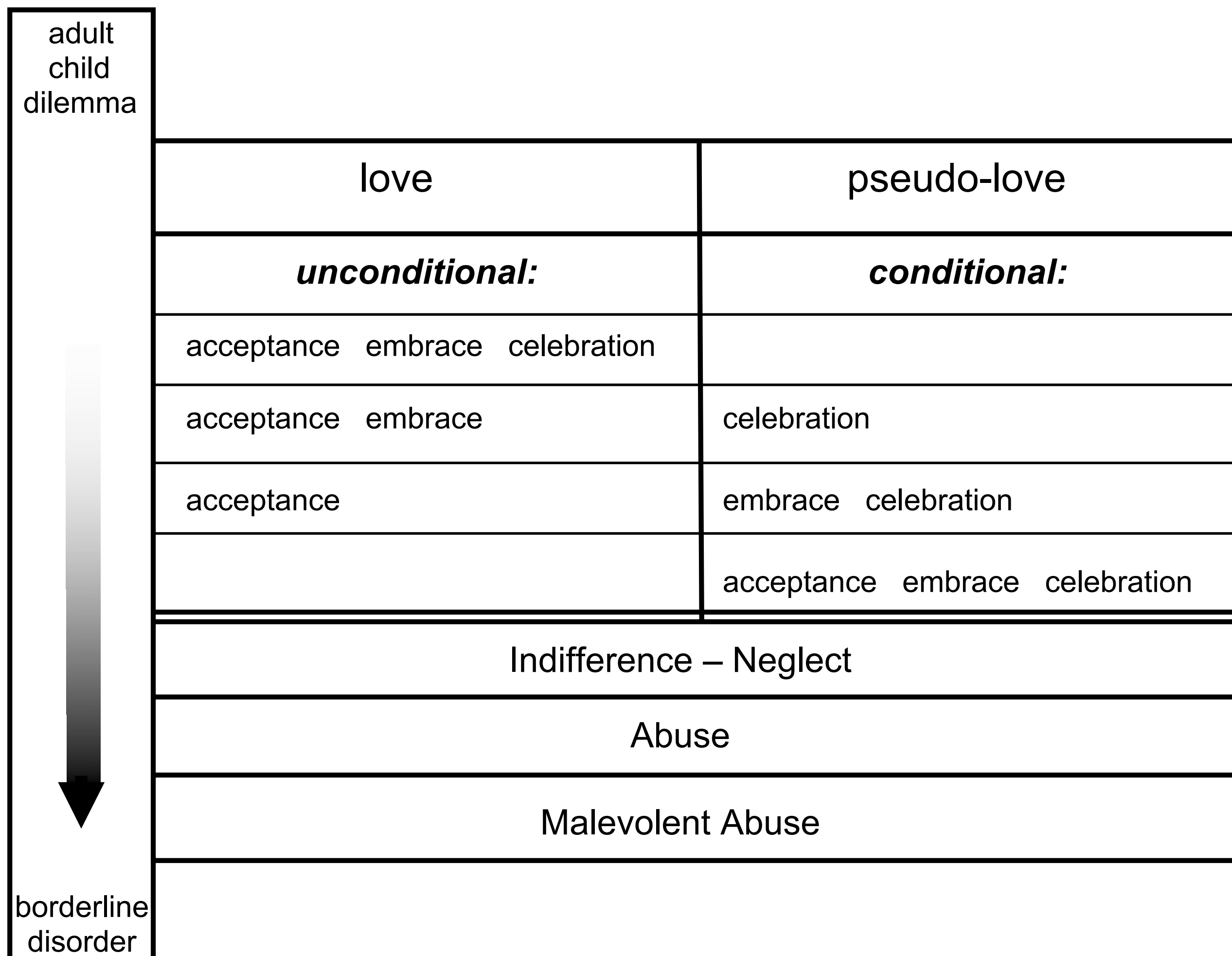
[27] I witnessed this over and over while working in detox settings, when gravely progressed alcoholics would check themselves in, then hours or even minutes later, leave AMA (Against Medical Advice) – only to present themselves for readmission almost immediately. This revolving-door behavior was spurred by antagonistic imperatives – they were compelled to drink; they were compelled to stop drinking. Each imperative sabotaged the possibility of sustained commitment to the other.

There is a kind of ordering of these elements of loving, such that the person who finds that they are unconditionally accepted and embraced, but not celebrated, is better off than the person for whom both embrace and celebration are conditional. And both of these folks are more “solid,” if you will, than the unfortunate person for whom all three aspects of love are conditional. This hierarchy, then, is part of a continuum along which the severity of the adult child plight can be indexed.

