CHEMICAL DEPENDENCE AND THE TRANSFORMATION INTO A PERSEPHONE WOMAN

by

SYNDE LYNNE ACKS-STEWART

A clinical case study

submitted in partial fulfillment

of the requirements for the degree of

DOCTOR OF PSYCHOLOGY IN CLINICAL PSYCHOLOGY

MERIDIAN UNIVERSITY

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This clinical case study has been accepted for the faculty of Meridian University by:

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It is thought by many that chemical dependence can develop in response to specific unmet emotional needs, and can be an intergeneration family dysfunction. This Clinical Case Study describes the psychotherapy journey of a young adult woman struggling with chemical dependence. Although attention was largely focused on her drug use, by the end of the six months of psychotherapy, she was well on her way to changing her identity from a lonely, self-conscious girl into an empowered young woman.

The Literature Review chapter includes biological, cognitive-behavioral, psychodynamic, and socio-cultural perspectives on chemical dependence, as well as imaginal approaches to chemical dependence. Key concepts and major principles from these perspectives help identify the ways chemical dependence can be experienced psychologically.

The Progression of the Treatment chapter depicts this woman’s struggle with cocaine dependence and its resolution. This section highlights themes, significant interventions, and turning points during the course of therapy. Imaginal Psychology’s
contributions to treatment interventions helped contain the client’s exploration of her vulnerabilities with acceptance and understanding.

The Learnings chapter addresses the mythic lens through which the client viewed her world and the chemical dependence that she suffered as a result. There were five significant learnings this study can contribute to the field of psychology. The first learning is that chemical dependence is highly correlated with a false self: the mask that problematically entrenches its captives in the pervasive, all-consuming experience of isolation, shame, and alienation. The second is that intoxication is sought for the mystery, magic, beauty, and interpersonal connection inherent in the experience. The third is that chemical dependence is experienced as a form of enslavement rooted in the bastardization of the feminine principle through the mind-body-spirit split. The fourth is that it is problematic to either be codependent, distanced, or adherent to rigid boundaries while treating a patient with chemical dependence. The fifth learning is that after the development of chemical dependence, the remaining benefit of the pattern lies in the transformative potential of sobriety.

The Reflections chapter presents the Demeter and Persephone myth as the backdrop to the client’s life. The client began suffering from a mind-body split early in her youth. Once she managed to process how the implications of this myth played out in her life, she was able to significantly improve her connection to her body, to develop soulful connections, and to minimize cravings for intoxication. Demeter and Persephone is a myth worthy of close attention when working with women who have undergone early trauma in their lives particularly relating to their interpersonal familial relationships.
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## CONTENTS

ABSTRACT ................................................................................................................................................. iv  
ACKNOWLEDGEMENTS ........................................................................................................................... v  
LIST OF ILLUSTRATIONS ..........................................................................................................................  
LIST OF TABLES .........................................................................................................................................  

Chapter  

1. INTRODUCTION ..................................................................................................................................... 1  
   
   Clinical Topic  
   Exploration of The Topic  
   Confidentiality and Ethical Concerns  
   Framework of Treatment  
   Client History and Life Circumstances  
   Progression of Treatment  
   Learnings  
   Personal and Professional Challenges  

2. CLINICAL LITERATURE REVIEW ......................................................................................................... 32  
   
   Biological Perspective on Chemical Dependency  
   Cognitive-Behavioral Perspective on Chemical Dependency  
   Psychodynamic Perspective on Chemical Dependency  
   Sociocultural Perspective on Chemical Dependency  
   Imaginal Approach to Chemical Dependency
Conclusion

3. PROGRESSION OF TREATMENT .................................................................................. 95
   Treatment Planning
   The Story of Treatment
   Legal and Ethical Issues
   Outcomes

4. LEARNINGS .................................................................................................................. 126
   Key Concepts and Principles
   What Happened
   Imaginal Structures
   Primary Myth
   Personal and Professional Development
   Applying an Imaginal Approach to Psychotherapy

5. REFLECTIONS ............................................................................................................. 158
   Personal Development and Transformation
   Impact of the Learnings on My Understanding of the Topic
   Mythic Implications of the Learnings
   Significance of the Learnings
   The Application of Imaginal Psychology to Psychotherapy
   Bridging Imaginal Psychology
   Areas for Future Research

Appendix

1. INFORMED CONSENT ................................................................................................. 180
2. CHERYL’S DIAGNOSES .................................................................................. 182


4. THERAPEUTIC INTERVENTIONS USED DURING PSYCHOTHERAPY ................................................................. 192

5. ALCOHOLICS ANONYMOUS 12 STEPS ........................................................................ 193

6. CHERYL’S ART .................................................................................................. 195

7. TABLES ............................................................................................................. 199

NOTES .................................................................................................................. 229

REFERENCES .................................................................................................... 259
# LIST OF ILLUSTRATIONS

1. Kore Abducted ................................................................................................................. 195
2. Demeter’s Suffering ......................................................................................................... 195
3. Pomegranate Poisoning ................................................................................................. 196
4. Demeter’s Rage .............................................................................................................. 196
3. Persephone, Queen of the Damned .............................................................................. 197
LIST OF TABLES

1. The Story of Chemical Dependence: A Cross Comparison of Theories –
   3 Steps: The Beginning, the Middle, the End ................................................................. 198
2. Sample Reflexivity Scale .................................................................................................. 205
3. Socio-Cultural Facts ........................................................................................................ 207
4. Relapse Warning Signs ................................................................................................... 209
5. Imaginal Structures Related to Chemical Dependence .................................................. 211
6. Prochaska and DiClement’s Stages of Change Model ..................................................... 216
7. Recovery Treatment Plans ............................................................................................... 218
8. Rational Emotive Therapy: Treatment Stages ................................................................. 224
9. Erikson’s Psycho-social Stages and Developmental Challenges ..................................... 226
CHAPTER 1

INTRODUCTION

Clinical Topic

The *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition Text Revision (DSM-IV-TR) dedicates 131 of 804 pages to Substance-Related diagnoses.\(^1\) The implication of the portion of the DSM dedicated to this topic is that substance-related symptoms impact a large percentage of people. As many as 19.9% of individuals ages 18-20 years have reported current psychoactive substance abuse.\(^2\) Each person who abuses psychoactive substances has family, friends, social, and/or professional contacts capable of being impacted by the behaviors associated with drug use. The primary substance related disorders include substance abuse, dependence, intoxication, and withdrawal. These four disorders are diagnosed according to the specific drug or combination of drugs abused, the pattern of use, and the symptoms resulting from use. Based on self-report studies, people abuse substances because they seek increased happiness, energy, acceptance, decreased anxiety, increased pleasure, to get high, and to reduce depression.\(^3\)

Chemical dependence differs from other maladaptive behavior patterns, often called *addictions*, by the biological impact of the intoxicants. The behavior of abusing intoxicants can become habitual. In habituated behaviors, a series of actions is enacted as if an individual is on autopilot, moving without contemplation about consequences or benefits from his or her actions. Once abuse of psychoactive substances is habituated, an
individual’s body adjusts and becomes dependent on the substance, which qualifies the habituation as both chemical dependence and addiction.

The term addiction is a lay term used for habituated behaviors that are resistant to extinction. The term originated from a mythic story about a man named Addictus who was seduced and eventually enslaved because of his response to the object of his attraction. This concept will be elaborated on in the imaginal approaches to chemical dependence section because the meaning behind it provides useful imagery for comprehending the big picture of chemical dependence.

Chemical dependence, defined in detail in Appendix 3, has been problematic for general populations across cultures for thousands of years. The practice of ingesting a psychoactive substance to have an altered experience can be traced to the earliest recorded history. These documents also recorded chemical dependence and associated problems. From ancient times to modern, social trends of psychoactive substance abuse have come and gone. The increase of symptoms amongst today’s youth is a profound concern. It likely impacted the amount of information included in the DSM by the American Psychiatric Association.

Most people are able to ingest psychoactive substances in moderation, but some cannot. Those who cannot use moderately either abstain from use in general or develop substance-related symptoms. By the time substance abuse results in chemical dependence, significant consequences have resulted from maladaptive behaviors. The consequences affect people, their loved ones, and their communities. The substance-related diagnoses, detailed in Appendix 3, each identify unique constellations of symptoms. An individual may have more than one diagnosis. The diagnosis of
polysubstance abuse applies only if an individual uses three or more substances
simultaneously on a regular basis.⁷

Theorists and statisticians alike widely accept the premise that chemical
dependence is problematic in modern industrial society. The societal consequences often
are often associated with paying for services associated with the decay in adaptive
functioning of the person with dependency. Tax payers fund community resources
associated with substance abuse including paying for jail and prison fees, court and legal
costs, community-provided medical services, police salaries, community resources
assisting those with illicit substance abuse problems, the cost of educating individuals
who do not make use of their education, and related unemployment fees. Another societal
consequence is the lack of public safety caused by crimes associated with illicit substance
abuse. The interpersonal consequences for chemical dependence typically involve
emotional turmoil relating to incidents involving rejection, betrayal, personal value
violations, humiliation, abandonment, physical deterioration, untrustworthy and/or
undependable actions, intense verbal altercations, and physical altercations or assaults.

The personal consequences often can be summed up as profound feelings of
shame, guilt, and misery associated with use of the psychoactive substances. This
Clinical Case Study illustrates the personal story of a young woman’s journey through six
months of psychotherapy addressing her chemical dependence. My client’s symbolic
story associated with chemical dependence can assist others by guiding them when it is
used as a backdrop for their stories. The story depicted ways she suffered from loneliness,
unmet emotional needs, and the assumption she would be rejected or abandoned if she
took assertive actions to get what she desired. The story also demonstrated a deeply
profound transformation that resulted in increased insight, increased resilience, honesty, and an expanded capacity to experience life. Individuals who can embrace the transformative potential inherent in chemical dependence can discontinue chemical dependence patterns and develop more fully into their potential.

Chemical dependence has been explored by specialists from various theoretical orientations. Imaginal psychologists recognize the value of each orientation and incorporate the wisdom of each into an integrated conceptualization. The first two orientations described here, biological and cognitive-behavioral, are direct and practical theoretical orientations that address pragmatic cause and effect type patterns that underlie the problematic symptoms. The cognitive-behavioral therapy (CBT) techniques utilize interventions that modify thought patterns that evoke dysfunctional emotional reactions and/or and underlying organic causes. Psycho-dynamic, transpersonal, and imaginal theorists view chemical dependence, as well as other struggles, as symptoms of a deeper systematic problem. Each of these theoretical orientations proposes that the psychological system must be repaired or transformed in order to alleviate maladaptive symptoms.

Biology is an obvious focus for scientific exploration involving the topic of intoxicants. Intoxicants are consumed and they both effect and affect the body in specific ways. The biological perspective provides a concrete understanding about bodily symptoms and deterioration associated with repetitive substance abuse as well as what bodies require to be healthy. Examples of biological interventions used in psychotherapy can include the following action steps: structured schedules, safety plans, social networks for support, development of a balanced nutritional intake plan, stabilizing healthy sleep patterns, use of breathing regulation or other anger management strategies, use of
meditation or other mindfulness practices, medication management, physical education regimens, and reduction of excessively stimulating activities such as watching television shows or movies or playing videogames that produce physical tension. Biological-oriented treatment plan components generally focus on behavior modification.

The cognitive-behavioral perspective provides information about how to actively improve the way an individual responds to stimulation by modifying underlying maladaptive cognitions into adaptive ones. Common maladaptive thoughts associated with chemical dependence generally relate to the following concepts: a high expectation for pleasure associated with substance abuse; attachment to ease of escaping emotional discomfort; a desire to feel ecstatic states; rigid beliefs about acceptance and idealized body images; sexual inhibition and critical thoughts about sexual expressiveness; self-defeating beliefs inhibiting optimal actions; reinforced personal doubts about one’s worth, belonging, personal power, deficits; and core beliefs that the individual is unlovable. Examples of thoughts are, “I need this,” “It hurts too much,” “I can’t take this,” “If I want sex, I’m a whore,” “Nobody loves me,” “I’m alone,” “There’s nothing I can do about it,” “I’m too fat,” “I’m stupid,” “I want them to like me,” and so forth.

CBT theorists detected the danger of the combination of self-devaluing cognitions and dependence upon the ease and relief intoxication can temporarily bring from stressors. This combination has the potential to create an accelerated deterioration because people with chemical dependence often increasingly avoid stressors and use intoxicants to assist with distancing themselves from painful emotions. Typical incidents like being cut off in traffic, being teased, or unsuccessful negotiating a task may inspire an individual with chemical dependence to want to alter his or her emotional state with
intoxicants. Psychotherapists and researchers have found that cognitive scripts are capable of being altered through the discipline of learning scripts that promote self-respect, compassion, discipline, limits, and self-acceptance. When an individual changes his or her cognitions about an incident, the emotional response to the incident also changes. For example, when someone cuts in front of a person on the freeway, having the thought “Oh, they are in a hurry” evokes a very different emotional response than “That arrogant jerk almost hit me!”

Psychodynamic specialists attribute chemical dependence to inadequately satiated dependence needs; failure to adequately negotiate stages of development; the development of a false self; and failure to manage internal personality structures in a balanced, effective way. A healthy self-identity accurately represents who that person is at his or her core and is inclusive of both positive and challenging traits. When a healthy identity is not created, which is often the case in people with chemical dependence, the psychological system performs with various maladaptive, compensatory functions. For example, imagine a vehicle’s engine with deteriorated spark plugs. Depending on the level of deterioration, the car may run but more gas will be required to cause the pistons to move. Like in a car with faulty spark plugs, an individual’s psyche that functions in an imbalanced way will have compensations resulting in systematic fragility. The fragility may result in unconsciously used defense mechanisms like leaking, avoiding, and/or exploding the person’s inappropriately oppressed, suppressed, and expressed desires. The imbalance often is experienced as emotional overwhelm, low frustration tolerance, and a yearning for the relief created by venting the repressed tensions or desires. The foundations of psychodynamic treatment approaches are based in the creation of a
relationship with the client where the client is able to have reparative experiences, thus enabling the client to progress through development stages he or she had previously not negotiated.

The socio-cultural perspective of chemical dependence acknowledges the cultural trends that impact and are impacted upon by social expectations. Incidence of chemical dependence, as well as the amount and frequency of use, has become increasingly similar in industrialized nations. Chemical abuse patterns in a society or culture are the patterns associated with incidence rates, and they include how much of the intoxicant is typically ingested, the frequency of use, and the public opinion about chemical dependence. Various diagnoses have different incidence rates in different cultures. Family patterns, twin studies, and community play key roles in determining the perception of drugs as well as their availability. An individual’s experience of chemical dependence can vary based on the lens of his or her demographic compilation. The treatment individuals receive from others is largely based on specific social pressures and/or expectations based on their culture, social zeitgeist, gender, familial role, social status, education, community expectations, and spiritual roles. A few examples can illuminate this point. In the early 1800s, few medications were reliable; physicians only documented concern about prescription medication dependence problems in morphine users. Today, there are over 376 controlled prescriptions monitored by the Drug Enforcement Agency. The use of drugs in Vietnam during the Vietnam War by American servicemen was significantly more accepted than the same amount of use by servicemen when they returned home to the US. Teen binge drinking is perceived very differently than binge drinking by people over age 60. Additionally, teen binge drinking is perceived differently by teens who drink
alcohol than it is perceived by chemical treatment specialists, police officers, parents, clergy, and other populations.¹¹

Individual and societal treatment interventions range from verbal confrontations to the death penalty. Therapeutic treatment approaches focus on providing clients with group opportunities to learn how they tend to relate to others, the impact of their actions on others, what their difficulties and strengths are, acceptable social behaviors, accountability, and responsibility. Alcoholics Anonymous or similar groups and residential treatment for chemical dependence are examples of socio-cultural treatment approaches.

Imaginal approaches to chemical dependence can be understood as approaches dedicated to helping individuals learn to accept and respect different aspects of themselves. Theoretical foundations for the imaginal perspective range and include indigenous wisdom and modern concepts recently published. Key concepts, like archetypes, were developed by Carl Jung. Jung developed Sigmund Freud’s theories by including spiritual components and an understanding that healing, or becoming whole, is possible. One imaginal approach used during the sessions explored in this case study was to invite Cheryl to depict the parts of her that discouraged appropriate risk taking, the parts that inspired her to improve, and the way she responded to discouragement and inspiration. Through these depictions, Cheryl developed self-awareness and resilience.

Significant concepts central to the exploration of chemical dependence in this case study include: Timmen Cermak’s physiological explanation of the awe, magic, and stimulation of endocannabinoids; Aaron Beck’s theory of cognitive schemas and automatic thoughts; D. W. Winnicott’s theory of the false self; Sigmund Freud’s theory
of *ego development*; Carl Jung’s concept of *archetypes*; Sylvia Brinton Perera’s depiction of the archetype Celtic Queen Mauve; Linda Leonard’s archetypal aspects of chemical dependence; Sheila Powell’s depiction of female development stages and the archetypal stories within which they are rooted; Erik Erickson’s theory of *identity development*; and many more. This case study offers a general overview of chemical dependence. It also provides specific nuances about one beautiful, passionate young woman’s struggle.

**Exploration of the Topic**

The topic of chemical dependence has held great meaning for me, both personally and professionally. On the personal level, my past use of drugs back in my youth was, even during the time I used, a great source of embarrassment. Professionally, in spite of having worked in the field for seven years, my actual theoretical knowledge on this topic was limited when I began working with Cheryl, largely because I avoided it whenever possible. My own feelings of shame resulted in my being quite resistant to reading and thinking about this area, over the years.

For at least four generations, many members of my family have been intellectual and social leaders. My parents’ and even my grandparents’ strengths were often praised while their weaknesses seemed to be ignored or trivialized. My role models avoided their emotions through distraction techniques like compulsive working, preparing for the future, using intoxicants at home after work, or delving into extracurricular activities. When I felt or expressed emotions that my elders avoided, they often responded with intolerance, impatience, and humiliation. My paternal grandmother taught, “If you keep moving, it (i.e., the pain/the problems/physical ailments) can’t ever catch up to you.” I
thus developed into a emotionally avoidant young woman who did not know how to self-soothe.

My father understood me better than others and I was most like him. I idolized him. Our relationship was either ecstatic or abhorrent. As a youth, I thought my father was a fun, brilliant, successful, driven role-model, who loved being in the zone. By zone, I mean a deeply satisfying sense of competence, confidence, success, and focus. Regardless of the task, successes were celebrated. In other arenas, I rarely had similar all-encompassing, ecstatic times like those I had with Dad. On the other hand, failure was punished with emotional distance, intolerance, impatience, and humiliation. I assumed that any problems in the relationship were my fault because I could see no limitations of my Dad’s.

Early in my adolescence, my parents divorced. I blamed and felt ashamed of both of them for splitting up. When my father made decisions that violated my personal code of ethics, I felt devastated and betrayed. My mother did not defend herself because she wanted to be fair. I felt enraged, impotent, and misrepresented as a female. I perceived mother’s actions as those of a naïve, helpless victim. I lost trust in the belief that males would act with integrity and I felt powerless in my identity as a woman. The loss of my coherent family unit was overwhelming. I hid behind a false self, subserviently attempting to please people I wanted in my life and antagonizing those I feared. Fear and insecurity were overwhelming for me, though very few others knew it.

At first, I sought healing by joining a church congregation. My maternal grandmother, toward whom I did not feel ambivalence, was proud of me and I absorbed her love. My mother approved although my father did not know how to react, likely
because his ancestry was Jewish. Eventually, I rejected the church after a peer’s mother

told me, in the presence of adults who listened to her but did not intervene, that my father

would go to Hell because he was not Christian.

At first, I tried numbing out with television. Shortly thereafter, feelings of

insecurity and self-hatred compelled binging and purging episodes. At 13, I began to

drink. I felt socially savvy, popular, confident, and successful when intoxicated. This was

dramatically different from how defective and worthless I felt the rest of the time. Two

years later, I was introduced to methamphetamines (meth). Once, during a profoundly

ecstatic adventure with a friend while using meth, my suffering was witnessed and

validated. My responses were normalized. The morning after when I experienced the

withdrawal phase of the stimulant, I had a profound sense of satisfaction. While it is

normal to feel agitated, uncomfortable, and overall unpleasant during withdrawal, I

merely suffered from fatigue. In spite of fatigue, I felt whole for the first time I could

remember because I was nourished by emotional and spiritual ecstasy. This experience

was comparable to the ecstatic experiences with my father. My sense of confidence was

renewed. I felt worthy of love and acceptance. The brief experience of relating

authentically with my friend helped remind me that I could be accepted, that I had viable

strengths, and it helped alleviate inappropriate feelings of shame, guilt, and

responsibility.

Between 15 to 19 years of age, I used methamphetamines sporadically.