However, the scale graduates down into negative values, and it is here that we encounter, increasingly, the potential for the borderline disorder. The situation where “love” is entirely conditional is not as bleak as the case where there is no prospect of even the counterfeit (conditional) version of love. This plight in turn - a kind of indifference; of inattention - is not as harsh as the situation where the parent figures invest in actual hurtfulness toward the child.

And, finally, there is a critical difference between a parent whose abusiveness toward a child is a by-product of their own out-of-control state, and the parent who manifestly takes a kind of gratification from the act of hurting the child. This last I have heard called “malevolent” abuse; a most apt term.

A schematic representation of this general idea might look like this:



It is important to appreciate that, as we move into the two abusive domains at the bottom, the existential burden for the child shifts from "I must be lacking in worthiness," which characterizes the levels above, to "I must be bad, to deserve this punishment." The person's options then are: 1) to embrace badness; 2) to flee, through various stratagems, from that inner belief in their own badness; or, 3) again, to try to somehow invest in both of these strategies, alternately or even simultaneously. Obviously, all of these paths lead to misfortune.

Obviously as well, any summary diagram/description such as the above will necessarily run roughshod over important details and features, not to mention nuances, of a matter as complex as the psychologies and behaviors of wounded humans.[28] This is to some extent the inevitable cost of brevity. I should, though, elaborate enough to purge our description here of any implication that all parents of borderline individuals are uncaring about, or intentionally hurtful toward, their children. The childhood experience of what I'm describing above as "indifference -- neglect" does not necessarily mean that there was a parent who was indifferent or inattentive in a straightforward behavioral sense. There are various scenarios where a parent, while feeling greatly, and perhaps even urgently, invested in caring for a child, is profoundly distracted by their own addictive plight, and/or their codependent entanglement with another addict. When this is the case, the child will register, as noted earlier, that, though there may be a lot of attention coming toward them, too often there may as well be "nobody home," because that attention is considerably informed by the parent's own narcissistic, guilt-ridden rendering of the situation, and lacking authentic and sensitive recognition of who the child really is; what their needs actually are. Thus the net experience for the child constitutes a kind of neglect, even in the midst of what may appear to be a deluge of attention.

Similarly, when such attentions are focused on disciplining the child and creating structure, again, absent an ability to really "get it" about who the child is, and what they need - that is, lacking the quality of appropriateness - these measures can readily be experienced by the child as oppressive and abusive. And, indeed, there is a fairness to this perception. "Abuse" essentially means to use someone or something in a way which is: a) - on behalf of the user rather than the one being used, and b) - working to the disadvantage of the one being used. My short-hand characterization of abuse is to call it *degenerative use* -- a utilization of something/ someone which detracts from, rather than contributing to, the well-being and integrity of those who are party to the "transaction." This can, and often does, happen in situations where the "abusers" imagine themselves, in all earnestness, to be acting on behalf of the best interests of the person they are, in fact, using.

Scales of Severity

And lastly in this regard: it is time to again revisit the idea of addictive phenomena manifesting to greater and lesser degrees (p. 7 above). The idea is not that the parents of individuals who end up with the borderline diagnosis are in all cases utterly devoid of the ability to perceive and respond to the real persons and needs of their children, but that there is a continuum of deficiency. This continuum ranges from the Kafkaesque to the commonplace, depending on the degree to

[28] One such detail that deserves mention, at the least, has to do with the propensity of abused children to "rescue" the abusing parents by reinterpreting the abusive behavior as acceptable, and even necessary. Not surprisingly, then, as they mature into adulthood, the prospects are great that they will reiterate some version of that behavior in the conduct of their own relationships.

which parents can intersperse, as it were, authentic regard into the mix; can rise out of their narcissistic preoccupations to realize the presence of an actual "other" person there, in the form of their child, and formulate responses and interventions having a significant degree of appropriateness. (Of course, the incongruity between these occurrences and the more disabled modes of parenting presents the child with yet another level of disjunctive experience to sort through, but one is, ultimately, better off with some love, than with no love; with some experiences of being authentically recognized, than with none.) Thus, the child of these parents is at risk of becoming BPD *to the extent that* the inauthentic and/or oppressive modes of relating are prevalent in the history of the relationship.

Flowing from this, then, it should not be surprising to observe that there is a continuum of severity in the manifestation of the borderline plight itself -- ranging from dilemmas so comprehensively disabling that the person spends the bulk of their life unproductively cycling among institutions and care-givers, to other instances where the person is able to operate in the world with conspicuous degrees of professional success.