Methamphetamines gradually lost their allure because the experience felt scripted and

decreasingly satisfying; the ecstasy eventually felt forced and the high lost its beauty. I

came to expect greasy skin and hair; disgust in response to food; the taste of tar dripping
down my throat; exhaustion coinciding with the inability to sleep; racing thoughts; compulsions to pick my skin; anxiety and paranoia; hollow professions of love exchanged between drug buddies; hangovers with relentless dry heaves; and sobering up to realize that yet another fair-weather friend was untrustworthy. There was nothing left for the drug to teach me.

The last time I used methamphetamines, a friend wanted to try the drug with me and I impulsively agreed. I took the drug without thinking about how I felt about my actions. Immediately after taking it, I realized why I had discontinued its use six months earlier after a similar insight about how the cost of use outweighed the benefits. I was furious at myself, wide awake throughout the night, and unable to get the drug out of my body. I was enraged with myself for using a drug that I felt incredible shame about consuming when I knew better; I felt stupid, dirty, and worthless. The entire experience was unpleasant enough to deter any further methamphetamine use. It was not difficult for me to stop using. I felt cravings to use but my perception of the drug was soiled with disgust and rage and the cravings were overshadowed.

As I explored chemical dependence and put my own experience into perspective, several theoretical concepts deeply resonated with me. My former supervisor, Rob Neiss, talked often about the notion that chemical dependence replaces emotional dependency needs. The source of my shame, I realized, was connected to my belief that I was defective and, thus, responsible for being abandoned. Rob’s words resonated, yet there was more to it.

Jalal ad-Din Rumi described my struggle best when he said, “Your task is not to seek for love, but merely to seek and find all the barriers within yourself that you have
When I used drugs, I bypassed my defenses altogether because I was fulfilled by the ecstasy of the drug. Spiritual ecstasy and the visceral sensation of intimacy were what I was sought. Timmen Cermak’s words brought tears to my eyes as he explained the human need for awe, magic, and the physiological sensations that can be evoked by illicit substance abuse. His words transformed my feelings of shame and my desperate need for secrecy about past drug abuse, transcended the taboo associated with illicit drugs, and facilitated an understanding that the soul’s longing is inherently respectable, beautiful, and profound. In this scenario, my shadow, or the unconscious awareness, was my value, my strengths, and my inherent human beauty. Through my personal exploration of the topic, I discovered the inherent value of being alive, patient, joyful, honest, compassionate, and tolerant of my mistakes.

Confidentiality and Ethical Concerns

My client’s confidentiality is protected through the use of a pseudonym throughout this Clinical Case Study. Specific identifying information has been modified to further protect her anonymity. In general, Cheryl’s demographic background and her drug use patterns are average for people with chemical dependence.

In order to acquire formal consent for the case study, a meeting was arranged with Cheryl. She was presented with a prepared, formal letter of consent that outlined the perimeters of confidentiality and how she would be protected if she agreed to be a part of the Clinical Case Study. The letter she was presented, without identifying details, can be viewed in Appendix 1. When we met, I explained to Cheryl that a pseudonym would be used in the Clinical Case Study and that the only place her real name would be was on the
actual signed letter of consent. As we reviewed the information on the letter of consent, Cheryl was encouraged to ask any questions she had. Cheryl said everything was clear and that she felt honored to be a part of this work. A copy of the letter of consent was provided to Cheryl.

The only ambivalence I had about using Cheryl, or any client, for a case study was that I did not want to impose. My own fear of exposure as a teen made it difficult for me to ask someone to reveal personal details. I needed to assure confidentiality for her and for myself in order to feel that this study was done with integrity. My concerns decreased as I discovered that I was capable of writing about my client with dignity, confidentiality, and reverence. My concerns dissipated as I collected information for chapter 2 and I discovered how Cheryl’s pattern of use and demographic fell within the norm for this diagnosis.

Cheryl appeared to have increased confidence during her interactions with me after I requested the use of our work as a backdrop for this study. She stated that being asked indicated that I thought the work done in therapy was worthy. I was concerned that her participation in this study would reduce her perception that she could be cherished without having to reciprocate. On the contrary, Cheryl indicated she felt the request honored her work and reinforced her self-esteem. By being asked, she felt validated at a core level. Retrospectively, I wonder if her willingness to contact me for a follow-up session a year after treatment had to do with her consent. I am curious if her consent helped her be more accountable than she would have been without the impetus of knowing her story would be documented.
During my work with Cheryl, I faced an ethical dilemma that involved Cheryl coming to therapy intoxicated. During the first session, Cheryl talked about intense, intimate details prolifically, which resulted in her feeling overwhelmed. She clearly wanted to continue the process and she simultaneously wanted to reduce the intensity. She opted to have an alcoholic beverage prior to the next session. In general, theorists advise not to provide therapy when a client is intoxicated, although this is not set in stone. Cheryl’s trust that she could her emotions was fragile. My counter-transference responses were feelings of intense protectiveness, frustration, and awkwardness about the newness of our adult-adult/child relationship. Our relationship previously was an adult-child relationship because I was an authority figure in her late adolescence. Our relationship naturally shifted during the course of the psychotherapy sessions described in this case study, which seemed necessary to allow progressed development.

Through the guidance of both Paula Solomon and Avrom Lefkowitz, I assisted Cheryl with tempering her disclosures so they were explored at a digestible pace. The codependent impulses I managed were a desire to control the situation with rigid limits, avoiding the shame of feeling incompetent to help, hiding behind intellectualization, and/or a desire to rationalize or excuse her behavior. These responses were transcended by empowering Cheryl to problem solve the intoxication dilemma. By inviting Cheryl to help problem solve, she was empowered to be responsible for the success or failure of her treatment. Cheryl appreciated that intoxication was a distraction. She also appreciated alternative methods for collaboratively mediating emotional flooding. No other ethical concerns arose during the sessions.
Framework of Treatment

In an outpatient setting, Cheryl received hour-long therapy sessions weekly over the course of six months in 2006 and one follow-up session 13 months later. The sessions occurred within the confines of TLC Child and Family Services, where I was employed as a mental health rehabilitation specialist (MHRS). Cheryl had previously been a client at one of the residential treatment facilities. TLC treatment philosophy is based on the belief that improving connections to self, others, and the larger community can facilitate healing. When clients have been in our care, we honor the role we played in their development and we remain in contact after the clients leave if it is mutually beneficial.

In Cheryl’s case, a trauma she experienced inspired us to provide supplemental psychotherapy. I was authorized to provide services to Cheryl. Approximately 16 months after the incident, Cheryl sought therapy to assist her with grief and the subsequent cocaine dependence she developed in response to the trauma.

During the time Cheryl received the sessions explored in this Clinical Case Study, the clinical director of TLC was Paula Solomon. She provided one hour weekly of individual supervision sessions and two hours of group supervision, and she was typically available in person or by email when difficult situations arose. Paula Solomon is a licensed psychologist. Her clinical theoretical orientation was based on psycho-dynamic theory and involved CBT interventions. Paula’s supervision tended to be pragmatic, clear, supportive, and infused with practical suggestions. She was particularly skilled at explaining therapeutic interactions with theoretical explanations. Her expertise in ambivalent attachment styles was invaluable when my client pulled for intense connection or rigidly guarded against it. The most helpful mentoring Paula provided was
her trust in my ability and her guidance to trust in Cheryl’s. Paula affirmed clinical successes and helped me to see the ones I overlooked.

In addition to the supervision available from Paula, Avrom Lefkowitz provided supervision when Paula was on vacation or was otherwise unavailable. Av is a licensed Marriage Family Therapist and his theoretical orientation was humanistic. At the time, Av had run groups with me for seven years and he was familiar with my clinical approach. Av was familiar with Cheryl because he co-facilitated groups with me when Cheryl was an adolescent client. This allowed him direct insight about her character. He taught me the value of process comments when I felt trapped. Also, he provided guidance about how to negotiate interpersonal boundaries in therapy by balancing freedom and responsibility without abandoning clients.

Cheryl was motivated to utilize the therapeutic interventions and she responded consistently to both the interventions provided and our relationship. She worked hard to reflect on her process and actions. Though she expressed desire and motivation to continue pursuing her goals, she occasionally reverted to past behaviors. These old habits included somaticizing emotional pain; distracting from her internal experience with sexual ideation, intoxication, and starving; and enmeshing with peers for a brief period followed by periods of isolation. Cheryl was not prescribed any psychiatric or non-psychiatric medications during the course of our work together. During the treatment, Cheryl was not interested in seeking psychiatric services.

In addition to addressing Cheryl’s struggle with chemical dependence, efforts were applied to help Cheryl expand her tolerance of interpersonal intimacy and overall intense emotions. One aspect of this goal was to manage temptations to self-sabotage. For
example, when intimacy was too intense within her relationship with her boyfriend, whom she adored, Cheryl would tempt herself to cheat by flirting with people outside of her relationship. Also, when she had the opportunity to get a promotion at work, Cheryl opted not to risk the challenge of accepting in spite of her desire to progress. Cheryl was intellectually strong and occasionally had rigid defenses when she wanted to participate in potentially sabotaging actions.

The theoretical orientations used during individual sessions were an eclectic combination of imaginal, transpersonal, psychodynamic, humanistic, and cognitive-behavioral orientations. Cheryl was encouraged to use her imagination, through an imaginal process, as a means to integrate and amplify the somatic, affective, and cognitive dimensions of her experience. Cheryl tracked specific evocative images throughout her sessions, which were used enhance her capacities and transform her identity. Talk therapy was the primary modality utilized during individual psychotherapy sessions. Treatment methods utilized included desensitization for affect and intimacy phobia and art therapy.

**Client History and Life Circumstances**

Cheryl was a biracial, 20-year-old, heterosexual woman with a high school diploma. She lived in Northern California in an apartment close to her parents’ home. She met all physical and intellectual developmental milestones early (i.e., she walked, talked, and learned to read early). Psychologically, Cheryl had difficulties negotiating components of each of Erikson’s developmental stages. While she had not sufficiently negotiated the stages, she had learned a great deal about each stage and was primed to
progress rapidly once she applied herself to the process.

Cheryl’s developmental struggles were directly related to her identity as a woman. Through the lens of Sheila Powell’s interpretation of Betty de Shong Meador’s female developmental stages, Cheryl successfully negotiated the first two stages of pre-oedipal attachment to her mother and she developed a loving identification with her father. She had not yet completed the final stage of integrating a mature female into her self-identity. She was aligned with her father and dismissive of his shortcomings. She was intolerant of her mother and assumed her mother would fail her.

Cheryl’s axis I diagnoses were posttraumatic stress disorder, cocaine dependence, cannabis abuse, alcohol abuse, opioid abuse, anorexia nervosa: binge eating/purging type in partial remission, and undifferentiated somatoform disorder. Her axis II diagnosis was borderline personality disorder in partial remission. For more details about her diagnoses, see Appendix 2.

Cheryl was a socially gregarious child until the sixth grade, when she deteriorated rapidly. At that time, authority figures reported that Cheryl was verbally aggressive with peers, chronically truant, enacted suicidal ideation, self-harmed, and was hospitalized for attempted suicide. While in the hospital, Cheryl reported that her mother repeatedly physically and emotionally abused her. She also reported that her father hit her with a belt as a form of discipline. These reports resulted in several Child Protective Service (CPS) reports. The reports eventually led to Cheryl being sent to foster care and then to residential treatment.

Aside from the obvious abuse, Cheryl’s family had odd, isolative social customs. Examples of this are how they ate meals in their rooms alone, including holidays, when
they were home. They neglected to socialize with one another unless it was done in the company of extended family or community members. Cheryl described the family’s interactions by saying, “We didn’t socialize altogether unless we were putting on a front to show everybody how perfect our family was.”

Cheryl was in the sixth grade when she was removed from her family after the hospitalization. She was sent to live with foster parents. After briefly returning home, she was placed in residential treatment. While in residential placement, Cheryl revealed that she had been molested by her brother when she was seven years old. Her mother denied the accusation. Both the rape and the denial of the violation were an on-going source of tension and distrust in Cheryl’s family. Cheryl successfully graduated from residential treatment. She made various attachments with house-parents, line staff, educators, peers, and clinical staff. Cheryl was attached with her father although she never developed more than a superficial relationship with her mother.

It is likely that the alienation among family members contributed to the sexual assault. Cheryl’s recollection of the rape included her mother walking in on it and telling Cheryl to clean herself up, and not to let it happen again. When Cheryl told her father about the incident, he asked Cheryl’s brother about the incident. Her brother denied the rape and her father was confused about what to believe. Cheryl was not permitted to return to the house where her brother lived for a few years after the report was eventually filed with CPS.

Cheryl was sent to residential treatment because her parents were concerned about the danger she was to herself; they felt unable to keep her safe. She was sent to live with a foster family. There were several times she could have been reunited with her family.
Her parents did not make accommodations for Cheryl to live with either of them without her brother according to CPS expectations. As a result, Cheryl was removed from her family home for approximately six years. Attempts at reuniting and living in the house with her brother resulted in Cheryl’s deterioration, suicidal ideation, and regression into self-injurious behaviors.

Cheryl had the intellectual capacity to be academically successful but her success was intermittent. She had difficulty concentrating and often struggled to complete work to her satisfaction. During periods when she felt comfortable and accepted by teachers, Cheryl prevailed. During high school, Cheryl had group therapy with me five times per week. She had weekly individual therapy with another clinician at that time. In the beginning of our relationship, Cheryl was 15 years of age and she demonstrated traits typical of an ambivalent attachment style.

Trust was established in our relationship slowly. During one profoundly impactful incident, I apologized to Cheryl for misusing my power while attempting to help her manage her eating disorder. Cheryl was dumbfounded because she did not remember any adult apologizing to her. The apology dramatically changed the nature of our relationship. She stopped vacillating between polarized extremes of pushing me away or seeking excessive time with me. She openly sought support when she was suffering and she was responsive to my observations.

At the time the sessions from this Clinical Case Study took place, Cheryl was in a monogamous relationship with a live-in boyfriend. She worked as a counselor teaching independent living skills. Her parents were involved in her life. She cherished her father and purposefully made time to visit him although she avoided her mother when it was
possible. Cheryl was emotionally estranged from her mother and brother and she
distanced herself from them by choice. Since her parents were married, Cheryl saw her
mother in passing when she visited her father. Cheryl was civil with her mother but did
not initiate discussions. Cheryl had not seen her brother in over a decade. Her mother
repeatedly alienated Cheryl by telling her unwanted updates about her brother despite of
repeated requests stop doing so. This reinforced Cheryl’s resistance to connect with her
mother.

Cheryl remained in contact with me intermittently after she was graduated from
high school. At the time we discussed Cheryl receiving psychotherapy from me, she
shared that she smoked cigarettes and marijuana. She admitted that she drank alcohol.
She did not feel that her smoking or drinking were problematic. Cocaine abuse had
caused problems in her life and she was concerned with the possibility she would relapse.
After the sessions from this case study began, it became clear that she was invested in
improvement. The only time she appeared uninterested in progress was after the
discussion about termination began. It is likely that this response was because, in her
words, she liked therapy and did not want it to end.

Her dedication to the work, our extensive history together, and her courage to heal
were the reasons that I selected Cheryl for this Clinical Case Study. I did not anticipate
that her participation would interfere with our therapeutic work. Some anxiety may have
been triggered by this request.
Progression of Treatment

During the first session, Cheryl provided important background information. Regarding drug use, she smoked marijuana nightly, drank alcohol weekly, and was a habitual cigarette smoker. She had begun using cocaine during the winter holidays the prior year and deteriorated within four months. Cheryl had not actively attempted to get cocaine. A friend offered it at a party and she took it. During her first use, she was authentic for the first time in her adult life without hiding behind rigid psychological defenses. She connected with others as she yearned to do without inhibiting, debilitating fear. Cheryl’s cocaine abuse resulted in a quick deterioration, as is typical of stimulant dependence. By that time, Cheryl’s boyfriend was pressuring her to stop using cocaine. She stopped using cocaine four months after she first tried it and two months before beginning psychotherapy. She quit without professional assistance. She endured withdrawal symptoms, like intense cravings and anxiety, which caused her to worry about relapsing.18

In the beginning of the psychotherapy sessions, Cheryl was socially reclusive despite profound longing for emotional connections. Our initial exploration led Cheryl to become aware of lures that compelled her to use cocaine. When she was intoxicated, she felt socially competent and warmly received. Awkwardness and expectations of rejection dissolved, leaving Cheryl unguarded, playful, resilient, and able to be nourished by social interactions. Also, cocaine reduced her physical hunger and allowed her to maintain the low weight she longed for. The control she felt about eating, and controlling her body shape, provided her with a tremendous sense of confidence.
Throughout my work with Cheryl, I often utilized aspects of Meridian’s approach to transformative learning known as the Imaginal Process. This approach was developed throughout the history of Meridian University by Aftab Omer. Omer emphasizes the notion that we are “multi-selved,” which is referred to as multiplicity. Further, the selves or subjectivities need to be brought to awareness and expressed. There are some generalizations that can be made about specific selves or “subjectivities.” The subjectivity that I particularly utilized was called the Gatekeeper. Omer defines gatekeeping as follows:

Gatekeeping refers to the individual and collective dynamics that resist and restrict experience. The term Gatekeeper refers to the personification of these dynamics. Cultural Gatekeepers restrict experience; cultural leaders catalyze the deepening and diversification of experience.

In essence, Cheryl’s obsession with cocaine was largely due to its ability to quiet her Gatekeeper. Her painfully coercive Gatekeeper inaccurately indicated that she was worthless, unlovable, unworthy, stupid, and defective any time she fell short of her image of perfection. It was so relentless that she agonized about any potential risk she entertained, and most powerfully about interpersonal connections. She expected others to reject and criticize her and she believed she did not know how to self-soothe or take care of herself if they did.

The Gatekeeper used low-level humiliation and fear in its attempt to deter Cheryl from making a mistake. She experienced a taste of what the Gatekeeper predicted she would encounter if she crossed the line. Gatekeepers ineffectively attempt to serve the larger function of protection. They patrol thresholds surrounding fragile aspects of the psyche. The Gatekeeper’s protection goal is to prevent specific, overwhelming experiences. It controlled Cheryl with emotional weapons: fear of rejection, fear of
abandonment, and threats of humiliation. While she longed for intimacy, the Gatekeeper’s threat was compelling enough to deter her from risking enough emotional connection to get her dependency needs met.

Cheryl did not know how to get her needs met, be authentic, respect herself, and let others see her while she was sober. She knew it was possible. Inside this kernel of hope, the therapeutic task of strengthening the subjectivity known as the Friend began. Omer explained, “The Friend refers to those deep potentials of the soul which guide us to act with passionate objectivity and encourage us to align with the creative will of the cosmos.” Cheryl was invited to honor the deeper goals of the Gatekeeper (i.e., to keep her safe). In that vein, she was assisted with identifying what she longed for, acknowledging the message of the Gatekeeper, and determining if the Gatekeeper’s message facilitated the manifestation of her goals. A great many of the psychotherapy sessions were dedicated to challenging inaccurate self-perceptions. She challenged these perceptions outside of therapy by taking social risks and tracking how others responded to her.

It is significant to acknowledge that the Gatekeeper was honored. While often the Gatekeeper can be a terrifying internal force, honoring its intention allowed Cheryl to explore her internal experiences with curiosity. She was discouraged from defending the Gatekeeper or other dark impulses. She was overtly educated about the mature notion that repressed, dark impulses do more damage than conscious, intense images.

As she began to recognize the degree of dishonesty, distortion, and overall inaccuracy of the Gatekeeper’s assertions, Cheryl strengthened her connection with the Friend and she developed capacities. Omer describes a capacity as “a distinct dimension
of human development and human evolution that delineates a specific potential for responding to a domain of life experience (e.g., Compassion responds to Suffering; Courage responds to Danger; Destinicity responds to the Future; Dignity responds to Failure; Fierceness responds to Injustice; Faith responds to Uncertainty; Reflexivity responds to Personal Identity, and so on).”

The capacity of reflexivity was focused upon to help her improve her reality testing. Reflexivity, according to Omer, is “the capacity to engage and be aware of those imaginal structures that shape and constitute our experience.” Cheryl practiced being reflexive as she became increasingly involved in social activities. Discovering how much others enjoyed her company allowed her to increase her social activities.

As she became increasingly involved in the various circles, Cheryl shifted her perspective. She stopped wondering if she was good enough to be accepted by others. She started to question whether the relationships she sought were soulful. She noticed where she was tempted to have intense experiences while she avoided depth connections.

Other interventions used during the psychotherapy journey were the use of humor, clarification during catharsis, the use of metaphors, and the use of distancing techniques such as conscious projection of a problem. Cheryl became better able to track her physical, emotional, intellectual, and spiritual interactions with others. By the time therapy came to a close, Cheryl was adaptively reflexive.