Borderlines, Addiction, and Substance Use/Abuse

One last area regarding the borderline syndrome itself, before we move on to the subject of undertaking healing work with this population: given the etiological sketch I've offered, wherein the individual experiences an intensified version of the "I'm not okay, and the world I live in is untrustworthy" adult child cosmology, it makes all the sense in the world that such a person would be particularly susceptible to addictive involvement. That is, the viewpoint of this paper is that the phenomena of addiction emerge from and revolve around discovering the ability to transform the experience of self. Since the borderline experience of self is so acutely and unresolvably charged, small wonder that this population is markedly prone to addictive entanglements (see diagnostic sketches, above). Thus one could readily conclude that the propensity for drug and alcohol abuse listed among the symptoms of the borderline condition means that, wherever there are such patterns of involvement with mood altering substances, these individuals are addictively involved with the substances.

In fact, it is not quite that neat. Although it is true that a high percentage of borderlines are abusively involved with drugs/alcohol - and that a high percentage of borderlines suffer from addictive entanglement[29] - the abusive relationship with drugs/alcohol does not necessarily constitute addiction. It may; the individual may indeed find that their use of these chemicals provides them with an existential remedy, and thus end up addictively involved. However, it is also commonplace for borderlines to use alcohol/drugs to self-medicate, without necessarily experiencing the kind of existential shift that would qualify them for addiction through that particular technology. Further, self-medication is only one of a number of possible uses the borderline might make of mood altering substances, which could lead to abusive involvement, but not necessarily addiction. One such use, which is attractive for many individuals, but singularly enticing for borderlines, is the fact that using such chemicals allows them to *control the experience of being out of control.* This is, of course, truly the borderlines ideal, in that they are thus able to access that signature goal described earlier: the ability to be both in and out of control simultaneously.

[29] By my way of understanding borderlines, 100% -- appreciating that the adult child dilemma is an addictive plight in its own right.

BPD, DBT, AA, and T'ai Chi

You may recall that the introductory descriptions of the Borderline Personality Disorder described the prognosis for recovery as "poor." Up until the early part of the last decade this was, overwhelmingly, the prevailing psychiatric wisdom regarding BPD -- compounded by a widespread sense that borderlines were, in effect, the "clients from hell," typically described by clinicians, and the literature, as "non-compliant," "resistant," "manipulative," "triangulating," "gamey," etc. Then, in the early 1990s Marsha Linehan developed a mode of therapy explicitly tailored to the borderline plight, called Dialectical Behavioural Therapy (DBT). This approach has yielded impressive results, offering hope for a population where little was thought to exist previously. We'll take a look at this modality, and relate it to the idea of BPD as a kind of exorbitant Adult Child plight at the end of this section, but first I want to describe some exceptions to the generally desolate picture regarding BPD prior even to the inception of DBT.

In the decade or so before DBT was developed I was part of a small cadre of clinicians who were, in general, less stressed about working with borderline clients than most of our co-workers, and more optimistic about their prospects for improvement. At the time I understood that difference in perspective - correctly, I believe - as a function of my intimate familiarity with, and access to, the fellowship and program of AA -- about which, more below. But I have come to appreciate that there was, for me personally, another factor which figured in my encounters with borderline clients in ways which worked to our mutual advantage, the roots of which went back to a time years earlier, shortly before I became professionally involved in clinical work.

At that time, as part of my involvement with an experimental theater troupe in Hartford, CT, I sat on the floor of a loft, watching with a kind of reverential awe as a young man silently moved through the formal, graceful patterns of his T'ai Chi Ch'üan practice, in a manner which married elegance and humility so perfectly that I was won over instantly. That initial exposure, my subsequent occasional personal ventures into the practice, talks with students and teachers more disciplined than myself, and readings on the subject, have left me richly impressed with, and informed by, the spirit and philosophy of this ancient system for promoting physical, emotional, psychological and spiritual well-being. Probably the area where this influence has manifested most generously has been with respect to my work as a psychotherapist. I have long felt that the principles embodied in T'ai Chi represent quintessential guidelines for the conduct of therapy. And there is a particular exercise practiced by T'ai Chi students called Push Hands which, for me, most keenly exemplifies the ideal therapeutic relationship. To quote from an (unattributed) online text:[30]

> Practicing the T'ai Chi solo form teaches one to remain balanced, focused and relaxed while in motion. However, only through the practice of T'ai Chi Push Hands does one improve these abilities while in physical contact with another human being. *To be balanced and relaxed while in contact with another person who is moving is a difficult task..* (emph. added)

[30] Patience T'ai Chi Association - http://www.patiencetaichi.com/push_hands.htm

Without undertaking to describe the physical elements of Push Hands exercises - of which there are several versions - the philosophical foundations and fruits of this practice are poignantly evoked in these excerpts from a classical essay on Push Hands by Xiang Kairen:

> "People who practice push-hands live according to the principle of 'neither let go nor resist'." Not letting go means not quitting the opponent's hand.[31] Not resisting means not opposing him.
>
> Adhering motions belong to the category of "not letting go". Following and joining motions belong to the category of "not resisting". That is to say, when the opponent advances, I follow and join his motion. And if he retreats I adhere to him.
>
> Whether adhering or moving away, you must be searching for, listening to the opponent's energy at each step of the way (whether the opponent moves an inch or a foot). You must not disregard any part of your interaction.
>
> Master Xu . . . . paid special attention to "central equilibrium" as the mother of the Thirteen Postures. All postures issue from "central equilibrium." He also paid attention to five words mentioned in the boxing manuals: "perseverance, diligence, daring, energy and appropriateness". He said that "appropriateness" was the most important.
>
> . . . . sometimes I would get aggravated by Master Liu's attack and use external boxing methods to strike. He would immediately stop pushing and say, "Push-hands . . . . is not fighting. Your mind must not be struggling with the thoughts of winning or losing."
>
> "Lure the opponent's advance into emptiness; harmonize with him, then issue power. Adhere, join, stick to and follow the opponent, without letting go or resisting."

While I believe that these principals can be applied to great advantage in any therapeutic setting (and a great many other life situations, for that matter), I've observed them to be acutely relevant to interactions with people struggling within the borderline dilemma. We have defined the borderline individual, after all, as someone who feels that they need to be simultaneously connected, and unconnected; simultaneously in control, and out of control. The manner of relating depicted above, then, is exquisitely fitting. When the client pulls away, I neither insist (futilely) that they stay -- not do I abandon them; when the client is pushy, insistent and demanding, I decline to either capitulate to or contest with them, while still maintaining my equilibrium, and remaining available for our relationship.[32]

[31] In these quotes, the term "opponent" refers not to an adversary in an antagonistic sense, but rather to one with whom you mutually contend, to promote enhanced skills and understanding for both parties. Those familiar with the notion of a "worthy opponent" from the writings of Carlos Castaneda will likely see a ready application of that concept in the therapist/client relationship dealing with BPD individuals -- with the sense of "worthy opponent" being thoroughly mutual and reciprocal.

[32] Clearly, these are ideals. My best work is imperfect -- and of course, I am not always at my best.

All this being true, it is important to appreciate that this approach, this perspective, does not constitute or advocate passivity. Note the phrase in the last excerpt above -- *"Lure the opponent's advance into emptiness; harmonize with him, then issue power."* The implication here is that, once you have achieved the desired harmonious relationship, and "lured" your client into a state of "emptiness" (that is, a situation which is outside of the whole "control" frame of reference), you can assert your power effectively, and in ways which are congruent with the idea that this is not a "win or lose" contest, but are, rather, in pursuit of goals involving mutual respect and life-enhancement.

Push Hands Anonymous

Remember this quote from the Prognosis section of the BPD descriptions:

> Borderline personality disorder has a poor prognosis . . . as noncompliance with treatment is common. However, people with this disorder who make it through their 30's and maintain sobriety, may begin to improve.

One can directly infer from this commentary that those borderlines who successfully invest in sobriety experience more success in extricating themselves from the most disabling features of their borderline plight, compared to those who don't. I would infer as well that the majority of those more fortunate individuals have participated actively in twelve-step recovery groups -- AA, and/or groups modeled after that fellowship. The entirety of my agency-based career, from the late '70s through the late '80s, predated the development of DBT. During those years I noted, as mentioned above, that I, and those of my colleagues with intimate twelve-step familiarity, seemed to find the task of dealing with borderlines much less daunting than did other clinicians; and as well, that we observed progress toward a generalized recovery, albeit slowly and spasmodically, for those borderlines who succeeded in establishing and maintaining involvement in the twelve-step milieu. (By "generalized recovery" I mean improvement across the spectrum of well-being; not merely abstinence from abusive/ addictive entanglements.)

There were - and are - I believe, several reasons for this. For one thing, addicts in early stages of sobriety tend, categorically, to resemble borderlines,[33] so the "official" borderlines are able to feel more at home in AA,[34] and less like the exceptional, freakish outsider. Further, and more fundamentally; the principles of healing that inform the sobriety process in AA are ideally suited to the needs of the borderline population. Of course, this is hardly surprising, if we are viewing the borderline plight as being an extreme instance of the adult child dilemma, and then recall that, in the perspective advanced in this paper, the adult child dilemma is itself an addictive plight; indeed, the "purest" of the three modes of addiction (p. 2 above). The central principles of AA have proven themselves profoundly relevant in facilitating the resolution of addiction in any of its forms, so if we define the borderline plight as being the most extreme manifestation of the purest of these dilemmas -- small wonder that the twelve-step principles prove to be singularly relevant and efficacious.