Cheryl’s newfound reflexivity allowed her to identify low-level pain or frustrations. Awareness about her suffering helped her prevent natural exacerbation of symptoms caused by ignoring the problems. At first, Cheryl struggled with allowing herself to tend to low-level frustrations because she thought it was pitiful that she felt so
sensitive. At that time, she had frequent complaints of physical pain that ranged from headaches to menses pain. Her pain appeared exacerbated, or exaggerated, as though she needed to assure herself it was a legitimate reason to receive care. She responded to her pain with illegally attained pain killers functioning simultaneously as intoxicants. She became more resilient and had fewer physical ailments. By the end of treatment, she was periodically ill and still had one intense physical problem, but did not over-medicate.

Regarding the chemical dependence, Cheryl stayed away from social circles in which she thought people would have stimulants for three and a half months. Then, she relapsed twice within two weeks. Based on self-report, she did not use stimulants again during the next 15 months. At the beginning of therapy, she used marijuana nightly and drank periodically. She did not intend to discontinue the use of either substance although she decreased them without intention. Toward the end of therapy, Cheryl reduced her marijuana and alcohol intake. Her cigarette use was fairly constant although we did not discuss her pattern of use in detail.

I believe that Cheryl benefited from our therapeutic work because she increased the ability to trust others, she learned to trust herself, and she developed healthy habits for satisfying her dependency needs. Furthermore, Cheryl's ability to be reflexive helped her become resilient. Through the course of treatment, Cheryl learned to identify her needs. She transformed the belief that she was unworthy of love into the belief that she had some important strengths. Since Cheryl believed she was worthy and she knew what she needed, she became able to take steps to get her needs met. She learned a variety of coping skills that she was learning to be proficient at utilizing when agitated. Cheryl learned how to ask for help when she needed it. Through this process, Cheryl was
supported to individuate, embrace her identity as a woman, and develop a higher regard for herself.

**Learnings**

The lessons I learned during the process of working with Cheryl and writing this case study reverberate through my life. One learning was that the healing of a mind-body split begins with intense emotions that an individual learns slowly, over time, to respect and soothe. Early in the therapy process, Cheryl repeatedly expressed feelings of overwhelm at the mere notion of addressing inner turmoil. Another learning was that codependence is a form of gatekeeping (i.e., codependence restricts experience instead of catalyzing the deepening and diversifying of experiences). I felt the impulse to rescue Cheryl from the years of grief and longing that I had experienced but if I had done that, she would not have learned to trust in her ability to experience and manage pain. This was an area where I needed to practice reflexivity and process the deep wounds of my past with supervisors and professional consults.

Persephone, Queen of the Damned, as Tanya Wilkonson depicted her, was evoked during the exploration of these symptoms. While writing this case study, I realized that the Persephone myth had been an underlying theme throughout our relationship. With this awareness came the learning that not only did I believe that Cheryl was a Persephone woman, I was as well. During this process, Cheryl and I transmuted fears about feeling pain into compassion, acceptance, and kindness for ourselves. As we did, our confidence and ability to radiate soulfulness increased.
Working with the ways Cheryl put the needs of others first, assumed she was not
good enough, and repeatedly deferred her needs was fascinating to me. Her strengths had
always been so obvious that it was difficult to imagine her belief that they were invisible
or nonexistent. While I did not share my personal story with Cheryl, she felt that I did not
make any judgments about her and that I understood her.

The idea of the true self has been a concept I have explored throughout my life.
Both Cheryl and I hid behind false selves that presented as shields of defensiveness and
antagonism. As I began to help Cheryl learn that her power, beauty, and spunk were
enriching instead of shameful, I too began to realize that my power was remarkable. This
learning deepened my understanding of how wounding a deformed female ideal can be to
relate to as a young woman. In my place of employment, during the time I wrote this
Clinical Case Study, I was promoted and thrust into the experience of learning what it
meant to have authority projected onto me by others. The humility, messiness, and
humanity became beautiful in a way I had not known before.

Interestingly, during the course of writing this Case Study, I began to wear
feminine clothes, flowing and soft, while feeling safe in my skin. In the past, this type of
feminine expression made me feel too vulnerable to endure. This progression allowed the
young girl in me to revel in the beauty of femininity. By the end of this process, the
young girl emerged transformed into a discerning, fierce woman capable of both beauty
and power.

As I began to examine my own imaginal structures, my life began to move in
directions that were incredible. For example, the projections I had on specific authority
figures melted away and I began to see them as imperfect, wonderful people who had
wisdom to teach. For the first time in my life, I felt a sense of freedom, relief, and contentment that I had been longing for all my life. Cheryl also experienced the freedom, relief, and contentment during our work together. It was glorious to see her risk participating in her life as her true self in a resilient, intimate, and confident way.

As our sessions came to a close, I found myself feeling admiration for the courage Cheryl had taken to accept the offer of a therapeutic relationship. She had been through so much and come far. While she was resistant to end our therapeutic relationship, I was quite clear she was ready to move forward. We collaboratively summarized the therapeutic work we had done over the six months of psychotherapy. She was struck by how different she had become. Cheryl felt surprised that she used to think going to social events was frightening. She had overcome this struggle enough to recognize that fear in others and to be compassionate with their pain. She commented several times about how withdrawn, fearful, and awkward others can act, how sad she felt for them because she knew it hurt, and that she knew they had to want to change before anything would be different.

When pressed to consider what helped facilitate the transformation, Cheryl indicated she felt consistently supported, safe, and beautiful when she was with me. The experience made her challenge the opposing, negative beliefs she had about herself, particularly when I used humor and put it in perspective. She talked about cocaine with a sense of disgust and I was relieved for her. It appeared that the seduction was lost and cocaine was not an immediate threat. I realized that by mirroring her and helping her learn to feel her body, she had become empowered through self-acceptance and self-
compassion. It was a journey that we had taken together and we both emerged transformed, empowered, human, and regal.

**Personal and Professional Challenges**

During the course of therapy with Cheryl, I struggled with feeling like an ineffective fraud. For example, I felt that I should have been better able to manage my own internal experience when I had cravings for alcohol after our sessions. Similarly, when Cheryl’s marijuana use increased, I felt as if I were not doing enough, did not know enough, and was failing her. These challenges turned out to be experiences that informed the work with Cheryl.

Over time, I became able to transform my codependent impulses into attempts to inspire Cheryl to take responsibility for her life. Continued support, presence, respect, and love proved beneficial to Cheryl, as well as the management of my counter-transference responses. I originally sought this case for an in-depth study because of the depth of our connection and the potential I saw in her. What surprised me was the realization of how similar her struggles were to mine. Coming into her power allowed Cheryl to learn to be her true self, which actively taught her to care for her soul. Coming into my power and beauty helped me own the mastery of my psychotherapy skills.
CHAPTER 2

CLINICAL LITERATURE REVIEW

The primary substance-related disorders include substance abuse, dependence, intoxication, and withdrawal. These four general diagnoses are specified according to the specific drug or combination of drugs abused, the pattern of use, and the symptoms manifesting as a result of the drug use. Many diagnoses have identical criteria to substance-related disorders and have specific exclusions that typically state, “The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.”

With more than 16 percent of all diagnoses in the Diagnostic and Statistical manual dedicated to substance-related disorders, it is imperative to understand the cause of this form of suffering and how it is distinct. Several self-report studies have discovered that drugs are used to achieve happiness, to pacify painful emotions, to increase energy, to go along with the group or to belong, to decrease anxiety, to increase pleasure, to get high, and to reduce depression. Expectations that drugs will be enjoyable inspire use. Brown, Goldman, Inn, and Anderson have shown that expectancies of alcoholics fall into six factors: drinking will transform experiences in a positive way, enhance social and physical pleasure, increase sexual performance and satisfaction, increase power and aggression, increase social assertiveness, and decrease tension. Alicia Clark attributes the cause of cutting and substance-related disorders to one or more of the following: a trauma reenactment, emotional stressors, peer pressure, academic pressure, romantic
breakups, identity issues, losses, loneliness, isolation, sensitivity to failure, and coming to terms with sexuality.\textsuperscript{35}

As a means of presenting the current research about chemical dependence in an organized fashion, information has been divided into five different theoretical orientations. Each orientation provides a unique perspective. The summation of all the information provides the big picture about the factors known to contribute to the problem, the lived experience, and the history of chemical dependence research.

Theorists from the biological perspective have identified psychopharmacological effects on the brain caused by chemical abuse and chemical dependence; physiologically caused behaviors, sensations, and emotions; typical behavioral patterns caused by intoxication and withdrawal; and withdrawal symptoms. The CBT theorists attribute the cause of chemical dependence to dysfunctional thoughts and beliefs that inspire the motivation to abuse chemicals, as well as emotional dysregulation, typical maladaptive coping skills, perfectionism, and inaccurate perceptions of self-efficacy. The psychodynamic perspective recognizes unmet needs as the primary drive inspiring chemical dependence. These theorists recognize that the variance in individual needs is a reflection of successes or failures in negotiating developmental stages. The impact of parent-child relationships will be represented in this section. The socio-cultural perspective on chemical dependence identifies social trends, social experiences, interpersonal expectations, patterns of use, and public opinions about illicit substances. The imaginal approach explores chemical dependence through the use of imaginal structures and the Imaginal Process. Imaginal structures are the
assemblies of sensory, affective, and cognitive aspects of experience constellated into images; they both mediate and constitute experiences. The specifics of an imaginal structure are determined by an interaction of personal, cultural, and archetypal influences. These influences may be teased apart by attention to the stories that form personal character and the myths that shape cultural lie. During the individuation process, imaginal structures are transmuted into emergent and enhanced capacities as well as a transformed identity. Any enduring and substantive change in individual or group behavior requires transmuting of imaginal structures. This transmutation depends on an affirmative turn toward the passionate nature of the soul.36

Imaginal structures evoked by chemical dependence generally are communicators that identify mind-body-soul splits and guide toward healing individual fissures. In this type of mind-body split, bodily needs, emotions, and visceral experiences are split off from awareness. Emotional tools become stagnant and deformed while mental aptitudes are used to exhaustion. When compensatory functions are exhausted, individuals with chemical dependence escape their pain through the ecstatic states created by chemical dependence. According to Omer,

Ecstatic states liberate consciousness from the constraints of identity. Integrative ecstatic states are states where awareness is focused, alert, and fluid. Ecstatic states have both integrative and disintegrative modes. Trance states are a special case of disintegrative ecstatic states.37

The origins of chemical dependence treatment are rooted in alcohol dependence treatment because alcohol has historically been the most widely abused substance.38 Benjamin Rush introduced the concept that alcoholism is a disease in 1784, a concept that quickly became a prominent theoretical postulate.39 For a significant portion of medical history, chemical dependence stumped treatment specialists. It is a unique form of psychological suffering because many treatment providers are chemical dependence counselors, experts with Alcoholics Anonymous (AA) theoretical beliefs or practices, and are not trained in general psychology. A theoretical exploration of chemical dependence
would be incomplete without AA and the treatment modalities modeled after it. AA is based on a complex philosophy that inspires and was inspired by universal concepts from each theoretical orientation. The Twelve Steps of AA are presented in Appendix 4.

All theoretical orientations are based upon practical concepts that are universally accepted. It is universally accepted that responsible drinking is different from intoxication associated with substance-related disorders because responsible drinking is free of consequences. Andrew Weil’s definition of a bad relationship with a drug includes four elements: 1. ignorance that the substance is a drug with the potential to harm the body; 2. the development of tolerance and the diminishment of the desired effect; 3. it is difficult separating from the drug and a person may feel as if he or she is controlled by it more than he or she controls the drug use; and 4. an individual suffers from adverse effects on health or from his or her behaviors.40

Unmet spiritual needs are becoming increasingly accepted as a root cause of chemical dependence. Timmen Cermak introduced the topic in a recent seminar titled “Advanced Topics in Addiction Treatment” with the following statement:

The highest which man/woman can achieve is wonder. Wonder functions as a replacement for magic. Science has led people to abandon the quest of magic or wonder. While science has rid us of ignorance, it also has diminished the opportunity for us to experience awe, . . . it’s robbed us of it. Awe, or excellence, levels us. The sibling of awe is humility. Those comfortable with humility are more able to connect with the awe and magic which allows us to see our true place in the world. This is imperative. Without appreciating the awe and humility, the scientific explanation falls flat. Substance abuse functions as a replacement for the missing sense of wonder. Anything else I say today is presented under this universal concept.41

Steven Rozenzweig agreed with Cermak and suggested the use of specific motivational interventions to infuse the experience of awe into a sober life style. He maintained that psycho-education, the provision of a convincing rationale for treatment,
enhancing expectations for improvement, support and encouragement, and a quality therapeutic relationship are all imperative factors of any therapeutic undertaking.\textsuperscript{42} Research has shown that treatment success increases with inclusion of the following: use of a personalized treatment plan, working with a client motivated and driven to become sober, clinical work lasting a minimum of six months, incorporation of coping skills training as an aspect of the clinical work, individual therapy, reality testing, and a community supporting the process of becoming sober.\textsuperscript{43}

The term \textit{addiction} is used by specialists from all theoretical orientations listed in this Clinical Case Study. The root word of addiction is the Latin word, \textit{addicere}, which means to speak or declare devotion to in a way typical of enslavement.\textsuperscript{44} The meaning of the word is connected to the story of a person named \textit{Addictus}. Addictus became enslaved to creditors as a consequence of being unable to pay for goods he purchased.\textsuperscript{45} The symbolism of the word itself tells the story of an individual who began doing something out of desire, was seduced by the object of his desire, acted compulsively, and ended up enslaved. In general, authors used the term addiction to describe maladaptive habituated behavior patterns including chemical abuse, eating disorders, self-injury, compulsive gambling, compulsive sex, and compulsive shopping. While the specialists often differ in beliefs about causes of or treatments for chemical dependence, they universally use addiction as an all-encompassing umbrella term. The primary difference between chemical dependence and other addictions is the biological response and physical deterioration caused by specific mind-altering substances or combinations of substances abused. Each type of chemical dependence is unique. People tend to feel a sense of belonging and similarity with others dependent on the same substance. In order
to understand what these people have in common, the exploration of the literature will begin with the biological perspectives of chemical dependence.

**Biological Perspectives on Chemical Dependency**

The biological perspectives on chemical dependence presented in this case study focus on physiological reactions to the repetitive use of mind-altering drugs. In general, this perspective is based on the disease model of treatment. From this perspective, people with chemical dependence are perceived as being victims of the disease who are not responsible for their chemical dependence. Freedom from responsibility, for many recovering people, is comforting because it allows them to take responsibility for the present while disengaging from the burden of excessive, debilitating shame for past actions associated with prior substance abuse. Those consequences are often overwhelming.

The physical reactions to substance abuse encompass the range from benign to fatal. The *Diagnostic and Statistical Manual*’s diagnostic criteria for substance dependence, withdrawal, and intoxication include physical symptoms like tachycardia, insomnia or hypersomnia, increased or decreased appetite, grand mal seizures, increased perspiration, nausea, psychomotor agitation or retardation, cravings, and more. Substance abuse is identified by interpersonal, educational, vocational, legal, or medical consequences. The physical consequences of substance abuse, as compared to substance dependence, are withdrawal symptoms that resolve reasonably quickly like agitation, malnutrition, and insomnia. Diagnostic criteria for dependence and abuse are shown in Appendix 3.
Cermak reports that the first intoxication experience will encourage future use if it is associated with ecstasy, fascination, hope, and relief from emotional or physical pain. Robert Dupont identified three specific physiological responses that elicit the ecstatic experience and three neurotransmitters integral in this process. Norepinephrine, dopamine, and endorphins play off one another by passing messages related to anger, fear, pleasure, pain, and stress. The abuse of any illicit substance causes stimulation in the pleasure center of the brain, inhibition of pain in the pain center, and alleviation of the pain associated with withdrawal symptoms.

A physiological experience begins in the brain when an animal begins to anticipate a pleasurable experience. Anticipation is based on prior experience only. The first time a substance is used, the brain is unusually stimulated by the novelty and unpredictability of the stimulus. The first use does not have the pleasure of anticipation although it does have an enhanced pleasure due to the novelty of the experience.

Brains continually strive to maintain status quo. When an individual becomes intoxicated, dopamine and other neurotransmitters are released. The brain responds by reducing the amount of dopamine or other neurotransmitters in the synapses. Once the chemical is out of the brain, the modifications made by the brain to maintain status quo while the intoxicant was present has left was the brain functioning with an imbalance. This imbalance typically causes anxiety, depression, or other undesired symptoms. If an individual uses a minimal amount of times and is not affected with psychotic or schizophrenic responses, the long-term effects are likely to be minimal or nonexistent.

After a chemical abuse pattern has been established, physical dependence or tolerance is established. Dupont describes physical dependence as “the simple cellular
adaptation of the body, especially the neurons in the brain, to the continued presence of a chemical that influences the function of the brain.**53** Once that adaptation occurs, the brain expects the drug to be in the system and it treats that state as the status quo. As the body filters out the alien substance, the brain functions outside its norm, which causes it to function with reduced/altered levels of dopamine and/or other neurotransmitters specific to the drug ingested.**54** Weil discovered that while chemically dependent people began to take drugs to feel their reward, they end up taking them in order not to feel anhedonia.**55**

Repetitive substance abuse affects the brain along specific, final common pathways. Anticipation triggers a release of dopamine into the nucleus accumbens and the ventral tegmental areas of the brain.**56** Dopamine causes the second and third effects. The second effect is the stimulation of pleasure and the third is the relief from pain. The limbic system, where the nucleus accumbens and ventral tegmental are located, manages pain, pleasure, memory, and emotions.**57** For the purpose of understanding the effects, pain includes stress, emotional discomfort, anger, fear, loneliness, hunger, and more.**58**

Each mind-altering drug affects the neurotransmitter and endorphin levels in the synapses of the brain.**59** The substances affect the brain in four different ways. They can stimulate increased levels of the neurotransmitters or endorphins, or inhibit them. They can act as reuptake inhibitors that prevent the reabsorption of neurotransmitters previously released into the synapse. Lastly, they can mimic neurotransmitters or endorphins. Each of these effects affects how a person feels emotionally and physiologically. The nucleus accumben’s outer shell is associated with impulsivity and is
required for habituating a pattern.⁶⁰ It also is a key element in the neural circuitry underlying Pavlovian conditioned responses.⁶¹

In the longevity study done by Terry E. Robinson and Kent C. Berridge, the results revealed that repeated substance abuse results in intoxication being liked less and craved more.⁶² While substance abuse is resistant to extinction for all the structural factors listed above, Robinson and Berridge demonstrated how the desire to discontinue use is both reinforced and confounded by incremental brain changes and habituation. The changes result from the combination of the development of hypersensitivity to drugs and drug-associated stimuli, through the production of incremental neurological adaptations, and the saturation of incentive salience, or cravings/wanting.⁶³ Robinson and Berridge propose that the sensitization of the neural systems responsible for incentive salience can occur independently of changes in neural systems. These systems mediate subjective pleasurable affects caused by the drugs and the neural systems that mediate withdrawal. In other words, the sensitization of incentive salience can produce compulsive drug seeking and drug ingestion even if the expectation of drug pleasure and/or the aversive properties of withdrawal are diminished, and even in the face of strong deterrents like the loss of reputation, job, home, and family.

Dupont echoes the above notion but attributes the cause of decreased pleasure and increased compulsions to cocaine use for different reasons.⁶⁴ Cocaine is a vasoconstrictor and an anesthetic.⁶⁵ Vasoconstriction is the constriction the blood vessels. The overall affect of vasoconstriction in the region of the brain affected by cocaine is numbness or inhibition. One part of the brain affected by cocaine is the frontal lobe. The frontal lobe is the portion of the brain that inhibits instinctive behaviors like
repetitive hand-washing or uncontrollable obsessive-compulsive behaviors. When cocaine is ingested, the vasoconstriction in the frontal lobe prevents the brain from inhibiting the compulsion to repeatedly use cocaine. Washton and Dupont assert that the typical pattern of cocaine abuse includes persistent ingestion of cocaine until an individual’s cocaine supply is depleted.

James J. Dahl demonstrated through the use of electroencephalogram (EEG) imagery that changes in brain functioning caused by long-term cocaine dependence persists for a minimum of three months after cocaine ingestion is discontinued.66 Through similar methods, Volkow found abnormal brain patterns in some people after 12 months.67 Dahl discovered that the executive-decision, thinking part of the brain often remains damaged for three to six months after substance abuse is discontinued. Volkow identified that brain changes resulting in depression or anxiety lasted six months, or more, after the subjects’ last ingestion of the substance they were dependent upon.68

The first physiological experience of intoxication begins with the first use of a substance. When it is first used in adolescence, the impact is more pronounced. Heather C. Brenhouse and Susan L. Anderson explain with rat studies and cocaine that increased chemical dependence in adolescence is partially due to an adolescent’s lowered capacity for self-control as compared to adults.69 Michael Riera explains that teens have inconsistent behaviors and attitudes that are often the result of rapid switches between concrete and abstract thinking.70 By age 18, an adolescent’s judgment is roughly equal to that of an adult.71 It is not until age 25 that a youth’s judgment involving the resistance of impulses or delaying gratification (i.e., developing the capacity for patience) matures into adult functioning.72
Ronald K. Siegel simply said, “We use drugs to change the way we feel.” John Flynn echoes this and attributes the cause of chemical dependence to the stimulation of the brain’s pleasure center and a compulsive obsession to re-experience the pleasure of the first intoxication. When the pleasure center of the brain was electrically stimulated in rats if they pushed a bar, the rats pressed the bar up to 700 times per hour.

The satisfying physiological response evoked by interpersonal connection occurs largely in the endo-cannabinoid system and with the release of the hormone oxytocin. Cannabis, or marijuana, stimulates this system by mimicking the endo-cannabinoid receptors. Cermak noted that the highest concentration of cannabinoids, the neurotransmitter that cannabis mimics, is in breast milk. The most concentrated and largest numbers of endo-cannabinoid receptors are found in infants. Louise O. Packard stated that chemical dependent mothers do not provide attention to their children because their natural instinct or drive to connect with their children is satiated by the drug. The importance of the stimulation of endo-cannabinoids was demonstrated by the rat study where a cannabis blocker was given to rat pups, which resulted in in discontinued suckling and death in 4 days. The endocannabinoid system receptors are found in higher concentrations than any other receptor in the brain and they are present in nearly every physiological system researchers have explored.

The dose response is a physiological response to a specific quantity of the chemical. In the words of Denny Hutton

The poison is in the dose. The drug itself is just a drug. To qualify them as good or bad reflects a failure to understand the nature of substances in general.

How the substance is taken and the amount ingested determines the effect on the body. For example, the neurotransmitter dopamine is the brain’s messenger for
pleasure. Andrew Weil identified that dopamine “reinforces behaviors essential to our survival” such as pursuit of food, exercise, or sex. In contrast, Dupont recalls that people with schizophrenia have excessive quantities of dopamine and schizophrenic people are seldom happy. In other words, the proportion of dopamine to the brain’s ability to appropriately absorb, release, and process it can evoke a variety of responses from pleasure to pain. The idea that more is better does not ring true with intoxicants. Volkow discovered that the consumption of multiple chemicals and/or ingestion of high doses of a chemical results in lower pleasure than moderate, single intoxicant use. Furthermore, side effects of the drugs are likely to induce changes in the brain that result in dysphoria and anhedonia, symptoms that meet the criteria for a diagnosis of depression.

In orienting this information inside of the entire chemical dependence paradigm, it is important to revisit the concept that people use drugs to change how they feel. Cocaine, according to the majority of academic and lay cocaine experts alike, causes a person to have a deep and profound sense of vitality, ecstasy, and overall libidinal joy. Freud was initially hopeful that he had discovered a euphoric panacea capable of treating morphine dependence, hysteria, depression, lack of self-control, and difficulty with attention or focus, and assisting people to manage their need for sleep or hunger. In his research, he discovered that the people of the Andes used it for medicinal purposes and as an aphrodisiac. People with cocaine intoxication often dismiss the danger even when it is profoundly real. Freud did this when he stated that cocaine was “absolutely harmless in long use,” and he dismissed problematic side effects by attributing them to “the quality of
the preparations." As in cases of hypothermia or heat exhaustion, rationalization is a
typical symptom of dependence.

Strangely enough, people dependent on both marijuana and cocaine who profess
that marijuana helps them abstain from cocaine might not be distorting the truth. Alan
Budney’s research team found that people who used marijuana while quitting cocaine had
higher recovery rates than people who did not. While that is accurate, Budney found
that people dependent on marijuana reported greater psychosocial impairment and health
problems at intake: symptoms including less earned income; a higher rate of never having
been married; more reports of headache, nausea, cough, and sore throat; more severe
depressive symptoms; more reports of paranoia; more severe legal problems; greater
work-related disability due to health problems; lower participation and instability in
conventional roles of adulthood (such as marriage); more psychiatric problems and
utilization of mental health services; and more criminal or delinquent behavior.

The intensity of the cocaine user’s stimulation during intoxication is drastically
different than the novel and relaxed sensations marijuana users experience. In the
amygdala, cannabis lowers the registration of novelty, affects the determination of
emotional relevance, and causes a person to forget aversive memories. It also affects the
regulation of appetites, pain threshold, anxiety, or fear. Cannabis affects people by
making everything interesting, symbolic, poignant, and emotionally satisfying without
requiring normal interdependence to satisfy dependence needs. Benedict Carey was
finally able to support the assertion that marijuana is addictive with research publicized in
2004. Volkow explained, “There is no question marijuana can be addictive; that
argument is over. The most important thing right now is to understand the vulnerability of young, developing brains to these increased concentrations of cannabis."\textsuperscript{96}

Common genetic factors accounted for 35 percent to 78 percent of the total genetic variance in heavy substance use.\textsuperscript{97} Heritability estimates for alcohol use range from .28 to .51, with a mean of .42.\textsuperscript{98} Hutton stated that 50 percent of children with chemically dependent parents become dependent if their fathers were and 80 percent if both parents were.\textsuperscript{99} Longitudinal stability for alcohol consumption was shown by Carmelli et al. to be more than 80 percent genetic.\textsuperscript{100} The National Institute on Alcohol Abuse and Alcoholism’s \textit{Alcohol Alert} translated the results of twin studies and alcoholism and have reported the following: Researchers have failed to identify a single gene responsible for alcoholism and likely there are multiple interconnected genes that play a role; genes determining the tendency to become tolerant to certain effects of alcohol are different from genes determining the severity of withdrawal symptoms even though these often co-occur; researchers are beginning to map some animals’ alcohol-related behaviors, which likely will set the foundation for identical research in humans.\textsuperscript{101} Research has shown the following: people requiring more alcohol to achieve an effect had higher rates of alcohol problems later in life; there is a confirmed genetic influence on alcoholism; children of alcoholics compared to children of non-alcoholics have four times the risk of developing dependence; the enzymes monoamine oxygenase and adenylyl cyclase are genetic markers that are lower in alcoholic than in nonalcoholic subjects; and confounding variables in twin studies include environmental facts such as children placed in traditional, well-established, two-parent homes.\textsuperscript{102} Some interesting research has been done studying the predisposition not to become chemically dependent
on alcohol. One discovery was that people with a deficiency in the enzyme ALDH2, an enzyme involved in breaking down alcohol, experience a buildup of metabolic intermediate acetaldehyde which causes nausea, is toxic to the body, dilates blood vessels causing flushing, and ultimately is correlated with the low risk of developing alcohol dependence.103

The abundance of biological information about chemical dependence provides a foundational understanding for how drugs affect the body. Of course, there is the matter of personal choice, responsibility, and will. Some of the biological impacts of intoxication are unyielding and some are not. The impact of cognition, development, motivation, and spirituality also play important roles in the manifestation of chemical dependence. The next perspective we will explore is the cognitive behavioral one.

**Cognitive Behavioral Perspective on Chemical Dependency**

Cognitive behavioral theorists attribute chemical dependence to a variety of maladaptive thought patterns and the subsequent emotions evoked by the thoughts. There are various types of maladaptive thoughts related to chemical dependence that generally center around unmet needs, expectations, distrust, inauthenticity, low frustration tolerance, issues of control, secrecy, inaccurate reality testing, low self-esteem, poor emotion management, deficient need satiation, and either inadequate coping skills or low use of the skills.

Throughout chemical dependence literature, it is common to find off-shoots of the theories described in this section. Purists of cognitive theory are at odds with those who adhere to the belief that chemical dependence is a disease because they attribute
substance-related disorders predominantly to faulty cognitions. The disagreement lies in the contrast between the belief that chemical dependence has the potential to be overcome completely once faulty cognitions are repaired and the opposing belief that it is a permanent disease that must be managed indefinitely. In general, the notion that chemical dependence is a disease predominates. The threat underlying in the belief that chemical dependence can be overcome is the threat of relapse.

Since chemical dependence is a learned behavior, even for those genetically predisposed, understanding the fundamental components of learning contributes to understanding motivations and reinforcement patterns related to chemical dependence. Abraham Maslow, Julian Rotter, Carl Rogers, Ivan Pavlov, and Burrhus Frederick Skinner identified key foundational components in the cognitive processes occurring in chemical dependence. Learning to abuse substances involves expectations, the process of habituation, resolving unmet needs, trust, and imitating observed behaviors.

Intoxication has both positive and negative reinforcement. The positive reinforcers are the ecstatic sensations inherent in the physiological response to the drug as well as the emotional feelings of interpersonal acceptance, levels of interest reaching satisfying captivation, sexual excitement, and feelings of power. Negative reinforcement provided by intoxication is the removal or nullification of negative stimuli including hunger, shame, overwhelm, incompetence, boredom, and/or feeling unloved. The physiological response to the nullification of these experiences generally is experienced as ecstatic.

Julian Rotter’s social learning theory is expressed in the equation $BP = f(E & RV)$, which translates to behavior potential ($BP$) is a function ($f$) of expectancy ($E$) and
reinforcement value (RV). In terms of chemical dependence, when intoxication can be expected to provide a high level of satisfaction and it is realistic to expect that intoxication can occur, the expectancy for drug abuse is high. The equation for the last sentence can be translated as “(BP) drug abuse = is (f) a function of (E I can get drugs) & [RV] the drugs will feel fantastic and/or relieve the pain I’m experiencing.”

Generalized expectancy of intoxication often has a dependably high reinforcement value because of the consistent potential for both the pleasure and the relief from pain inherent in the experience. People with chemical dependence have established the belief that all other actions will likely fail to provide the degree of pleasure associated with the generalized expectancy of intoxication, thus intoxication becomes the behavior with the highest BP.

It is commonly accepted that trustworthy behavior is not expected from people with chemical dependence. The interplay between distrust and the inability to trust is riddled with misery. While it is unclear if there is a causal relationship between being untrustworthy and chemical dependence, there is definitely an association. Dupont explained this phenomenon with the following quote:

With respect to aggression, fear, feeding, and sexuality the brain is selfish. It wants what it wants right now. The brain knows only ‘more’ and ‘no more’. . . . When it comes to natural pleasures, the brain has powerful feedback systems to say ‘enough’ (unlike with mind-altering substances). Automatic brain mechanisms do not consider other people’s feelings or needs or know the importance of delayed gratification. That is why I call this basic pleasure/pain organ the selfish brain.”

John Howard Prin delved deeper into Dupont and Rotter’s concepts by illustrating the role secrecy plays in chemical dependence. Prin recognized that people with chemical dependence tend to be sensitive to social rejection. The sensitivity often results
in the promotion of a positive social image, an image protected by withholding information that could potentially evoke unwanted responses from others. Prin explained that keeping secrets functions to protect the individual’s social image in a controlled, safe manner; empowers the individual with chemical dependence to control how he or she is seen; and inadvertently exacerbates the hidden shame. The individual perceives himself or herself as weak and defective for having chemical dependence. The weakness is compensated for by social power gained through self-promotion; the image of social power becomes a false self or a mask created by the persona to protect against secrets of which an individual is ashamed. The mask comes to be experienced as a safe shield behind which to hide. Prin recommends the use of authentic living, integrity, and rigorous honesty for treatment of chemical dependence and other habituated patterns.

David Hartmann discovered that increased internal locus of control levels are affiliated with lower chemical dependence and relapse rates. When people feel imposed upon, hurt, done to, or controlled by experiences outside of their control, the act of alleviating pain through abuse of a substance momentarily shifts the locus of control from external to internal. Possessing the ability to improve one’s felt experience first by taking an action directly resulting in pain relief (i.e., using drugs, and secondarily by increasing feelings of self-efficacy by having caused the relief) results in the creation of a compounded experience of internal empowerment. Unfortunately, the solution is temporary and confounds the actual problem-solving process. Dupont explains that once intoxication is achieved, the original problem loses priority, pleasure simultaneously
gains priority, and the original problem often becomes more complex because it is avoided and ignored.\textsuperscript{120}

Returning to the basic components of learning, conditioned responses and operant conditioning play a central role in chemical dependence. Ivan Pavlov observed that a non-related stimulus can create a conditioned response after repeated trials (i.e., a bell can cause a dog to salivate if the bell is rung prior to the dog receiving food repeatedly). Extrapolating from Pavlov’s theory, the experience of intoxication comes to be associated with discussions about drugs, pictures of drugs, paraphernalia, drug references, etc. which come to evoke a pleasurable experience (conditioned response), thus creating an increase in potential to create habituation through increased motivation to use, talk about, or surround oneself with drugs or drug-related stimuli. B. F. Skinner expanded on Pavlov’s work to demonstrate the effects of rewards and punishments in operant conditioning.\textsuperscript{121} Skinner determined that intermittent and/or variable rewards unpredictably dispersed, typified in the patterns of gambling and chemical dependence, provided the most behavioral reinforcement.\textsuperscript{122} Clark Hall’s concept of a habituation is defined as a bond developed between a stimulus and a response; the bond strengthens each time the behavior is exhibited.\textsuperscript{123} The operant conditioning and habituation inherent in chemical dependence patterns demonstrate incrementally continuous increases in the degree of reinforcement for drug abuse as well as resistance to extinction.

William Glasser identified the resilience of chemical dependence patterns and found a way to recreate the positive attributes without the consequences.\textsuperscript{124} He discovered that activities like meditation or running practiced for a minimum of 30 consecutive minutes daily established mindfulness, provided ritual, reduced stress, and
made lives more satisfying. Glasser determined that the habituated behaviors he called positive addictions had the potential to teach discipline, increased degrees of self-love and self-worth, and evoked a sense of inner peace that cumulated to result in a strengthened character with an increased adaptivity. In addition, repetitive thoughtless action functions as a type of meditation that creates a state of mindfulness, inner peace, and ease which inherently increases the pleasure of experiences. Jennifer Schneider, Luigi Zoya, and William Glasser all recognized that inner peace comes from the mindfulness developed in ritualized activities.

Glasser’s work is a classic example of identifying patterns of behavior, determining what would best serve the situation, modifying patterns accordingly, and then enjoying the linear, predictable effects of the strategy used. It is structured much like cognitive behavioral therapy (CBT). It is a system of psychotherapy designed to increase reality testing, identify internal thought scripts, and correct distorted conceptualizations in order to reduce the excessive emotional reactions and self-defeating behavior caused by underlying distortions. As this occurs, individuals become increasingly capable of recognizing their objective and subjective experiences.

CBT has been designated as a central method for addressing chemical dependence in mainstream psychology for several reasons. One of those reasons is that clinicians using CBT can provide immediate, practical, empowering, direct, and dependable interventions. As was demonstrated above by Maslow, Prin, Rotter, Dupont, Hartman, and more, the sensations of insecurity, distrust, powerlessness, and helplessness are core causes of chemical dependence. When these sensations are experienced and substance abuse is removed as a means to alleviate pain, CBT techniques provide alternatives to
utilize during recovery when clients are restless. The actions help individuals to expand their tolerance for emotional pain, increase a sense of efficacy, and overall improve self-worth. CBT also establishes the onus of responsibility on the client to practice what he or she learns in treatment. CBT treatment plans can be modified to include evidenced based practices (EBP), like individualized planning and family involvement, to increase successful outcomes.

CBT is based on concepts developed by Aaron Beck. Beck asserted that a cognition is a two-step process involving a thought followed by a responding emotional reaction. Beck contends that original experiences become markers in an individual’s life that are subsequently used as a comparison for following similar incidents. Many authors representing biological perspectives suggest that drug use occurs in an attempt to recreate the first intoxication experience. Beck’s theory is similar. For example, when a person diagnosed with chemical dependence is distressed and unable to soothe himself or herself, the powerlessness and desperation may be linked to feelings of inadequacy from childhood. Beck referred to the link between the present and past as automatic thoughts that typically were experienced by people with chemical dependence as the fear of rejection, domination, abandonment, psychological impairment, loss of control, self-depreciation, depreciation by others, failure to cope, death, and injury. A hypersensitive alarm system evokes automatic thoughts identifying perceived potential psychological or physical danger. The hypersensitive alarm system in people with substance-related diagnoses often have glitches in their systems called false alarms, which leave them in a constant or heightened state of distress. According to Beck, a dysfunctional belief network consists of subjective, unrealistic beliefs resulting in
dissatisfaction, which manifest as negative self-concepts and negative views of past, present, and future situations.\textsuperscript{136}

Albert Ellis recognized how overgeneralizations about past associations can result in anxiety caused by irrational or illogical thoughts.\textsuperscript{137} These thoughts are fueled by the belief that the impending outcome will be catastrophic, rather than merely annoying or inconvenient, if a certain event occurs.\textsuperscript{138} In CBT treatment plans, maladaptive cognitions are purposefully replaced by scripts that assure a person, soothe him or her, and instill positive expectations for the future. Beck found that the manifestation of dysfunctional cognitions predisposes individuals to have chemical dependence.\textsuperscript{139} To address these issues, targeted CBT client plans address low frustration tolerance, anger management, abusive behavior, assertiveness training, problem solving, skills training, and dealing with catastrophizing.\textsuperscript{140} Beck’s proposed mechanism for change consists of aligning the belief system more closely with reality, challenging dysfunctional beliefs, modifying cognitive scripts, and purposefully replacing the beliefs with positive concepts that support the path to sobriety.\textsuperscript{141}

Due to the high incidence and frequency of relapse, various theorists have identified a list of relapse warning signs. Table 1 shows a cross comparison of warning signals. Warning signals typically include “honeymooning”/denying problems, doubt that a chemical dependence problem exists, self-pity, impatience that recovery takes so long, expecting others to fix the individual, “stink thinking” or negativity like blaming or being chronically dissatisfied, being overconfident or defiant, falling into the belief that life is not fun without drugs, adhering to rigid attitudes and beliefs, impatience, argumentativeness, depression, exhaustion, dishonesty, unrealistic expectations,
forgetting gratitude, and difficulty managing emotions and stress. Even the most devout CBT authors referenced in this case study promote Alcoholics Anonymous attendance and the belief that alcoholism is a disease, presumably as a precaution to prevent collusion with the above self-sabotaging factors. Laudet, Stanick, and Sands report that AA attendance correlates with increased sobriety rates and that it is detrimental to disregard AA or AA philosophies.

One CBT off-shoot acknowledges the significance of affects in the substance abuse dynamic. Leigh McCullough suggested that affect phobia is the underlying drive for chemical dependence. Affect phobia, translated literally as the fear of affects, is treated with traditional desensitization techniques. Donald Nathanson describes shame as a primary inspiration for alcohol consumption because intoxication both alleviates shame and replaces it with joy. Sylvia Brinton Perera explained that chemical dependence is related to the fear of or resistance to being vulnerable, a resistance inspired by the maladaptive coupling of vulnerability and shame. Vulnerability is required for intimacy. Intoxication alleviates fears of vulnerability, which allows interpersonal intimacy needs to be satisfied. Perera suggests that a targeted client plan focused on decoupling vulnerability from shame is likely to decrease the need to cope with excessive inappropriate emotions and unmet dependence needs.

Many cognitive theorists focus on the concept of control. Washton asserts that a primary treatment goal of chemical dependence is improving realistic comprehension of internal and external locus of control. This concept is central in the chemical dependence treatment world and is represented by one of Alcoholics Anonymous’s most popular prayers, the Serenity Prayer:
God grant me the serenity to accept the things I cannot change; courage to change
the things I can; and wisdom to know the difference. Living one day at a time;
Enjoying one moment at a time; Accepting hardships as the pathway to peace;
Taking, as He did, this sinful world as it is, not as I would have it; Trusting that
He will make all things right if I surrender to His Will; That I may be reasonably
happy in this life and supremely happy with Him Forever in the next. Amen. —
Reinhold Niebuhr

Washton and Boundy explain that chemical dependence often becomes an
increasingly entrenched cycle as those who are dependent tell themselves, “I can quit if I
want to.” Washton and Boundy explained how the obsession with control compounds
an already fragile position as follows. When control is not obtained, individuals generally
become frustrated, then feel compelled to anesthetize their emotions. In this tenuous
position, individuals attempt to control their substance abuse behaviors unsuccessfully.
When they are unsuccessful, they feel impotent and incompetent. In response to their
feelings, the intensity of their compulsions to use substances escalates in desperation for
temporarily relief from shame, failure, and the discomfort of feeling out of control.
One suggested treatment strategy suggested by Washton and Boundy was to reduce the
clients’ attachment to control in order to help them be more realistic about what is and is
not within their scope of ability.