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[33] This remarkable assertion certainly deserves further comment and elaboration – which is, I'm afraid, beyond the scope of this paper. Those familiar with the trajectory of the sobriety journey will probably intuitively recognize the aptness of the observation, however.

[34] Where I say "AA" during these remarks understand that I mean "AA and the other twelve-step fellowships."

Because the borderline is so much at the mercy of contradictory imperatives regarding their immediate, day-to-day experiences of relationship and self, transformative address of these dimensions of experience - relationship, and self - are most urgently required for the BPD individual to begin to heal. And it is here that the almost uncanny fittingness of AA comes into play, for, to put it fancifully, *the ecology of the twelve-step community replicates the Push Hands exercise.* In order for this last remark to make sense, we need to try to grasp something of the essence of AA -- which is no small challenge since, as Bill Wilson put it, AA is "*. . . an utter simplicity which encases a complete mystery.*"[35] We cannot fully reveal the simplicity nor unravel the mystery in this paper -- but we can evoke something of each of these by describing two essential features of this fellowship.

The first of these is that *there is no such thing as AA!* If, for example, one wished to sue AA, and set out to track down AA as a legal, corporate entity, they would find themselves utterly thwarted; grasping for a thing that is inapprehendable. Of course, this cuts both ways. Suppose you and I, dear reader, decided that we were going to sponsor a new AA meeting, and we took out a full-page advertisement in the local paper, stating time, place and format of the meeting, then concluding with this promotional punch line: *FREE BEER!* There is nothing that "AA" could do about this, because there is no identifiable "AA" to challenge or contradict us in our choosing to represent our extraordinary gathering as an AA meeting.[36] The historical origins of this feature of the fellowship are summed up in this quote, again, by Bill Wilson: "[In the early days, we felt that AA should have] the least possible organization. In the years since then, we have changed our minds about that. Today we are able to say with assurance that Alcoholics Anonymous - AA as a whole - should never be organized at all."[37] Since there is no such legal entity, there is no foundation for any hierarchy or chain of authority which can enforce rules of conduct, or - most critically - establish terms of membership in the fellowship. Once more, quoting Bill Wilson on the subject, "You are an AA member if you say so. No matter what you have done, or still will do, you are an AA member as long as *you* say so." (Emph. in the original.)[38]

The second essential point regarding AA that makes it such an ideal ecology for borderline individuals is the fact that *only losers need apply.* I put this provocatively, but not at all contrary to the spirit of AA, whose members often give their local groups names like "Here Because We're Not All There," "Mixed Nuts," or "Haven't Got a Clue Group."[39] Now, I don't mean that I believe that alcoholics and/or borderlines are in fact losers; but I do know that, by the time they're ripe for AA, that's how they feel about themselves. Lost -- crazy -- stupid -- desperate. "Powerless . . . lives unmanageable . . ."[40] Losers.

Without trying to analyze it in detail here, I will simply report that there is, in the twelve-step program and fellowship, an alchemy whereby this catastrophic sense of humiliation transforms

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[35] Bill Wilson and Dr. Bob Smith were the two co-founders of AA; of the two, Bill was more given to conceptualize about AA, and was the principal author of much of the original AA literature. He is quoted here writing to an AA member, in 1943.

[36] Needless to say, there would be innumerable AA members who would be most displeased with our actions – but they would have no legal standing other than as individuals.

[37] *Alcoholics Anonymous Comes of Age* - p 118

[38] ibid. - p 103

[39] Real group names -- honest.

[40] Key words excerpted from the first of the twelve steps.

into humility; that this humility in turn breeds authenticity, where before there was prideful posturing and defensiveness -- or despair. *Humility* and *authenticity*. While these qualities are urgently appropriate for borderline individuals, they are also likely to be quite unsettling, especially at first encounter. This could make the the AA venue intolerable for borderlines, were it not for these features of the fellowship:

1) *"Not Resisting" and "Not Letting Go" are built into the non-organization of AA:* The milieu is like the molecules in air, which don't constrain your freedom of motion, but nonetheless surround you at all times. You can push AA members away - stalk out of a meeting in a rage - and there will be other members and other meetings available to you. Or the same ones will welcome you back. And you can do this as often as you need to, as long as you need to. You might burn out some folks, but there will always be others.