In addition to desire for control, Beck found that people use drugs to find
temporary relief from anxiety, tension, sadness, or boredom. He observed that some
people with chemical dependence have a drug of choice that is preferred because of its
specific pharmacological properties and social meanings. He believed that alcohol was
viewed as manly and associated with sports while cocaine was associated with women,
group acceptance, and sexual activity.
The reality is that specialists in all theoretical orientations and chemical dependence treatment fields are aware that there are satisfying and pleasurable aspects of drug use. Brown, Goldman, Inn, and Anderson have shown that expectancies of alcoholics include six beliefs: drinking will transform experiences in a positive way, it will enhance social and physical pleasure, it will increase sexual performance and satisfaction, it will increase power and aggression, it will increase social assertiveness, and it will decrease tension.\(^{157}\) When a person makes a decision to become sober, that person is operating with the same psychological patterns that reinforced his or her chemical dependence. In this mind set, persons choosing sobriety are profoundly aware that they will be deprived of their ability to acquire immediate, temporary reprieves from pain. Pamela Jennings honored that the loss of the drug experience has to be grieved.\(^{158}\) The grief involves the loss of the pleasurable experience. Another aspect is the loss of the emotional security that comes from knowing there is a quick fix to any emotional turmoil.

CBT theorists each identify a component of the psychological system that is being compensated for by intoxication. Whether substance use is associated with joylessness, distrust, loneliness, desperation for control, boredom, shame, incompetence, low frustration tolerance, the desire to numb pain, or another reason, the fact is that people with chemical dependence experience suffering. The combination of biological and CBT perspectives offer an overview about what happens in the body and what types of thoughts compel an individual to flee from his or her experience. One question that arises time and again in psychology is, “Why does it happen to one person and not another?”
The psychodynamic theorists have some ideas about the deeper impetus for substance abuse and dependence. The next section explores those concepts.

**Psychodynamic Perspective on Chemical Dependence**

According to psychodynamic theorists, the most simplistic elements predisposing individuals to chemical dependence are an imbalance in the overall structural functioning of the psyche. The imbalance results from unmet dependence needs, the inability to manage emotions, and habituation of chemical abuse initiated to temporarily resolve emotional turmoil and emotional investment in stressors.

The founder of the psychodynamic theory was Sigmund Freud. Freud’s first published work described the euphoria experienced during cocaine intoxication. He asserted that the pleasure was caused by the “disappearance of elements in one’s general state of well being which cause depression.”

Freud described his cocaine intoxication as follows:

The psychical effect of cocaine mur, in doses of 0.05-0.10 gram, is exhilaration and constant euphoria. Exhilaration is not like that of alcohol is entirely wanting. One feels self reliant, vigorous and active, not the mental excitement of alcohol, theain, and caffeine but simply normally strong, capable of doing work. Now come the most marvelous effects of coca. Long, persistent, intense mental or muscular work can be performed without fatigue. Food and sleep so imperatively demanded of conviction that it could be dispensed with, prevails. One can forgo sleep, thought sleep will come if desired.

It does not appear random that Freud’s theory included a life force drive because cocaine has been associated with the visceral feeling of vitality. Many myths about the origin of the coca leaf describe the plant as a gift from the gods to help someone survive a hardship. The Incans called the coca leaf, “Mama Coca,” and the prefix “Mama” indicated both that it was perceived to be similar to a mother and that it was essential to
the survival of the empire, like maize and cinchona (from which quinine is derived).\textsuperscript{163} Freud’s dedication to tracking life force, maternal and paternal influences, the oppression of life force, and the sensory experience of freedom are all tied to ways patients could establish profound satisfaction in life.

Michael Balint recognized the importance of the nonverbal connection. He identified that the internal element present in people with narcissistic conditions prior to intoxication was emotional overwhelm, a state similar to madness, which was caused by an interpersonal clash with an important love object and perceived as irreparable.\textsuperscript{164} Those individuals sought to escape the unbearable fate of the perceived loss of a relationship through the feeling of harmony they remembered from first high. Balint described this harmony as the feeling that all is well between them and their world; “In my experience the yearning for this feeling of ‘harmony’ is the most important cause of alcoholism, or for that matter, any form of addiction.”\textsuperscript{165} Louise Kaplan depicts the tension felt between desiring ecstatic sensations and recreating the humiliation of inadequate parenting.

The adult who dares not entrust himself to the arms of an ordinary partner is like the disappointed child whose mother’s face is always turned away, the humiliated child who looks up to see frowns instead of mirroring admiration. The adult gambler prefers the risk of an impersonal magical partner who might restore his lost omnipotence, to a human partner who might disappoint him. She lures him and then turns her back. So, whether he chooses the dice table, the heroin ecstasy, the alcoholic reverie, or the everlasting search for the all-perfect lover, such a person will sooner or later confirm his worst apprehensions. As the card turns, he waits for Lady Luck to smile on him. Chances are her face will be turned away. Instead of recovering his lost impotence, he refinds vulnerability and humiliation.\textsuperscript{166} Jean Leidloff also noticed the longing beneath drug seeking. During her cross-cultural research, she found that the unmet need to be held in-arms enough during infancy
results in a constant state of fear or anxiety.\textsuperscript{167} She hypothesized that “many forms of addiction—to alcohol, tobacco, gambling, barbiturates, or nail biting” become a substitute for the security of the in-arms experience.\textsuperscript{168} Ronald Fairbairn expanded on this and suggested that maladaptive behaviors like chemical abuse often are a reaction to unmet needs associated with moments of perceived and real neglect.\textsuperscript{169} In those moments, the reaction is often overwhelm caused by exceeding optimum frustration levels.

The lack of propensity to trust inherent in people with chemical dependence causes them to treat and be treated by others in a unique way. Rotter’s research indicates that a person who trusts less is experienced as being less happy, less ethical, less likely to give others second chances, prone to enact less conventional and more immoral behaviors, less attractive to the opposite sex, less sought out to be a friend, likely to have had a less happy childhood, and more likely to be dishonest than a person who is more trusting.\textsuperscript{170} Conversely, Rotter found that people who are trusting are more likely to be happy, free of confliction, and more well-adjusted than their untrusting counterparts.\textsuperscript{171}

It is a risk to trust people. When individuals guard against pain, they often avoid risk. The difference between risk and gullibility is not necessarily perceived by people who are not trusting. While less trusting folks may believe they are preventing themselves from being gullible, they are not statistically less gullible than people who trust more.\textsuperscript{172} Rotter wrote that people who struggle to trust believe that others cannot be trusted so there is less moral pressure to tell the truth.\textsuperscript{173} In some circumstances they feel they need to lie, cheat, or manipulate situations defensively in response to a perceived
maladaptive social structure. Rotter suggests that the more distrusting a person is, the more his or her quality of life deteriorates through increased fear and defensiveness.

Perera found that people with chemical dependence had maladaptive developmental progression caused by rampant incidents of helpless frustration. Melissa Schwartz explains, “Overwhelming experiences are a necessary and innate part of life. When overwhelming experience happens to us, we lack access to the capacities to deal with the experience: that’s why they’re overwhelming. Unmet dependence is experienced as an overwhelming experience.” She indicated that resilience is developed through the integration and critical analysis of those overwhelming experiences. Unprocessed overwhelming incidents of individuals with chemical dependence lead them to perceive the world as excruciatingly painful, so they compensate with intoxication.

Anxiety is frequently written about by authors exploring chemical dependence. Their references stem from the symptom Freud called anxiety neurosis that he described as free-floating anxiety or general apprehensiveness, which is experienced when one’s libido has been compromised and one’s needs remain unmet. Libido, in lay terms, is an individual’s primal life force. Suppression of life force creates compression in the psychic system and is experienced as anxiety. Hillman stated that anxiety is caused by what has been repressed.

Maslow conceptualized a hierarchy of prioritized needs, beginning with the need for physical safety and ending with the need for actualization. It functioned as a way of identifying what the symptom of anxiety indicated was unfulfilled. According to this theory, when a person’s foundational needs are met, that person becomes free to seek
fulfillment of higher needs. It is generally accepted that fulfillment of a need is experienced as pleasure while an unmet need is painful. Substance-related diagnoses are all integrally related to the quest for need fulfillment. The experience of intoxication has the potential to satisfy needs on each level of the hierarchy. For example, cocaine can temporarily satisfy the need for food, water, belonging, esteem, intimacy, competence, and actualization.  

Marijuana or LSD can lower the threshold for novelty by making even the simplest concepts seem profound. These novelties satisfy the need for actualization, competence, and satisfaction. Profound experiences that evoke a sensation of satisfying awe can increase feelings of competence, self-worth, and overall self-esteem.

Stephanie Brown built on Maslow and Erikson’s work by creating a model of chemical dependence recovery that addresses the ways families enact and reinforce distrust, teach children to discount their perceptions of reality (which causes inertia instead of competence), reinforce a false self or a diffuse identity, lack mature role modeling, and inspire fear. She explores Erikson’s pathological manifestations and discusses various interventions for helping clients overcome their inclinations. Brown emphasizes the necessity of assisting clients to develop a sense of self, guiding them to connect with AA and its underlying philosophy supporting sobriety, and inspiring hope for the possibility for developing interpersonally safe connections. Stephanie Brown mapped ways Anna Freud’s defense mechanisms of avoidance, rationalization, denial, and reaction formation are utilized during recovery from chemical dependence. Brown explained that feelings vary in intensity during the initial recovery process and that denial, reaction formation, and rationalization all increase at that time.
Vivien Marco-Speiser professes that reconciliation with, or an acceptance of, the mother is a critical task required to avoid recapitulating the initial rapprochement period of development. Powell verifies Marco-Speiser’s work in her comprehensive explanation for this occurrence with information supported by Perera, de Shong Meador, Woodman, Seligman, E. Balint, M. Balint, Samuels, Winnicott, Gillespie, and Jung.

According to Powell, de Shong Meador’s female developmental model has three stages: the first is the pre-oedipal attachment to the mother; the second is a period of loving identification with the father where females mediate the triangulation of relationships; and the third is the re-identification of the individual with her female origins and identity. Powell suggests that women often become stuck remaining identified with the father, a problematic stagnation that inherently leaves them disconnected from their identification as women. This plays out as the resurgence of primitive anxieties in adolescence, manifest as a mind-body split, and results from failure to integrate both masculine and feminine aspects. Powell tracks the longing that young women have for the visceral, sweet experience of intimacy, a longing that can be compounded by the unmet need for healthy infant intimacy experiences with women/mom, and describes how much females sacrifice toward that end.

Pathological manifestations rely on extensive unconscious use of defense mechanisms. Each of these pathological manifestations plays a central role in the development of chemical dependence because it confounds the task of satiating interpersonal needs. The interaction between the id, ego, and superego also impacts the development of pathological manifestations. If persons feel strongly that they cannot allow their instinctive impulses to manifest because it would result in abandonment,
humiliation, rejection, or other social dejections, they withdraw or develop false selves. In the case of a person with chemical dependence, the ingestion of a mind-altering substance alleviates psychic pressures caused by the imbalanced system.

Leigh McCullough theorized that a primary cause of chemical dependence lay in what she called affect phobia, or the fear of affects. In her theory, psychic pressures develop when simultaneous activation and inhibition of affects occur (i.e., the activation and inhibition function as intra-psychic forces pushing in opposite directions). When internal aversions to affects are experienced, it is confusing for a person to differentiate “me versus it” in attempts to identify the problem. McCullough suggested that the confusion confounds an individual’s ability to resolve problems. She noticed that the intra-psychic pressure creates anxiety and unconsciously motivated defense mechanisms, including avoidance sought through chemical dependence. McCullough proposed a chemical dependence treatment plan targeted at systematic desensitization for all affects.

Anger and resentment are the focus of many treatment researchers. Joseph Nowinski and Stuart Baker agree with the idea that anger evokes anxiety, a form of suffering that alcoholics attempt to anesthetize with alcohol. They emphasize the threat that resentment, or unexpressed/denied anger, can have on sobriety for the same reason. Leonard Ingram employs their theory with the explanation that anger, which he suggests is caused by a perceived threat to one’s well being, is excessive in people with chemical dependence because they inaccurately perceive reality. He recommends reality-testing as a means to reduce the degree chemical dependence people feel threatened. Reduction of the threat would cause them to feel less primitively driven to
resolve the need to feel safe, which inherently means they would be less driven to use
intoxicants. Ingram suggests utilizing a client plan targeted at helping the client to
learn to tolerate the experience of anger, appropriate anger expression, embracing
personal responsibility, and personal accountability, suggesting that such a plan will
significantly reduce the need to cope, which simultaneously reduces the compulsion to
abuse substances. Wei-Fen Lin’s forgiveness therapy is a four-step process in which a
person who was victimized by a prior injustice(s) considers the alternative of forgiveness,
makes a decision to forgive or not, and learns the skills to forgive. The results of Lin’s
treatment research revealed that less substance abuse and fewer compulsions to abuse
substances were attributed to a lower degree of anger and a lower vulnerability to being
victimized. By learning to forgive a perpetrator, Lin discovered, people shifted their
perspective away from the victim stance thinking error and moved toward becoming
resilient survivors as they learned assertiveness training. Lin’s premise is that
unmanageable anger, guilt, and hurt underlie the motivation for substance abuse. For the
purpose of the study, forgiveness was defined as “a personal decision to give up
resentment and to respond with beneficence toward the person responsible for a severe
injustice that caused a deep, lasting hurt.”

Robert Karen described a scenario that may explain how emotions become affect
phobias. He noticed that when parents reject aspects of their children, the children feel
ashamed and deformed by their unwanted feelings. These unprocessed emotions result
in the development of a negative set of assumptions about oneself. Karen added that
the negative assumptions were created because the child perceived that it was too
dangerous to blame the parent for his or her actions directly. While it is impossible to
be a perfect parent and some of this is to be expected, inadequate parenting causes
tremendous fragility in children’s psychic systems. Melanie Klein, John Bowlby, and
Mary Ainsworth’s all proclaim that inadequate parenting can result in a failure to
internalize a sense of safety, leaving the child with the perception that the external world
is frightening.214 This perception can lead to constant high levels of anxiety that cannot
be maintained indefinitely. Arnold Washton and Donna Boundy propose that the failure
to internalize a sense of safety plays an integral part in the development of chemical
dependence:

The single most distinguishing trait of the addiction-generating family is that it
fails to meet the dependency needs of its children, not necessarily by outright
neglect and abandonment but, much more often, simply by failing to acknowledge
the child’s emotional reality. Families do this by conveying to the child that it is
“not O.K.” to have certain feelings and perceptions. The result for the child is that
she learns to repress her true self (her emotional integrity and vitality) and erects
in its place a false self.215

Trust, safety, and anxiety are all related to one another. Jason A. Colquitt and his
team identified that trust possesses three aspects: trustworthiness, which is the ability,
benevolence, and integrity of a trustee; trust propensity, described as a dispositional
willingness to rely on others; and trust, which is the intention to accept vulnerability to a
trustee based on positive expectations of his or her actions.216 If those aspects are not
learned in the first stage of development, a constant state of mistrust is established.217
The development of mistrust causes an individual to experience heightened levels of fear,
insecurity, and psychic pain. Trudy Govier believes self-trust is a necessary condition of
personal autonomy and self respect.218 While clients have to determine their relationships
with the outside world, self-doubt inhibits the ability to internalize the connection
inherent in the use of trusted others. An extreme example of this concept manifests with clients who have dependent personality disorder.

In regards to chemical dependence, an interesting assertion by Pamela Jennings was that people with chemical dependence experience a grief process specific to and determined by unresolved past losses of loved ones.\textsuperscript{219} In other words, they experience grief about the loss of the positive aspects of drugs that mimics the way they have experienced attachment losses with humans previously in their lives.\textsuperscript{220} Sheila Powell also references the importance of mourning and overcoming naïve beliefs in childhood fantasies of safety.\textsuperscript{221}

In this theoretical orientation, there is an abundance of information about incestuous relationships. Samuels explores the roles of gender in therapy and how slippery identification of incest can be.\textsuperscript{222} Simply put, individuals in our culture are fascinated with the father.\textsuperscript{223} As roles have changed over the last century, women are in the workforce more and fathers are increasingly involved in parenting. It is to be expected that the role of fatherhood is being continually redefined. I have often been confused about the depiction of the concept of incest in psychological literature. While it is abundantly clear that it happens, I have felt there are times when the relationships between fathers and daughters, or mothers and sons, have been unnecessarily demonized. Powell’s explanation below clarified the problem and alleviated my confusion.

Powerful identification with a father who offers the girl love and some measure of respect, and honours her individuality and separateness because of her sex, may lead to her development as an independent thinker. We cannot omit the possibility that it might lead to her doubt about her adequacy as a woman, especially if the mother has been devalued by the girl for some reason.\textsuperscript{224}
In recognition of the reality that chemical dependence and its associated behaviors are socially rejected, several theorists explain how people in pain, seeking sweetness, are seduced into the depravity of this lifestyle. Craig Nakken explained that people with chemical dependence often confuse the need for intimacy for a desire for intensity.\textsuperscript{225} Arnold Washton and Donna Boundy identified several incentives motivating chemical dependence. They found that intoxication is generally experienced as the temporary satisfaction of needs for the following: creative play, a sense of autonomy and personal potency, vitality and aliveness, predictability and consistency, and self-acceptance and self worth.\textsuperscript{226} Specifically, the “high” can provide a relief from the pain of isolation, a distraction from feelings, the illusion of control, a sense of pseudo-pleasure, a sense of predictability, and an enhancement of one’s self-image.\textsuperscript{227}

Lynne M. Cooper demonstrated a predisposition to engage in risky or problematic behaviors during adolescence.\textsuperscript{228} Neiss verified that “getting high can satisfy dependency needs without requiring the emotional risk of trusting another person; mind-altering substances or intoxication, unlike interpersonal relationships, are predictable and dependable.”\textsuperscript{229} Intoxication provides the temporary ability to relieve needs on all levels of Maslow’s hierarchy (transcendence, actualization, aesthetic needs, needs to know and understand, esteem needs, belonging and love needs, safety needs and physiological needs).\textsuperscript{230} Intoxication has the power to satisfy needs with a “quick fix” for various forms of suffering and generally reinforces the belief that needs can and should be met immediately.\textsuperscript{231} Robert Dupont identified that chemically dependent people are enslaved to immediate pleasure despite the prospect of the potential for catastrophic long-term negative consequences.\textsuperscript{232} Brown’s treatment for managing the ambivalence between the
desire to use drugs and the opposing desire to remain sober is the use of the paradoxical therapeutic intervention.\textsuperscript{233} In this intervention, the therapist enacts the position that the client enjoys intoxication and the therapist does not understand why he or she would want to quit. The client becomes challenged to defend why he or she wants to quit in an integrated, embodied way that authentically desires sobriety.\textsuperscript{234}

In short, the need to connect with others is powerful and it affects the motivation for people’s behavior in various ways. When it appears to individuals that they are unable to be accepted as they are, they compensate through various defense mechanisms including chemical dependence. The longing to belong is profound and when it inspires chemical dependence, it is important to find ways to connect with others in healthy, satisfying, and complete ways. It is necessary to recognize social expectations for belonging, specific arenas where expectations best suit the identity of the client, and to honor the humanity of our clients. The next step in this exploration is the socio-cultural perspective on chemical dependence.

**Socio-cultural Perspective on Chemical Dependency**

The socio-cultural perspective details the impact of chemical dependence and how it is influenced and reciprocally influences many arenas of culture. Mind-altering drugs have historically been included in a range of activities from public social celebrations to sacred, reverent rituals. Documentation of the use of these substances goes back as far as 10,000 years and can be found in the earliest historical records. The world-wide use of mind-altering substances was described in historic texts with two predominant opinions: they are divine and/or they are disgusting. In the spiritual, religious realm, mind-altering
substances have been used in rituals in honor of many specific deities. Some deities who ruled over beer, wine, and other similar substances were depicted in scenes full of festivity, joy, and hedonistic pleasures. Other deities were associated with nature and specifically with agriculture and deep levels of interpersonal connection. The deities devoted to mind-altering substances all ruled over the experience of vitality, joy, connection, love, and a vibrant exuberance for life.

The religious concepts inherent in the depiction of the deities in combination with self-reports indicate that the reasons that people abuse drugs include the seductiveness of intoxication, desire for relief from unpleasant emotional states, the titillation of doing something illegal and trying not to get caught, boredom, the association between drug abuse and powerful public icons, an effort to impact their public personas, and occasionally for practical purposes like completing more activities or work.