2) *There are models, but no intrinsic hierarchy:* Although no one is in a formal position of authority, guidance abounds; rather than there being bosses and cops, there are exemplars -- of more and less successful strivings for integrity and authenticity.

3) *Everyone is there to learn; to heal:* The notion is very strong within AA that sobriety is an ongoing path one treads, rather than a destination one gloriously achieves.

This is not to suggest for a moment that there are no problems involved for borderlines trying to use the twelve-step resources: Because AA *is* so much like Push Hands - allows so much latitude for individual behavior and interpretation - a person can easily construe their experience within the fellowship in ways that end up feeling as though there *are* bosses and cops, rules and requirements -- even though objectively this is not true. And, there will almost always be others - who may or may not be borderlines - who are willing, or even eager, to join in the drama provided by that kind of unfortunate reframing. In this, and other regards, a professional helper who is knowledgeable about the twelve-step ecology is an invaluable ally for those striving to negotiate their way within this unfamiliar and emotionally charged terrain.

Humility; Accountability; Humanity

And, speaking of professionals -- before closing it is important to acknowledge the presence of a critical new voice and methodology in the mental health field; that of Dialectical Behavioural Therapy (DBT), mentioned above (p. 12). Remarkably and admirably, Marsha Linehan, the originator of DBT, has crafted a clinical approach which in many respects incorporates the qualities of Push Hands described above, within a treatment modality which is both rigorous and flexible, imbued with both daring and humility. And, unlike AA, which, because of its resolute renunciation of formal organization, is not susceptible to empirical scrutiny except through indirect and inferential means, DBT lends itself to - and methodically initiates - clinical trials to establish and enhance its efficacy.

Like AA, however, DBT represents a systematic set of principles regarding how people will interact with one another, tailored to ameliorate a specific life-difficulty. In the case of AA, the difficulty is alcoholism; for DBT, it is the borderline disorder. But, in both cases, the principles prove themselves to be applicable to populations much broader than the narrow group for which they were originally intended. I will close this paper with some thoughts about why this correspondence exists, but first, without attempting to describe DBT in any detail here, I'll note the following features which closely parallel the "AA/Push Hands" epistemology:

1) The healing work is founded on the paradoxical proposition that both *acceptance* and *transformation* be, not merely reconciled, but jointly and harmoniously incorporated within the life process.
2) It is understood that all participants - therapists as well as clients - will be participants in DBT group processes, on behalf of their mutual and reciprocal advantage.
3) The idea that therapists are imperfect, and will make mistakes, is taken for granted(!) -- as is the idea that therapists have their own needs and interests, and that the therapeutic process needs to honor and accommodate these, as well as the needs and interests of the clients.

In brief, the formula which informs DBT work might be summed up in the same four-word prescription which, in my understanding, informs the journey of sobriety in the twelve-step fellowships; *surrender control; accept responsibility* -- with the understanding that this precept applies to all participants in the process.

And who else might find themselves well advised to follow this prescription?

Earlier I shared my appreciation of the idea that "addicts are like everybody else -- only more so." If that is the case, then we might say that "borderline individuals are like everybody else -- only *very much* more so." It is often the case that, if we stare long and bravely enough into the heart of aberrant behavior, we find -- ourselves staring back at us! We find that we're looking at the human mind, heart and soul grappling with those issues which are both blessings and curses, gifts and burdens, for all of us. It is a motif as old as all our traditions of literature and philosophy that we will seek for and "discover" the magic spell; Alladin's lamp; the Ring of Power; some instrument or method of control which will allow us to achieve our heart's desire -- only to find that the exercise of this power ends up, after many adventures and misadventures, taking us further from our heart's desire than we ever imagined possible, helpless, distraught and estranged in some dreadful and desolate landscape.

This is the story of the addict. This is the story of the person struggling with that extreme addictive dilemma called Borderline Personality Disorder. This is, as well, the story of *Homo sapiens*. It makes all the sense in the world that we prefer to identify the addicts, the borderlines, as anomalous unfortunates, outside of our personal frame of reference or field of experience. Who, after all, would want to identify with such states of turmoil, gracelessness, and degradation? *That* would be painful! But in this matter we are well advised by a vertiginous but clarifying notion of R.D. Laing's:

Pain is inevitable.
The only pain we can avoid
is the pain of trying
to avoid pain.

If we are prepared to search deeply, somewhere in the heart of the addict's dilemma we are likely to discover ourselves. While this is almost guaranteed to be, at the least, uncomfortable, tolerating this discomfort qualifies us to begin practicing, if we will, that remedy which brings release from bondage for the addict, and, gradually, realization of the enormous potential in their life - and in ours - for meaning, grace, and fulfillment.

And that remedy? Again . . .