Culture, ethnicity, gender, and context influence the development of individual. Context is defined by John Santrock as the backdrop from which every individual originates. He contended that people are affected by cultural, social, historical, and economic factors that impact the foundation of cities, neighborhoods, communities, peer groups, and religious and/or spiritual focus. He noticed that behaviors and beliefs are passed from generation to generation in a particular group of people connected through ethnicity. Santrock defines ethnicity as an individual’s cultural heritage, religion, language, genetic roots, values, history, and customs. He described gender as being male or female. The ways people are affected by and mutually affect their cultures are central to understanding the relationship between chemical dependence and psychology.
Prior to Benjamin Rush’s work, which first identified alcoholism as a disease, people with chemical dependence were viewed as weak-willed degenerates. Both attitudes about chemical dependence have endured. For the majority of history, the treatment of chemical dependence was left to medical doctors, mental institutions, religious specialists, and penal authorities. Currently, treatment providers include specialists with certificates in chemical dependence counseling, Alcoholics Anonymous (AA) meetings, psychiatrists, and psychologists. Alcoholics Anonymous philosophies are at the core of most treatment plans and so far, research from all fields has supported the use of AA strategies. When AA originated, the majority of people seeking treatment abused only alcohol. Today, it is far more common for people with substance-related disorders to abuse a variety of substances. Alcoholics Anonymous and its subsidiaries have used anonymity as a way to assist people with overcoming chemical dependence issues without amplifying the social consequences already incurred. Joining AA offers the opportunity to experience belonging when a person with chemical dependence needs to abandon the social connections that have reinforced his or her drug use.

The shame and pride associated with intoxicants have sculpted the related sociocultural mores. Shame has been identified in virtually every culture. The cause of shame is dependent on an individual’s specific cultural expectations and mores. As social customs create a pleasure-less society, the glorification of mind-altering substances and sex escalates. When exploring illicit substances, it is imperative to understand the demographics in which people live as a beginning to understanding the social pressures, stereotypes, and expectations they encounter in their lives. For example, cocaine is often
depicted as a preferred choice by women, whereas alcohol tends to be associated with men. 248

Stanton Peele traced how chemical dependence was a function of poverty and deprivation. 249 In dangerous environments with group approval of substance abuse, such as the Vietnam War, widespread drug use is likely. 250 When people are removed from those environments and returned to less stressful circumstances where there is less support for drug use, individuals do not continue excessive use unless they were heavy users prior to military service. 251

Considering the idea that intoxicants have been used for pleasure, it is not surprising that people who have less pleasure would be most tempted to abuse drugs. Many patients seeking or referred to drug treatment for chemical dependence have been given a dual diagnosis. 252 A number of studies have shown that substance abuse diagnoses run in families at a higher rate than other serious mental illnesses. 253

Interpersonal connections are drastically impacted by people with substance-related diagnoses. While people in relationship to individuals who suffer from chemical dependence often feel unable to affect them, Robert Dupont maintains that “people who are not addicted can raise the ‘bottoms’ for addicted people. This means creating painful consequences that help addicted people recognize that their lives with alcohol and other drugs are unmanageable.” 254 This topic has become so popular that the television show “Intervention” on A & E, which portrays estranged family and friends intervening with deteriorated loved ones who are chemically dependent, was a 2009 Emmy Award winner. 255
The impact of the social customs on adolescent females has been observed as increasingly detrimental since the 1960s. Mary Pipher attributes the increase of clinically significant symptoms to the increase in societal investment in media and its underlying sexualized, dangerous messages she calls *hurt isms*: capitalism, lookism, and sexism. She theorized that the reaction to the hurt-isms has been an increase in substance abuse, eating disorders, post-traumatic stress reactions, phobias, sexually transmitted diseases, self-mutilation, and suicidal ideation.

Not only do youth seek excitement, they often suffer from isolation and confusion. The isolation especially appears to have a profoundly negative effect. While this may seem hopeless, it is not. Lynda Kay Burton Higgins noticed that simply having a mentor whom a young women could trust provided a statistically significant increase for five characteristics: global self-esteem, competence, lovability, body appearance, and identity integration. There was also a decrease in harmful behaviors including chemical dependence.

Albert Bandura’s popular theory about role modeling noted that children imitate people who have a high social status. He recognized the importance of *vicarious reinforcement* because children mimicked up to 80 percent of behavior when they witnessed a person enacting an action with a self-rewarding attitude. The 80 percent mimicry rate has the potential to increase when children witness someone with whom they are bonded enacting the self-gratifying behavior. J. R. Koopmans and Dorrett Boomsma found that children between the ages of 15-16 had between 58 percent to 88 percent resemblance of parental patterns in alcohol abuse while older children were less impacted by parent’s patterns. Bandura’s social learning theory is based on the
premise that children imitate behaviors, particularly behaviors that possess the rewarding experience of interpersonal power. The media have become an increasingly influential part of American life. They are even more influential on individuals raised around chemical dependence. Stephanie Brown recognized that children raised in alcoholic homes are taught not to trust their perceptions or not to seek reality testing because it is likely that neither will be consistent with their alcoholic parent’s perspective. As they attempt to discover what life outside of an alcoholic home is like, they tend to turn to the media and discover fictitious perceptions with unrealistic expectations.

American youth are exposed to media an astonishing average of six hours and 32 minutes daily. Much of that time is spent alone without supervision or help comprehending the accuracy of the images. The concern about media stems from the exaggerated stereotypes depicted, excessive violence, hyper-sexual behaviors, and misrepresentations of life overall. An example of the exaggerated stereotypes can be seen in the movie Mr. and Mrs. Smith. During the scene where the characters meet, they proceed to drink more than seven shots of alcohol at one meal, the equivalent of binge drinking for either gender, and they do not slur their words or otherwise demonstrate symptoms of alcohol intoxication. The study “24 Hours: Unplugged” had 200 college students give up media for one day. The results of the self-report indicated that the test subjects felt isolated, disconnected to everyone including those they felt closest to, bored, and increasingly anxious throughout the 24 hours. The University of Maryland’s blog about this research read as follows: “American College students today are addicted to media, describing their feelings when they have to abstain from using media in literally the same terms associated with drug and alcohol addictions: in withdrawal, Frantically
craving, Very anxious, Extremely antsy, Miserable, Jittery, Crazy.”

Appendix 3 lists a range of contemporary stories depicting intoxication, chemical dependence, and public opinions about them that have impacted many clients, including Cheryl.

Families where chemical dependence manifests largely function in what Omer would describe as a symbiotic mode, which emphasizes oneness, enmeshment, and sameness. The larger culture functions in a decentralized mode, where the preference is anarchy over hierarchy. Christina Grof explained that cultural messages encourage people to satisfy their sense of deficiency through various external activities or material substances. She recognized how people who have been denied their heritage and spiritual roots, through repression or conquest, feel a deep sense of alienation from themselves, others, the world, and their spiritual deities. Responses to the alienation range from enmeshed connections to isolation and a sense of deficiency.

In the symbiotic mode, criticism is perceived as an act of an enemy that inherently creates a fertile foundation for scapegoating. Families or close friends engaged in codependence with the individual who chemically dependent enact the symbiotic mode. Brown describes in detail the extent to which families shelter the person from his or her consequences or manipulate to get what they want by trying to control the individual. Shame-anxiety blocking is most associated with groups that value sameness above all else. In response to social pressures to be the same as others, the formation of identity is substituted by projective identification; i.e., one function of the pressure to be like others is the derailment of the formation of identity. The symbiotic mode encourages the presentation of a purified identity instead an individual’s authentic self.
Those who live with people who are chemically dependent often have the same lack of identity formation as the individual with the diagnosis.

The symbiotic mode feels dramatically different than the decentralized mode. This is important when realizing what clients will face as they begin to live life without being enmeshed with others. The larger society functions in a decentralized mode.\textsuperscript{283} Robert Bly’s concept of the \textit{Sibling Society} is a kindred term to decentralized.\textsuperscript{284} The contrast between the two modes is the difference between being enmeshed and being abandoned. Clinicians need to be mindful of the social environment in order to help the client create a social circle where he or she will feel supported, rather than isolated or abandoned, during the recovery process. Bly recognized that the lack of elders largely contributes to the abundance of chemical dependence because it results in youth feeling an overall feeling of hopelessness, lack of direction, and confusion about how to manifest one’s individual potential.\textsuperscript{285} Bly also attributes some of the struggles with female development identified by S. Powell, M. Piper, and B. Meador to the Sibling Society mode of functioning.\textsuperscript{286} In a world where people must assert themselves in order to attain status or get needs met, and the female forms of power have been distorted to appear weak, masculine modes of being become overly used and people generally have imbalanced functioning strategies.\textsuperscript{287}

During the process of recovery, individuals generally leave enmeshed, codependent relationships and enter into sobriety without trusted, sober social connections. Treatment for chemical dependence must focus on providing mentorship and facilitating the development of healthy relationships. This focus will allow the individual to get his or her underlying dependence needs met while developing a sober,
authentic identity. Ideally, the recognition of Omer’s symbiotic and decentralized modes will assist a treatment provider with comprehending the importance of developing support networks for newly sober clients.

Many of the chemical dependence trends depict Bly’s Sibling Society values and Omer’s decentralized modes of being. One such trend is that the age of first use of an illicit substance has lowered. Mark Goldman found in January of 2008 that 50 percent of children surveyed had started drinking by the eighth grade.\textsuperscript{288} Goldman went on to say that 38 percent of people who began drinking at age 13 developed an alcohol dependence problem.\textsuperscript{289} Structured interviews and twin research studies by Carol Prescott and Kenneth Kendler found strong evidence linking early drinking onset and the risk for alcohol dependence.\textsuperscript{290} The results from the National Survey on Drug Use and Health indicate that people who abused alcohol prior to age 15 were more than five times more likely to report alcohol dependence than a person who first tried alcohol over age 21.\textsuperscript{291} Similar data were demonstrated for cannabis use.\textsuperscript{292}

Mark Willinbring stated that alcoholism is a unique addiction because many people can drink socially without falling into chemical dependence.\textsuperscript{293} He asserted that substances like cocaine, heroin, and methamphetamines typically do not have social users who maintain control of their use. Most people can say they know someone who abuses marijuana and has not been drastically socially impaired by that use. For others, it is the source of marital discord, legal problems, and vocational or educational consequences. There are strongly held polarized opinions among individuals participating in academic and social discussions alike as to whether or not a person can be dependent on one substance and use another substance but not be dependent upon it.
The history of drugs depicts periodic social shifts of opinion regarding drug abuse. Authors who wrote about chemical dependence consistently agree that individuals who freebased cocaine in the early 1980s were perceived drastically differently than the crack abusers in the 1990s, even though the substances ingested were nearly identical. In a therapeutic arena, it is important to acknowledge how clients judge their drug use and how they are perceived by others according to the current spirit of the time characteristic of their age or generation. While the social rules may be very similar across generations, the way the rules are embodied can be very different. Chemical dependence has been around for a long time but it has not always been as rampant as it is today. Acknowledging the problems that manifest at the personal and cultural, or micro and macro, levels will paint a picture of the larger story and orient a person inside of the reality of their situation. From this place, individuals can begin to understand the source of their struggles as they are validated for the pain inherent in their symptoms.

Imaginal Approach to Chemical Dependency

Imaginal Psychology, as conceptualized by Omer, recognizes the original intention of psychology and is primarily concerned with the care of the soul. Imaginal Psychology has a few central components that need to be defined in order to comprehend the theoretical orientation, components which include the origins of the term Imaginal Psychology. According to Omer, “Soul refers to the mysterious stillness, aliveness, and otherness at the core of being.” Thomas Moore asserts that it is impossible to precisely define soul but he intuitively believes it has to do with genuineness and depth. We can infer more about its meaning when we consider what Freud intended when he used the
German word “seele,” meaning soul, to describe the mind, ego, self, and psychological aspects of the psyche. Soul and imagination are related. The root word of Imaginal is image and Omer noted that images manifest from the imagination. Henry Corbin described the imagination as the organ of the soul that allows the soul to know itself.

Obsessions, addictions, violence, and loss of meaning are symptoms Moore attributed to the “loss of soul.” He explained that when the soul is neglected, it does not go away; it manifests as symptoms that attempt to try to heal individually. Moore indicates that the alleviation of individual symptoms does not resolve the problem. His solution is to seek out guidance for restoring lost wisdom about soul, to care for the soul, and to live soulfully. One way of living soulfully is to experience ecstatic states. Omer explains,

Ecstatic states liberate consciousness from the constraints of identity. Integrative ecstatic states are states where awareness is focused, alert, and fluid. Ecstatic states have both integrative and disintegrative modes. Trance states are a special case of disintegrative ecstatic states.

Omer indicates these experiences are a psychological necessity of which modern people are deprived. He theorizes that the organization of the American culture prevents ecstatic states with all of its ‘isms.’ Omer theorized this was a response to the decentralized mode of being, a mode described in the socio-cultural section.

Psychology is logos of psyche or the field of study, reason, or “word” of the soul. The imaginal approach is sourced through what are seen as psychology’s predecessors in psychology, through the fields of religion, arts, and indigenous wisdom, to assist with understanding psychological processes. Omer’s development of Meridian’s approach to transformative learning involves imaginal structures. Omer wrote that
assemblies of sensory, affective, and cognitive aspects of experience constellated into images; they both mediate and constitute experiences. The specifics of an imaginal structure are determined by an interaction of personal, cultural, and archetypal influences. These influences may be teased apart by attention to the stories that form personal character and the myths that shape cultural life. During the individuation process, imaginal structures are transmuted into emergent and enhanced capacities as well as a transformed identity. Any enduring and substantive change in individual or group behavior requires a transmuting of imaginal structures. This transmutation depends upon an affirmative turn toward the passionate nature of the soul.\textsuperscript{308}

James Hillman developed archetypal psychology, which was built on Eugen Bleuler’s concept of depth psychology. In Bleuler’s depth psychology, the approach focused on moving downward through deep layers of the mind, through repressed or childhood memories.\textsuperscript{309} Hillman expanded on this by including exploration of the deeper spiritual dimensions of human experience.\textsuperscript{310} Use of imaginal approaches further deepens meaning by re-sacralizing and re-enchanting human experience, which Omer asserts is an imperative response to the traumatic secularization of the modern period.\textsuperscript{311} Thomas Moore described his understanding of the central task in psychotherapy as follows:

Tradition teaches that soul lies midway between understanding and unconsciousness, and that its instrument is neither the mind nor the body, but imagination. I understand therapy as nothing more than bringing imagination to areas that are devoid of it, which then must express themselves by becoming symptomatic.\textsuperscript{312}

Mary E. Connors found that integrative treatments of symptomatic disorders, including substance abuse and eating disorders, evoke optimal responses in clients.\textsuperscript{313} The value of an image is that it is integrative and can be perceived viscerally, intellectually, and spiritually simultaneously.\textsuperscript{314} This approach to chemical dependence treatment targets the core problem of the mind-body split. The imaginal approach inherently strengthens mutually entailed \textit{capacities}, capacities that were previously retarded by neglect and/or excessive use. The integration functions as a reparative
process unifying aspects that were previously compartmentalized. Capacities, according to Omer, are defined as a “distinct dimension of human development and human evolution that delineates a specific potential for responding to a domain of life experience (e.g., Compassion responds to Suffering; Courage responds to Danger; Destinicity responds to Future; Dignity responds to Failure; Fierceness responds to Injustice; Faith responds to Uncertainty; Reflexivity responds to Personal Identity, and so on.)”

One practice used in the imaginal approach is to develop awareness about the interplay between the Gatekeeper, the self, and the Friend. Omer referred gatekeeping as “individual and collective dynamics that resist and restrict experience. The term Gatekeeper refers to the personification of these dynamics. Cultural Gatekeepers restrict experience; cultural leaders catalyze the deepening and diversification of experience.” In contrast, the imaginal structure called the Friend “refers to those deep potentials of the soul which guide us to act with passionate objectivity and encourage us to align with the creative will of the cosmos.” Melissa Schwartz described the Friend as an internal mentor whose message consistently is, “You are a valuable, soulful being who is worthwhile and capable.” The Imaginal Approach is targeted at strengthening the friend’s influence and disempowering the irrational terrorism inherent in the Gatekeeper’s attacks.

Differentiating the Gatekeepers from the Friend can be confusing, to say the least. Tracking the ecstatic imperative may assist with this task. The ecstatic imperative refers to the soul’s creative and symptomatic expression of its passionate and plural nature, despite the constrictions of personal identity and requirements of conventional culture.
The distinction between the Friend and the Gatekeeper can be made by assessing the qualitative differences in the *Two Modes of Desire*. The Two Modes of Desire include a desire experienced as a yearning in relationship to the future and the desire as craving or clinging in relationship to the past.\textsuperscript{321}

The Gatekeeper is typically associated with discomfort or anxiety, but that is not always the case. One example of an experience where it is easy to confuse the Gatekeeper and the Friend occurs with the “what ifs”: “What if I had called five minutes earlier, what if I had said it a different way?” and so on. The “what ifs” are questions posed in relationship to past occurrences that cannot be changed. It may not be painful to entertain this type of question but it is problematic because such questions may involve an individual in perseverating about past incidents without hope for the future. The Friend may ask questions like, “What could I do differently in the future?” This type of question allows individuals to explore what they want or hope for, how they could try to respond differently to similar stimuli, and so forth. The Friend minimizes unnecessary self-beratement while it simultaneously inspires personal accountability and responsibility.\textsuperscript{322}

In terms of reintegration, the mind-body split is central in chemical dependence. Intoxication is a deeply felt body experience. The image of the body, or Mother Earth, is an integrated image often associated with chemical dependence. It is a commonly known religious reference that the body is the vessel of the soul. Jung described the earth as the female body.\textsuperscript{323} A bodily experience of a story can provide a unique awareness about subtle, important nuances. Omer taught that stories provide enzymes to digest our experience.\textsuperscript{324} He expanded this concept by noting aspects involved in transformation and therapy.
Our imaginal structures facilitate the digestion of our own stomachs. We become afraid that we can’t eat after that. The Greater story holds us here. Our beliefs have become relativized. When you look at King Agamemnon, you can better able to see your relationship with your dad. This is a storied vision of your universe. Ground your interpretation in time. A moment is how a soul punctuates time. . . . When you respond to the moment, you can see what was living in the moment by unpacking it—unpacking by identifying all of the responses to the moment. When more and more people respond, meanings get made. As the lungs breathe, the soul stories. We know the state of our soul by how we experience them. Every image has a telos (Greek word meaning purpose, end, or goal). Repressing images sacrifices your future. The telos is the link. The use of Ritual helps bring us back to reengage with the telos. ‘Rita’- the way of the river is directly related to the dow.\textsuperscript{325}

Perera utilizes the story of the Celtic Queen Maeve to illustrate many aspects of chemical dependence. She described the mind-body-soul disconnection and how people enact that disconnection by ignoring, rejecting, or dismissing their bodily experiences.\textsuperscript{326} The archetypal mother is an aspect of Queen Maeve.\textsuperscript{327} Perera describes her as a mother earth goddess who is whole, complex, diverse, and vital.\textsuperscript{328} Distorted mother and father archetypes predispose a person to chemical dependence. The way the mother archetype manifests is determined by the actual mothering received.\textsuperscript{329} According to Mary Ester Harding, the positive maternal image is the normal and prevailing one.\textsuperscript{330} The positive portion of this archetype can be minimized by the domination of the devouring mother in the psyche when an individual has not gotten his or her maternal needs met.\textsuperscript{331}

One perceived problem in the father-daughter relationship, when incest is not occurring, is the way the relationship is used to compensate for the daughter’s need for her mother, a feminine sage or role-model. Regardless of desire, a father cannot be a female mentor. A woman’s re-identification with the feminine signals a profound change where she becomes deeply rooted in her identity as a woman.\textsuperscript{332} Perera depicts a detailed process of the overcoming chemical dependence through the reintegration of the
feminine. Powell and Seligman support Perera’s theory when they describe people with this affliction as disembodied, half-alive beings. Hope Edelman suggests that the dynamic described by Powell is connected to a need for constancy driven by the insecurity underlying chemical dependence and other addictions.  

The unmothered child often wants to grasp things because she’s so afraid they’ll go away, that they won’t be there when she needs them . . . back to back relationships, overeating, overspending, alcoholism, drug abuse, shop-lifting, overachieving—all are her attempts to fill that empty space, to mother herself, to suppress feelings of grief or loneliness, and to get the nurturing she feels she lost or never had. 

Perera incorporates the complete array of feminine archetypes in her image of Queen Maeve: a powerful, awesome, ecstatic image related to passion with the potential for birth, murder, and destruction. She has a regal status by virtue of her queendom, is a sexual seductress, the mother, a healer, the wife, the muse, goddess of war and wisdom, and the lover. Marion Woodman validates Perera’s assertion that the feminine has been wounded when chemical dependence manifests with the following statement: “What is missing is the balance which would restore the quality of living. The goal-oriented, rational, perfectionist, masculine principle has to be balanced by the feminine.” 

Andrew Samuels recognized how the archetypal image of the father is distorted in people with chemical dependence. He indicates that the distortion of the masculine is directly related to the distortion of the feminine. Samuels explained this distortion he saw in a client by explaining that the manifestation of the masculine/animus was expressed as a lack of respect for the feminine/anima as it was specifically enacted as a lack of appreciation for enriching experiences and a lack of discipline.  