Surrender control -- accept responsibility.

Postscript

In November of 1994, less than two months before he died while experimenting with heroin, a young man wrote these words:

When you're lost you don't need somebody to find you,
you need somebody to be lost with you.[41]

Whether we are talking about those with whom we work, and try to help, or those with whom we live, and try to love, it is in the moment that we embrace our mutual humanity - our mutual lostness - that we qualify ourselves for the possibility of being found -- together.

[41] From "The Gulf Between Us," in *Even On the Wind, Selected Poems* by Ozzy Klate (age 17).

Appendix 3

The Promises

This excerpt from the "Big Book" of AA characterizes the rewards of sobriety thusly:

> We are going to know a new freedom and a new happiness.. We will not regret the past nor wish to shut the door on it. We will comprehend the word serenity and we will know peace. No matter how far down the scale we have gone, we will see how our experience can benefit others. That feeling of uselessness and self-pity will disappear. We will lose interest in selfish things and gain interest in our fellows. Self-seeking will slip away. Our whole attitude and outlook on life will change. Fear of people and of economic insecurity will leave us. We will intuitively know how to handle situations which used to baffle us.

Who among our clients would not be brilliantly served by such a transformation – or, more realistically, by making significant progress along those lines? Who among *us* would not be so served?

Appendix 4

Codependence

The term "codependent" was originally brought into the language of addiction as families of alcoholics were studied. It was observed that very often members of families containing active alcoholics could be seen to organize their behaviour dramatically around alcohol, even though they themselves were not alcoholics -- and frequently not drinkers at all. The idea put forth at that time was to the effect that, even though these other family members were not primary consumers of alcohol, they were nevertheless substantially dependent on it for certain emotional and psychological functions, so the term "codependent" was invented to refer to these individuals. This idea, although the product of insightful observation, has gradually been replaced by the more comprehensive concept of addiction to relationships. Thus what is being observed in these families are instances of people dependent not on alcohol per se, but on alcoholics. Over the last two decades this dependency has come to be recognized as a major addiction in its own right.

Now, if people addicted to work are called "workaholics," then someone addicted to alcoholics could be called an "alcoholicaholic." Compared to that linguistic abomination, we are much better off having retained the term "codependent," even though its original meaning has been abandoned, and the population to which it refers is no longer limited to members of families with chemical dependencies.

And, there is, coincidentally, a sense in which the word works very well, and that is that codependents in their active addiction generally require other codependents in order to sustain their "fix," because non-codependents[42] will draw away from the relationship, as the codependent dynamic - the neediness - becomes apparent to them. Thus codependency in its active manifestation tends to involve two or more codependents, who are mutually and reciprocally dependent -- hence co-dependency. The term itself in this paper refers to:

> *the state of having one's experience of personal viability and adequacy contingent upon being in certain kinds of relationship(s).*

The kinds of relationship will vary, sometimes radically, from one person to another. However, the experience of codependency will always fit within the following sentence:

"Unless I am in a _________ kind of relationship with _________ kind of person or persons, I feel less viable and adequate."

[42] Separating people into "codependents" and "non-codependents" is somewhat misleading. In fact most people experience some degree of codependency. However, those toward the "non" end of the scale will be unavailable for relationships which have codependency as their primary premise, or bond.

Appendix 5

Notes on Detachment

For starters, what, in the terms of this discussion, is the nature of attachment, that we find ourselves enquiring into the merits of detachment? Imagine the ramifications for two people joined together at the hip by a leather belt through belt loops at the sides of their waists. These folks are palpably attached, and this status qualifies virtually everything they might wish, individually or conjointly, to undertake -- such as, for example, a simple conversation between themselves. They would find, in the attempt to turn to face one another, that they would be brought into such close proximity that bellies and noses would touch, unless they strained away from each other. Such a degree of closeness makes the free flow of conversation impossible. Similar, and even more objectionable, dynamics assert when the attached parties attempt a posture of disregard; in turning away from one another, their backsides are brought into contact. Hard to ignore someone under those circumstances.

Further, should either or both of the two parties desire to do anything other than stand in that one place forever, they must either negotiate an agreed-upon course of action, or one party must coerce the other. And of course this constraint is a constant, so long as the attachment is in place. But let's suppose that, through happy agreement, less sanguine compromise, or simple, ugly coercion, the two individuals have resolved to move to another place. The moment they step forth they will find the goings to be quite awkward -- and will, probably rather quickly, discover that if they extend their adjacent arms around one another, in a casual embrace, the going will instantly become more smooth and coordinated. This is just fine -- so long as the persons involved feel the kind of affection for one another that would merit such a gesture. But, whether they do or not, the pragmatics of their situation will strongly recommend this posture to them.