Two central concepts worthy of elaboration are the words “addiction” and “drugs.” Perera explained that the words addicere or dicere translate as “to speak or
declare,” which she describes as a spiritual devotion or enslavement.\textsuperscript{341} The story represented by the root of the word \textit{addiction} depicts a man named Addictus who was enthralled by the foreign, exciting goods at the market place.\textsuperscript{342} He bought goods on credit he could not afford, which resulted in the punishment of being enslaved to his debtors.\textsuperscript{343} The story is profound on many levels, including that Addictus was seduced by the foreign, exciting items in the marketplace, he acted without integrity in response to the seduction, and he was punished by enslavement. In the books listed in the bibliography, it was common in all theoretical orientations for chemical dependence to be described as an addiction that was enacted through any behavioral pattern practiced to evoke an ecstatic experience and/or to distract from pain, stress, or overwhelm. In terms of the two Modes of Desire, addictions are desired, then enacted, in attempt to repeat early intoxication experiences while avoiding future pain. Avoidance or restriction of future experiences are, by definition, the Gatekeeper’s realm.

Robert Dupont explains the primitive desperation inherent in an individual suffering from chemical dependence.

The inner experience is not that of a willful tyrant; it is the experience of a slave bound to the brain mechanisms of addiction. Addicted people are slaves to their own hooked, selfish brains. They are as much the victims of the disease of addiction as their family members and others on whom addicts bring so much suffering.\textsuperscript{344}

Chemical dependency is often experienced by people as though their master, the drug, seduces them like a snake charmer in a Saturday morning cartoon. This charmer hypnotizes, lures them, and cunningly convinces them unconsciously to need, find, and use the drug without any regard for their best interest. Luigi Zoja explains that two lures to use the drugs are the excitement and foreign novelty.\textsuperscript{345} The temptation is most
seductive for adolescents, the population with the highest use rate, because they naturally seek exciting and exotic stimuli. The need for exciting stimuli becomes compounded by unmet needs for ecstatic experiences.

Christina Grof’s premise is that chemical dependence is the result of unmet spiritual needs. Spirituality is capable of providing the humble understanding that we humans are exquisite creatures capable of great beauty when we allow something bigger to channel through us. The traits that facilitate the occurrence described in the aforementioned sentence include faith, love, compassion, humor, authenticity, discipline, trust, and surrender. Spirituality involves the experience that individuals are held by something more profound than can be explained in a linear fashion, that we do not have to be perfect, that greatness may come from us but it is not something to be arrogant about, and so much more. Grof asserts that spiritual deficit leaves us confused, hollow, and desperate for satiation.

An aspect of religion that satisfies the need for ecstasy and spiritual connection is ritual. Luigi Zoja recognized that chemical dependence has the following components: initiation, ritual, belonging, secrecy, increased self-awareness, feeling needed and useful, being spiritually linked to a higher power, optimal frustration, and reintegration of the mind-body split. Nakken explains that the purpose of a ritual is to deepen a person’s commitment to a particular world view or devotion. Rituals used during chemical abuse reinforce the maintenance of chemical dependence patterns even though, strangely enough, these rituals seem to be the least fulfilling of all forms of ritual.

Throughout my studies, the concept of disrespecting a deity surfaced time and again. Actions that would evoke retribution from the gods included misguided rituals,
over-indulgence, lack of gratitude, and/or disregard for the sacred. It is an accepted belief that disrespected deities are vengeful.\textsuperscript{356} When emotions, bodily responses, interpersonal connections, or other experiences are not valued because an individual rejects or avoids acknowledging bodily sensations, there are consequences.\textsuperscript{357} In concrete terms, disrespect for the feminine occurs when women abuse themselves through malnourishment, gorging, self-injury, disregard, rejection, disrespect, or poisoning through actions like repetitive intoxication, eating disorders, behavioral addictions (to gambling, intensity, shopping, etc.), and constant attempts to control emotions rather than honor and be guided by them.\textsuperscript{358}

To be clear, there is value in intoxication when it is not abused. Many spiritual or religious contexts use intoxicants during rituals to help connect people to deeply spiritual experiences. Erich Neumann wrote about the deity of the Great Mother and how rituals dedicated to her often included the use of intoxicants.\textsuperscript{359} Perera noted that altered states of consciousness relax inhibitions and encourage spiritual and interpersonal connections.\textsuperscript{360} Jung expressed this notion in at least two letters of his correspondence, one to Bill Wilson and another about former patient. He wrote, “‘Alcohol’ in Latin is \textit{spiritus}, the same word [we use] for the highest religious experience” and, “His craving for alcohol was equivalent on a low level of the spiritual thirst of our being for wholeness, expressed in medieval language: the union with God.”\textsuperscript{361} Grof suggested that the only way to satisfy the craving for wholeness is with an on-going relationship with a “vast inner spiritual source.”\textsuperscript{362} At a visceral level, the spiritual connection can occur through a connection to people, nature, animals, food, sex, concepts, and universal experiences and is established through attunement.\textsuperscript{363} Throughout history, poets and
artists used substances to help them attune with the universe and with universal patterns often identified as truths.\textsuperscript{364} Intoxication has the potential to facilitate transformation. The problem occurs when the use of intoxication is overused to create spiritual connections.\textsuperscript{365}

People with chemical dependence generally seek to avoid suffering. While there is a variety of reasons for this, an underlying resignation that problems can be neither fixed nor tolerated fuels chemical dependence. In reality, suffering is an important part of development. James Hollis acknowledges that suffering is imperative to development and that finding meaning is the goal of life.\textsuperscript{366} Hollis equates addiction, neurosis, and ideological attachments with the avoidance of suffering. He suggests that the antithesis would be to face the suffering, discover the deeper spiritual meaning behind it, and develop a mature wisdom through the process.\textsuperscript{367}

But without the reverence, humility and strength to accept suffering and the many deaths that the ever changing life process requires us to experience, she is the maw that draws us into our numbing addictions, our frenzied passions and the living deaths which they bind us.\textsuperscript{368}

One comment by Omer and previously cited was that when multiple people identify responses to a situation, or unpack the moment, meanings get made. When this is done without collaboration, collusion can occur, creating another central problem to chemical dependence: codependence. Codependence manifests as distorted interpersonal boundaries. It is a form of suffering manifested by the dysfunction related to an individual’s pattern of focusing on the needs and behavior of others while ignoring or minimizing personal needs. People with chemical dependence are naturally codependent.\textsuperscript{369} Dianne Doyle Pita described classic counter-productive, codependent responses in therapists who work with chemical dependence, such as rescuing, enabling, controlling, becoming the \textit{messiah}, joining/enmeshing, or otherwise engaging in poor
boundaries by taking actions like excusing the client’s responsibility for his or her actions, telling the client what to do, or bullying the client into sobriety.

Perera describes how codependence manifests in the archetypal split with the image of the scapegoat complex: through the Holocausted goat or black sheep, the accuser, the priest or perfectionist, and the wandering goat. The priest and accuser attempt to control behaviors, the wandering goat rescues others by trying to minimize the pain or negativity for the people around them, and the victim bears the emotional burden of the entire problem. Each role manifests as a distortion of reality because no one individual fully owns his or her responsibility, or holds others accountable for his or her part. These who play a role in the scapegoat complex tend to blame others or to take excessive responsibility. Tanya Wilkinson explores this dynamic through the lens of the victim: victim as a betrayed innocent, a redeemer, a seeker, a pariah, and a trickster. She explains how people relating to someone with chemical dependence often feel trapped, as if they are hurting the addict if they hold him or her accountable for his or her actions. The helplessness along with the internal chaos caused by having ignored intense emotions lay the foundation for chemical dependence development.

The family dynamics associated with addiction generally include profound degrees of blame, isolation, and anger. In regards to the mother and daughter, Edelman described the motherless daughter, regardless of actual age, as a darker, less fortunate self that is void of the comfort and security a mother represents. She recognized that real or imagined mother loss generally wounds women at a primal level. Mary Elizabeth Canterna Douglass described mother loss as “an issue of soul.”

It is not a problem to be understood and resolved, but rather a mystery to be experienced. It is not an end, but rather an integral aspect of the
Life/Death/Rebirth cycle. The continuity of the life force flowing through the Mother line transcends the limitations of human rationale and serves the basic fabric of matriarchal consciousness. To face death and have a soulful relationship to the experience of Mother-loss, one must have access to this feminine consciousness, a dimension of reality deeply forgotten and lost in modern western culture.\textsuperscript{376}

Edelman points out that daughters who lose their mothers during childhood or adolescence mature faster than their peers at both a cognitive and behavioral level, but they retain only juvenile coping resources.\textsuperscript{377} Further, a child who loses her secure home base often becomes parentified, meaning that the child assumes excessive responsibility for her age, and has to develop self-confidence, self-esteem, and a feminine self-image by piecing together components on her own.\textsuperscript{378}

When the abandonment is the cause of the loss, children assume that it was their actions that caused the problem.\textsuperscript{379} This assumption often results in deep shame inspiring the belief they are not worthy of love, kindness, or better circumstances.\textsuperscript{380} Children cannot withstand severe emotional pain for enduring periods of time so their grief process looks different than it does in adults (i.e., they communicate emotions through play, may appear emotionally blunted or agitated, and they often grieve in bits and pieces over long periods of time as they become developmentally capable and emotionally stable enough to understanding their loss).\textsuperscript{381} Alcoholism, drug addiction, mental illness, and childhood abuse all can render a mother incapable of responding to her child emotionally.\textsuperscript{382} Edelman suggests that these symptoms can manifest in daughters with mothers who are physically present but emotionally numb or absent.\textsuperscript{383} As a young woman progresses through the process of healing from abandonment, she will have increasing accuracy in comprehending actual personal responsibility about the cause of her loss.\textsuperscript{384} Each
movement forward may be marked by periods of grief and coupled with emotions like anger, rage, guilt, and shame.\textsuperscript{385}

The motherless daughter and the father’s daughter are central themes in the research involving chemical dependence in women. Clarissa Pinkola Estés, Edelman, Reis, Perera, Moore, and Meador stated that addictions are a response to over-identification with fathers and/or isolation from or alienation from mother figures.\textsuperscript{386} Edelman described addiction as a love substitute when she wrote, “A motherless daughter uses addictions to heal herself from the outside in. She tries to medicate with alcohol or drugs, satiate with food or material goods, and master her environment with achievement and success.”\textsuperscript{387} Edelman quoted Estés when she wrote, “Back to back relationships, overeating, overspending, alcoholism, drug abuse, shoplifting, overachieving—all are her attempts to fill that empty space, to mother herself, to suppress feelings of grief or loneliness, and to get the nurturing she feels she lost or never had.” Reis said that women with chemical dependence try to anesthetize the pain, numbness, shame, fear, and havoc created by “the loss of the latest lover.”\textsuperscript{388} Efforts to function with the absence of meaning are fruitless and ultimately, the absence of meaning prevents developmental growth.\textsuperscript{389}

Steven Fox bridged many of the above topics as he acknowledged the importance of the Great Mother archetype and how chemical dependence is evoked by the need for ritual, the lack of initiatory experiences, missing mythical death and rebirth processes, lack of a clear self-identity, as well as unconscious venting of the Shadow.\textsuperscript{390}

Linda Leonard described a series of imaginal structures that depict the lived process of chemical dependence through three stages she identified as the flight, the fall,
and the creation. Carol Pearson identified a few archetypes reflective of developmental stages. According to Pearson, the Orphan, the Destroyer, the Lover, and the Sage each play key roles in a chemically dependent person’s life. Several other archetypes of hers also apply to this topic, including the Innocent, the Caregiver, the Seeker, the Creator, the Ruler, the Magician, and the Fool.

Shame and personal responsibility are integral parts of chemical dependence. Kore, Persephone’s name before she was initiated, ate seven pomegranate seeds during her incarceration, which prevented her from returning to the surface, i.e., it was her fault that she could not leave. Athena, the goddess of wisdom, was protected against shame when she was weaned by the goddess of shame. Chemical dependence is again related to the experience of missing an internalized, soothing archetypal mother. Adolf Guggenbühl-Craig depicted the enactment power and control as distorted attempts to be accepted, valued, and regarded with unconditional positivity.

Various theorists describe paths toward healing the symptom of chemical dependence. Many theorists proclaim that honesty is imperative for healing. Prin’s concept of rigorous honesty is similar to Angeles Arrien’s concept of the bone gates. Arrien’s bone gates depict a vehicle that cuts away anything that is not authentically part of our true selves: denials, indulgences, competition, comparison, seduction, strategizing for personal gain, cynicism, and anything that obstructs in the development of character, wisdom, and integrity. The Four Agreements by Don Miguel Ruiz are to be impeccable with your word, don’t take anything personally, don’t make assumptions, and to always do your best.
Samuels recommends being honest with oneself while working to integrate all aspects of the psyche as a means of reducing internal tension. Persephone became a goddess by healing from her traumatic loss of innocence and digesting the symbolic fruit of the underworld.

Inhibiting dogma had the benefit of helping to raise consciousness and even to discipline the indulgence in eruptive passions that can disrupt society. On the other hand, Western ascetic religions, in denying archetypal desire as a source of life and a primary pathway to access an individual’s experience of transcendence have contributed to the splitting off of a primary source of vitality. . . . When desirousness is unconscious and unmediated, it tends to come forth through the shadow mixed with power and aggression as coarseness, pathology, perversion and addiction or through sublimated forms that may lack in its fully embodied visionary potential.

Conclusion

In summation of the Literature Review, theorists in the biological view of chemical dependence recognize the physiological and behavioral responses to an intoxicant. Studies have been conducted that identify genetic, physiological, and neurological explanations for the inspiration to abuse and develop dependence on substances. Psychopathology affects an individual’s emotional experiences and has potential to negatively impact his or her physiological well-being.

Cognitive-behavioral theorists generally agree that chemical dependence develops as a learned, habituated process that is reinforced by beliefs. These beliefs become entrenched early in life, are reinforced, and when left untreated, can severely impair one’s ability to function adaptively. These cognitive schemas can lead to distorted automatic responses that influence affects and behavior.
Psychodynamic theorists focus on the underlying issues that drive how individuals experience themselves and the world. Identity development, which is determined by actual experiences, determines which assumptions individuals make about their lives. In chemical dependence, the assumptions that life will be overwhelming and painful, and will prove that an individual is inadequate, must be redefined to overcome the suffering inherent in this pattern.

Socio-cultural theorists focus primarily on how our external world affects our internal world. They feel that a person’s demographic distinctions will influence whether or not the individual will develop chemical dependence. They also acknowledge the impact of the current American media culture, which reinforces externalized joy, minimizes identity development, and disregards the trust of elders.

Theorists within the imaginal approach concentrate on the underlying causes of chemical dependence that cause the suffering to manifest. Imaginal psychologists attend to the ways the soul expresses itself, making meaning out of the expression, and strengthening the client’s capacities. Given that soul expresses itself in images, mythic and contemporary stories provide a useful lens through which chemical dependence can be viewed.

Each perspective depicts how individuals with this particular form of suffering have needs that have been ignored, devalued, and disregarded. In the biological perspective, the desire to evoke sensual experiences of which they previously have been deprived eventually results in the physical state of suffering. The suffering may be an indicator that an individual has a deeper organic problem typical of dual-diagnoses. For cognitive behaviorists, theorists consider maladaptive thoughts or beliefs to be the root
cause of intolerable emotional distress. Lies, devaluing oneself, and the belief that the world is unsafe all contribute to the reinforcement of chemical dependence.

Like humanistic psychology, Imaginal Psychology strives to treat the person rather than the symptom. Understanding the symptoms through various lenses can assist with reintegrating parts previously rejected or devalued. Imaginal Psychologists, like the socio-cultural theorists, take into account an individual’s culture, spiritual beliefs, and gender and how these things are influential in the person’s life.

One gap in the research is the limited number of qualitative research studies specific to chemical dependence that convey the individual’s deep experience. While theoretical work has been done by Perera, Leonard, Wilkinson and others who have provided a general overview, it is clear that continued research would serve the vast population of individuals affected by substance-related disorders.

Specialists from all theoretical orientations contribute to gaining understanding and providing treatment for people with chemical dependence. Each perspective offers valuable tools and approaches that may work with individual clients. While all clients are unique and need to be treated accordingly, there appears to be some consistent proof that many tactics described in this chapter are beneficial in treating chemical dependence.
CHAPTER 3

PROGRESSION OF TREATMENT

Treatment Planning

At the time, TLC did not require the use of a formal client plan. While the client plan was not required, it was necessary to identify key issues to be addressed during treatment. Cheryl stated that she wanted to maintain sobriety from cocaine. It soon became clear that her cravings were related to intimacy and dependence needs. Four treatment goals were established. The goals were to discover and implement healthy ways of satiating the need to connect with others, to maintain sobriety from cocaine, to develop increased tolerance for body sensations, and to actively practice self-care. Within these goals were short-term objectives which included identifying the pros and cons of cocaine intoxication, developing increased tolerance for honesty, learning to acknowledge and attend to physical sensations including affects, and practicing self-care when necessary. The interventions used included assisting Cheryl with identifying imaginal structures and identifying constellations of symptoms or patterns of behavior, humor was used as a distancing technique to help Cheryl develop objectivity, and she was provided compassionate curiosity. For more details about specific interventions, see Appendix 4.

The first goal was to discover and implement healthy ways of satiating the need to connect with others. During the third session, Cheryl identified that a primary lure to use cocaine was associated with the freedom it provided from inhibitions. Cheryl was
encouraged to associate an image that could represent her experience of the inhibitions. She felt that the image of enslavement or incarceration depicted the visceral, felt sense of her experience. Cheryl believed she was repulsive at her core and she thought others would abandon her if they discovered her core identity.¹ In response to her anticipation, Cheryl was flooded with catastrophizing fears of public humiliation and rejection. During cocaine intoxication, she was free of inhibitions and able to be herself.

The second goal was to maintain sobriety from cocaine. She did not make use of Cocaine Anonymous, largely because she was ambivalent about identifying herself as a cocaine addict. Cheryl struggled with typical questions including, “Am I am addict?” She was provided with psycho-educational facts in response to her inquiries, such as the stages of developing chemical dependence established by the Azure Acres Alcohol and Drug Treatment Program.² Cheryl felt annoyed by the complexity of her relationship to drugs. She self-identified as a habitual cocaine user but felt that the nature of her compulsions implied that she was a cocaine addict. Cheryl believed all other intoxicants failed to cause significant negative effects in her life and she did not want to discontinue their use. She was encouraged to notice when she felt more or less invested in sobriety so that we could discuss the underlying causes of her ambivalence.

The third and fourth goals were interconnected. The third goal was to identify and tolerate bodily sensations. Cheryl had a mind-body disconnect so extreme that she was unable to notice feelings of hunger, sadness, frustration, or pain unless they were exaggerated. Cheryl’s identification of the imaginal structures evoked by specific momentary physical sensations allowed her to address her integrated experience without compartmentalizing or addressing one area at a time. One helpful distancing technique
frequently used was for Cheryl to imagine someone else treating her the way she treated herself. She was then asked how she felt about that someone. In regards to starvation, lying to others, and other maladaptive actions, Cheryl grasped concepts she had not previously been able to comprehend. It appeared that Cheryl’s problematic physical pains were often the result of small problems that became exacerbated by neglect. Throughout treatment, Cheryl was assisted with identifying physiological cues indicating she had emotions or physical pain, and learning to experience and tolerate the sensations.

The fourth goal was to respond to her physical sensations. Cheryl liked cocaine because it did the one thing she had not learned to do: take care of herself. Cocaine satisfied the need for food, sleep, and love while helping her to achieve her perception of the ideal weight. Cheryl was assisted with tracking when she ate, starved, and avoided emotions through eating or starving. Then, she was assisted with exploring tactics for self-care that soothed her and relieved her of tension or discomfort. Coping skills like learning to cry, journaling, running, screaming in a pillow, dancing, and so forth felt foreign to her initially. She discovered effective strategies and she adjusted to using them over time.

Cheryl worked hard at her goals. She grieved the loss of not having received what she needed in her youth. Her grief was evoked in response to the awareness that she had not been taught how to care for herself. While there was pain and frustration in learning to feel, there was also beauty. Cheryl experienced sweetness and ecstasy when she successfully risked authentic social connections. Her joy compelled her to continue working through the therapeutic journey.
The Story of Treatment

When I first met Cheryl, I was struck by her electric personality. She was approximately fifteen years of age, beautiful, charismatic, and simultaneously engaging and defended. Cheryl was in several groups at a non-public high school (NPS) for at-risk and learning disabled students where I was employed. Cheryl was painfully distrusting in spite of her longing to relate to others. In group, she rigidly asserted her opinions with conviction, stood her ground, and demanded accountability and responsibility from others. My response was appreciation, respect, and compassion for the obvious pain inherent in her rigid intolerance. When she developed trust with others, she often sought support from them during moments of distress. She was responsive when trusted people approached her about their concerns for her well-being. Cheryl’s principles appeared to be a source of strength that helped her throughout her entire life because they afforded her with dignity, self-respect, and respect from others.