There are numerous ramifications which can be inferred from the above sketch, serving admirably as metaphor for this discussion, but for the purpose of these notes I will settle for the summary observation that, in this as in other instances of attachment, the connectedness of attachment establishes a kind of proximity and mutual dependency which mitigate against the possibility of intimacy.

To stay with this imagery for a bit, it is well worth noting that either party can detach the belt -- there does not have to be mutual agreement on this matter. But this observation may prompt the question: what is the "belt," in the experiences of attachment that provoke this discussion? Well, on the surface, the belt would seem to consist of feelings we have regarding the other person. But more searching scrutiny reveals that the core feelings at stake are really about ourselves -- that somehow, through the magic of codependency, our experience of ourselves as adequate and viable has become hostage to the outcome of the relationship in question.

So, to the extent that the relationship does not proceed according to our script, or external imperatives we have "bought," we feel that we are "not okay." For those several of us who bring adult child histories to our work in the human services, this experience is intolerable, urging us to try harder and harder to accomplish goals which are . . . . unachievable.

As the frustration mounts, we find ourselves feeling that we need to allocate blame, and there are, in general, three candidates; two being particular, and one general. The two particular candidates for blame are: ourselves, and the client; the more general candidate is "the system" -- the powers that presented us with the unachievable assignment in the first place. Typically, blame is distributed, in varying portions, among all three, contaminating to some extent every aspect of our professional involvement.

* * *

Time to move on from this happy scenario, and establish a couple of important distinctions, the first being to distinguish "attachment" from "joining." Joining is a desirable feature of our clinical work, and is a mode of relating which includes trust, fidelity, integrity, some measure of affection, and respect for a client's emotional space and dignity. It allows for but does not insist on intimacy, and contributes to an enhancement of self-regard for both parties. Compare this characterization with the imagery of attachment developed at the beginning of these notes.

The second distinction is, in pure linguistic terms, arbitrary, and that is to establish "disengagement" as being substantially distinct from "detachment." I have several thesauri which list these two words as synonyms. However, in this discussion I use "disengagement" to refer to the emotional, and if necessary physical, act of separating from the party with whom one is attached. Emotionally, disengagement involves learning how to not care. Sometimes this is done with a certain degree of finesse -- even couched in the language of recovery. Masters of such subtleties have been said to have a "black belt in Alanon" -- a testimony to their ability to selectively (mis)apply the principles and precepts of Alanon to rationalize staying in a dysfunctional situation for years on end. And mental health settings have their percentage of practitioners who have rescued themselves from the anguish of codependent attachment through the expedient of ceasing to care.

A more straightforward, and in general healthier, version of disengagement is the simple - or sometimes not so simple - act of leaving. It is often the case that a person needs to physically disengage in order to even be a candidate for recovery -- to be able to invest in the internal processes which will allow them, over time, to achieve a reasonable degree of detachment. And what are these internal processes? In brief, they involve a redefinition of self, a redefinition of context, and consequently a reconstruing of what is possible and likely in the relationship between self and context. At the heart of the redefinition of self is the recognition of worthiness where previously was experienced unworthiness; in the redefinition of context is the discovery of trustworthiness where there had been experienced untrustworthiness.

As this kind of first-order change proceeds, the experience of self is less susceptible to being taken hostage in codependent attachments; the experience of an adequate and viable self is no longer contingent, but is rather intrinsic. And this transformation, in a seemingly paradoxical manner, facilitates the prospects for intimacy and passionate engagement, whether it be in personal, clinical

or collegial relationships, in a manner reminiscent of the liberty achieved, once the leather belt is untied, to invest in authentic sharing and collaboration. This liberty is the product of being relieved of inappropriate responsibilities; specifically we are relieved of the responsibility of assuring a certain *outcome*, and our mental and emotional energies are thereby released to attend conscientiously to the integrity of our *intent*, and of our *effort*. These areas - intent and effort - are the legitimate - and exclusive - domain of our responsibility.

An interesting side benefit of detachment is that, as we become more centered in detachment - more clear about the purview of our responsibility - we become less susceptible to the efforts of others within the systems we operate in to challenge our viability and adequacy. And this seems to be not so much a function of occupying the "moral high ground" in some adversarial or polemical sense, but some more subtle - and profound - shift in how we find ourselves, and are found, to be positioned in the social "equation." One interesting feature of this shift is that the moment we try to capitalize on it with a manipulative agenda, it ceases to apply, because the integrity of our intent has become compromised; we are back to the old game of trying to dictate outcome. Ah, well . . . as it says in AA's Big Book – we claim

progress,
not
perfection.