From ages seven to nineteen, Cheryl’s behavior patterns developed in response to her need to avoid or distract herself from suffering. She engaged in the habituated behaviors of self-injury, abusing prescription medications, and sexual promiscuity. She also vacillated between withholding self-rewards and then binging. She had marked areas of vacillation between extremes in the arenas of food, finance, perfectionism, and secrecy. Aaron Beck described addiction as typified by “any activity that affects the reward mechanisms of the brain [which] may lead to compulsive, self-defeating behavior.”3 Cheryl’s cyclical behavior during her developmental years met Beck’s criterion in both normative and unique ways.
Throughout her youth, Cheryl exhibited predictable behavior patterns. There were prolonged periods of self-control marked by attempts to be perfect, refusal to spend money, consistent self-care, control of self-harm impulses, excellence at vocational or educational tasks, and she would deprive herself of emotional intimacy. During this portion of the cycle, Cheryl would allow herself minimal need satiation while trying to believe she did not need anything. She held her body rigid and she complained of excessive fatigue and muscle soreness. After containing herself militantly, the cycle would shift when a triggering incident would occur and then she would desperately strive to maintain a sense of control. The triggering incidents often related to a failure to live up to exaggerated expectations, arguments with romantic partners, being confronted, or having emotional responses she could not control. She attempted to recreate order in her life by engaging in an activity with rigid focus at a constant accelerated rate (i.e., house cleaning, filing, running, etc.).

After Cheryl was graduated from high school, she periodically called to touch base. It had been approximately a year since she graduated when I was told that two former students had tried to revive an infant who died from sudden infant death syndrome (SIDS). I reconnected with Cheryl at the funeral. It was unusually difficult to read any of Cheryl’s nonverbal cues because she had been drinking, which she disclosed at the time. Cheryl indicated that she wanted to talk in a less public place.

The clinical supervisors at TLC were receptive to offering pro bono temporary treatment to Cheryl, and one other, due to the need, lack of resources, and the nature of the relationships she had previously established with the clinical staff. Shortly after the funeral, Cheryl was contacted and offered aftercare sessions. At the time, she did not
schedule sessions, but she did 14 months later. During the time between the funeral and her request for services, Cheryl experienced many changes. She had several romantic relationships. She began using various mind-altering substances. She explored different vocations and generally began to live an adult life.

When she contacted me, Cheryl said she felt like another “group home failure” because she had lost control of her drug use. Cheryl described her drug use as obsessive. She explained that she felt scared because she liked it too much. She had quit cold turkey without use of community resources two months prior to contact. Cheryl was surprised at how quickly her life deteriorated after she began using cocaine.

Our prior relationship provided a foundation of trust that served the therapeutic work we did together. She anticipated acceptance, praise, and support and she was receptive when she received it. When I told her I was proud of her for asking for help, Cheryl said she knew I would feel that way. She wanted recognition for recognizing her problem and taking steps to fix it. She indicated that she had needed to be sober for a while before she remembered that her fears of rejection were irrational because she knew I was welcoming and hopeful she would take the help offered to her. She was validated and given compassion around the terrible ordeal of both from the death and the drugs. Cheryl was assured that it was an honor to work with her again. Cheryl indicated she was grateful for the opportunity.

During the initial phone discussion, Cheryl said she “got drunk at the funeral and stayed that way for a year.” She described alcohol as a pain-killer. She was not fond of alcohol but was desperate for the relief it brought. She indicated that she had discontinued self-injurious behaviors during residential treatment. She had not found a
replacement for it and she did not know how to manage the horrific grief she felt. Nearly a year after the death, she was introduced to cocaine and her alcohol abuse drastically reduced.

The ecstatic experience of cocaine felt like a direct contrast to alcohol. Alcohol was a sedative that put her to sleep and anesthetized the pain. Cocaine felt invigorating, hopeful, and inspiring for Cheryl and it evoked feelings of excitement, amazement, ecstasy, compulsion, and eventually obsession. Her infatuation with cocaine was inspired by the social acceptance she received, the dissolution of hunger, the resulting weight loss, exotic sexual feelings evoked by the drug, and the inspiration she felt when intoxicated. Her feelings of vitality were a dramatic improvement over the numb, consistently depressed state she had endured during the prior year. She described feeling as if she had been freed from constant pain, sadness, and in her words, the “blah.” Cheryl knew that cocaine was a problem when she felt obsessively compulsive and unable to control her use in arenas she had previously considered inappropriate.

Cheryl’s description of her relationship to cocaine was dramatically different than her description of relationship with other intoxicants. She wanted to quit cocaine because she felt obsessed, compelled, and enslaved by it. Cheryl did not like the constant cravings, the excessive amount of time she spent thinking about it, trying to get it, coming down, or otherwise engaged with it. She enjoyed other intoxicants but she felt free to reject them and free from nagging cravings. She was disgusted by people who obsessed about drugs and she thought they were “stupid.” The years she had spent identifying substance related behaviors that she thought were stupid helped her to notice when she began enacting them herself.
The first session began with an intensity that was profound, excessive, and overwhelming. The bulk of treatment focused on the topics explored during this session. It was partially overwhelming because it felt as though there was far too much to accomplish in one hour. Cheryl had been exposed to enough therapeutic work in her youth that she was able to track her experience skillfully. Her observing ego was adept and she had been waiting for the opportunity to share all the things she had experienced, thought, and witnessed herself doing. She frequently commented that there was so much to tell me but she did not know if she could say it all in the first session, and she wanted to. We reconnected, focused on the treatment goals, established her relationship to the diagnostic symptoms, established a new adult-adult/child relationship, and began to orient ourselves toward the treatment goals.

We were thrilled to see one another. My first impression of Cheryl was that she looked healthy. She had gained some weight, which is normal for clients between the ages of 18-20, and this seemed hopeful because she looked strong and had color in her face. Once she began talking, she spoke quickly about personal details as if she could not talk fast enough to express all the information that she wanted to express. In one regard, it was as though nothing had changed. In another, Cheryl was a young woman, not a child. I was no longer an authority with control to influence her life as I had done when she was in residential treatment. As she spoke, Cheryl was provided unconditional positive regard, curiosity, and acceptance as a means to facilitate the development of our new alliance. She was encouraged to notice self-criticisms and contrasting self-supportive thoughts in order to develop awareness about the influences the Gatekeeper and the
Friend had on her. Recognition of the imaginal structures was used and reinforced throughout the sessions.

Cheryl was asked to talk in depth about the first time she used cocaine. She described her experience in the following way. She was at a party on a date when a man she had not met before, a man who became her boyfriend after that night, offered her cocaine. He was a moderate user who thought of cocaine as a mild, party drug. He was attracted to Cheryl and he offered her some as a means to create an opportunity to get to know her. The next morning, Cheryl discontinued the short-lived, prior relationship and focused her attention on the new man.

The story was somewhat surprising to me because Cheryl had never made impulsive relationship decisions in the past. A part of me was pleased that she had let herself try something new. Another part of me was scared for her because I understood the seductive power stimulants could possess for people with rigid control styles. Cheryl was asked what was seductive about cocaine. She smiled and said it offered the ultimate permission to be free. When asked how being high was different from being sober, she said, “If I’m sober and I talk, I say something people think is weird and they look at me funny. Then they walk away and stay on the other side of the room. If I don’t talk, people judge me. When I’m on coke, I can be me and I am funny. I say zany things and they love me.”

Cheryl was asked, “If cocaine is so good, why quit?” The paradoxical intervention used here was suggested by Stephanie Brown as a means to assist clients with feeling the embodied desire to discontinue drug use. Cheryl responded by sharing about her feelings of shame related to her drug use. She was upset that she lost control: she
strategized so she could use it without consequences and her strategy failed. At first she used cocaine on weekends. Before she knew it, she began to justify using it on weekday nights, and eventually she used it daily. When she used it at work and in other arenas she deemed inappropriate, she realized that she had crossed her own lines. She was clear she would feel humiliated if her boyfriend left her because of her drug use, which was a realistic possibility if her use continued. Cheryl explained that cocaine was less exciting than it had been prior to developing physical tolerance. She was sad she could no longer use cocaine without consequences or to recreate the initial high.

Since her social desires were a significant motivator, Cheryl was asked if she had considered attending recovery groups like Alcoholics Anonymous or Cocaine Anonymous meetings. Cheryl firmly rejected the idea. She was not interested in what she called “another group of treatment friends.” She expressed the belief that the people who attended CA were militant and she did not want to have to defend being there. She believed she had not hit bottom as badly as they had.

Cheryl was resistant to calling herself an addict. I felt this tension intuitively and did not press Cheryl to alter her stance. Her perception of addicts was individuals who used drugs for extensive periods of time, prostituted themselves, had deteriorated bodies (lost teeth, thin hair, acne scars, etc.), were unable to control their behaviors, engaged in criminal acts to get drugs, acted without integrity, and otherwise incurred more severe personal consequences than she had. When she thought about the idea of saying she was an addict, she felt like a fraud.

Cheryl was supported to identify herself the way it served her. She was provided Prin’s assertion that rigorous honesty is an imperative component of recovery. Cheryl
was struck by this concept as well as intimidated by what it would entail. She believed it was necessary to overcome cocaine dependence, although she was afraid of being that vulnerable. The fear she expressed evoked a sense of protectiveness in me. She was encouraged to take calculated risks by determining those with whom it was worthwhile to take interpersonal risks. This concept and the concept of integrity were revisited frequently during our sessions.

Cheryl listed seven key people she could trust: four were adults and three were peers. She was asked how she let herself trust me. Cheryl said she watched me consistently demonstrating a non-judgmental attitude toward others, so it seemed worth the risk. She was praised for taking care of herself. She was given the observation that she knew more than she gave herself credit for. There were various moments during this session that I purposefully enacted the imaginal structure of the Friend. Cheryl was responsive each time. She recognized the passionate objectivity and was receptive to these interventions.

Cheryl asked about Tanya Wilkinson’s *Persephone Returns: Victims, Heroes, and the Journey from the Underworld* because I had referred it to her previously. I briefly summarized the story of Demeter and Persephone, as it was told by Tanya Wilkinson and Robert Graves, and I explained a few key points. She inquired about my inspiration to refer the book to her. My inspiration had been intuitive. After the session, when I thought about it more deeply, I realized that my inspiration had stemmed from my recognition of various patterns she demonstrated that were consistent with Wilkinson’s assertions: her dedication to her father, her hatred for her mother, and the way she subjugated her own needs for the sake of others as a means to earn the right to get own needs met. I told her
there were several parts of the book dedicated to getting needs indirectly met that reminded me of her.

Cheryl appreciated Wilkinson’s distinction between being a victim and being victimized. She talked for a short time about how much she resented peers who acted like victims and did not own their personal responsibility. Cheryl adamantly resisted the idea that she was a victim. I encouraged her to recognize that being victimized was something real that she had endured, something she actively needed to explore in the process of healing. She agreed that she had suffered. As a means to assist Cheryl with making her nonverbal experience verbal, Cheryl was provided with a scratchboard upon which to create art.

Cheryl created four images, each portraying a portion of the story of Persephone (see illustrations 1-4). After completing them, she sat for a while. Eventually she shared that she could not imagine what the Queen of the Underworld would be like. After sitting for another few minutes, she expressed regret about not utilizing the therapy sessions offered to her after the funeral. When asked why she had not, Cheryl retracted her body and sat back in her chair. She lowered her eyes and said she felt guilty about being unable to revive the baby; she did not want to think about it, and then she did not want to think about the ways she coped with her grief. When she realized what she was doing, she wanted to ask for help but could not tolerate being rejected. After becoming sober, she felt more secure in the idea of asking for help because she was better able to trust that she would get what she asked for. Cheryl then disclosed how she felt she had been to hell. She had a natural ability to use stories as a backdrop for her experience. She easily connected with deep symbolism.
We had never spoken about her rape, yet she disclosed information in a way that indicated she thought we had. She proceeded to unpack the moment by talking about her response to the rape. She reminisced about how she used to look up to her brother, she adored her father, and she consistently felt her mother was “an ice queen.” She described her brother as a savior who validated her experience that her mother’s actions were not good.

The rape was an unthinkable horror because the person who helped her make sense of the world betrayed her. She did not know what to do because he was so important. She revealed that she periodically thought about telling everybody that she had lied about the rape, even though she hadn’t, because she wanted her brother back. In spite of how she longed to connect with him, she knew she would betray herself by lying so she did not do it. As Cheryl talked, she was provided active listening, compassion, and mirroring.

Cheryl explained that the rape, while horrid, was not the worst part of the incident. She recalled her mother walking in the room during the rape, then leaving without intervening. Then, when the act was concluded, her mother called Cheryl to her room, chastised her for allowing “it” to happen, and then directed her not to let it happen again. Cheryl’s mother did not overtly say what she was not supposed to allow. Cheryl believed whole-heartedly that her mother knew she had been raped and blamed her for it. When she spoke, I felt disgust, rage, an intense desire to obliterate her mother, and a desire to rescue her from her mother’s wrong-doing. Rather than take a stance, I provided active listening and validated her feelings.
Cheryl indicated that her mother’s betrayal transformed her. She used the movie *Drop Dead Fred* to describe how she felt. From prior experiences, Cheryl knew that I appreciated her use of images to depict her experiences. When she did this, she indicated if the images felt perfect to her or if they needed modifications to be accurate. Cheryl called her mother called the “Mega-beast,” indicating that her mother was perfectionistic and domineering. Like the main character in the movie, Cheryl had responded by learning not to care about anything. She was asked how she did that. She disclosed how numb she felt after the rape. When the numbness went away, she used self-harm to distract herself from her emotions. She recalled hitting her wrists against the shower bar, getting bruises, her mother asking how she had been hurt, and telling her mother she did not know what happened. She was asked if she hurt herself anymore and she laughed, saying she was too vain to have bruises. I assured her it was good that she did not continue hurting herself the way others had.

Cheryl was struck by the reality that she had not talked openly about this with anybody in a long time. She was grateful to be able to feel vulnerable and safe. It reminded her that one reason she described cocaine as a savior was because it allowed her to be vulnerable and invincible simultaneously. The imaginal approach I used with Cheryl was to infuse language into the session that depicted integrated body images. During the first session, she responded to the discussion by feeling flooded with fear at the mere notion of being vulnerable. The fear triggered desire to escape. She openly discussed how seductive it was to attain psychic freedom from emotions with cocaine. She said cocaine relieved her from the constraints of her Gatekeeper and allowed her to connect emotionally with others, a relief she did not know how to attain sober. She was
encouraged to notice that she was emotionally connected during this session. Cheryl agreed but was quick to point out that the sessions had needed to be offered to her several times before she felt comfortable enough to take them. She was discouraged from discounting her courage and she was directed to notice how quickly she discounted herself. Cheryl responded to these types of redirections frequently by admitting that she understood what she was doing.

In order to enlist her help with her treatment, she was invited to explore how her imaginal structures interacted with one another. She was asked how often she discounted herself. She did not know. Cheryl was asked if she ever intervened with the part of herself that put her down or limited her choices. She did occasionally but it was uncommon. She was provided psycho-education about Imaginal Psychology and asked to consider actively intervening on her own behalf more often. Cheryl was tentative about trying new things, although her desire to feel better inspired her to take action.

Humor was used throughout this session and many others. Cheryl joked about “a little annoying red-head on her shoulder” who prodded her to do the right thing. Red is the color of my hair, and Cheryl was teasing that she had internalized my guidance and had already begun telling herself things she anticipated I would tell her. The language for the Friend tended to be discussed this way.

When asked when she last remembered connecting authentically when sober, Cheryl talked about being a little girl. Prior to being raped, Cheryl had a sense that she felt cherished and safe with her grandmother and occasionally with her brother. After her grandmother passed away and the rape occurred, Cheryl trusted a few people but all of
them had trust limitations. Aside from her grandmother, godmother, foster parents, and me, Cheryl identified her dad.

Cheryl was asked if she remembered ever feeling connected to her mother. She denied ever feeling close with her. Cheryl was asked about her relationship with other women. She thought it was not easy for women to like her because they were often competitive or they simply misunderstood her. She joked they were jealous because she was so beautiful, which was an attempt to present a reasonable truth without being arrogant. She also said she felt it was possible for women to like her because her godmother and grandmother thought so highly of her. Both of these role models saw her inner beauty and they adored her. Cheryl referenced my ethnic background and indicated that I reminded her of her godmother. She had said this before, but the maternal projection had not been as profound as it was when she said it this time. It validated my feeling that I had a mother projection on me in spite of how dramatically different I was from her description of her mother.

She was asked how she was able to trust her father. She recognized that her father was still married to her mother and they continued to have contact with her brother. While her mother had never admitted that the rape had happened, her father had written letters and had conversations with Cheryl’s brother in attempt to discover the truth. Even though he had not taken sides, Cheryl felt seen and cared for because of his efforts.

This last portion of emotional disclosure tipped the scales and it was clear that Cheryl felt overwhelmed. Due to the amount and intensity of information disclosed, Cheryl was given the process comment that her disclosures were intense, there would be plenty of time to talk about other details, and it was necessary to transition out of this
therapy session. She was encouraged to work with this because shifting out of a session this intense would be difficult if it were abrupt. She said she had wanted to say some of the things she had said for a long time and there was more to be said. While that was true, she admitted that it felt like too much at one time. She was responsive to the process comments and to the assurance there would be time to discuss everything. She was asked to engage in some coping strategies. We discussed options like writing in a journal, meditating, and doing art. She said she would talk with her boyfriend later if she needed to. Additionally, she was asked if I could call her and check up on her and she was receptive.

To assist with the transition, Cheryl was asked where she felt safe and she described images of tall redwoods and the ocean. She shared how she could feel God in those places, which felt safe to her. She was asked to visualize either of those places and to let herself be soothed. The session was ended after a meditative period, a brief discussion about weekend plans, and with the tenderness contained in compassion, validation, and honoring the work done in the session.

The first session was significant in therapy because it depicted the rationale for the goals and Cheryl’s potential to accomplish her goals. In the subsequent sessions, Cheryl struggled with desiring intimacy and resisting it. Together we modulated the intensity of our connection to allow her to become desensitized to the sober experience of intimacy. The intimacy of the first session matched the intimacy experiences of people intoxicated by cocaine as they have been documented by the autobiographical references in this case study. While it has been some time, it felt equally intimate to the experiences I had twenty years ago when I was intoxicated on stimulants.
At the beginning of the second session, Cheryl arrived with glassy eyes. She said she had consumed an alcoholic beverage and claimed she was not intoxicated. She was not slurring her words but she seemed defended or dismissive of sensitive concepts in a way that hindered the therapeutic process. Upon further inquiry, she revealed that she had been smoking pot daily since the last session although she was not high on marijuana at that moment. We talked for a brief period and did not continue because of her altered state. Cheryl accepted the limit that we not have the session that day although she indicated that she thought I was overreacting.

In the next session, we discussed Cheryl’s alcohol use. She said she was not embarrassed about the alcohol. She said she realized that drinking is something adults do and she unconsciously wanted to convince me she was an adult because she felt like a child around me. A portion of our time was spent acknowledging the reality that she used to be a child and she clearly had become an adult. Cheryl was provided some observations about the ways she had matured. Her experience was normalized, as was her skill level.

I communicated my experience of the first session by sharing the image of a water faucet that was turned on high and flooding the sink. She was told that she appeared to be hungry to be seen by someone she trusted and I knew she trusted me. I was interested in hearing her, which seemed to encourage her intensity. Cheryl agreed and stated that the image felt accurate to her. While our intentions were honest, the result was overwhelming. We consciously discussed turning the faucet on at a lower rate to help her learn to be with her experiences of vulnerability, intimacy, and the honesty.
From this point forward, one strategy used at the beginning of each session was for Cheryl to provide a self-report following a PETS guideline. When Cheryl would discuss a situation that felt overwhelming to her, she would identify how she felt physically (P) and emotionally (E) about it. After acknowledging her bodily experience, she was asked about her thoughts (T). She was encouraged to identify unified images depicting her entire experience. Lastly, Cheryl would self-report her level of spiritual (S) connection or disconnection. Cheryl often thought very quickly and through the use of PETS, she was able to slow down, attend to herself, and integrate her full experience.

This helped identify imaginal structures and communicate her present experience. When we first began to use this tool, Cheryl struggled to find words to describe emotions or physical sensations, largely because she relied on saying she was fine, tired, or okay. Over the course of the six months, Cheryl increased her vocabulary of emotional and physical terms so that she was able to communicate about herself more sensitively. As she became more competent in identifying her physical cues, the occurrence of physical types of suffering decreased. She also used imagery to talk about her relationship to her struggles. Cheryl revisited the idea of experiencing vulnerability and safety at this time. She shared images of women warriors having sex, giving birth, and otherwise engaging in vulnerable actions without being submissive or in danger.

After the client plan was established, Cheryl was encouraged to talk in small doses about her family of origin and her early developmental years. Cheryl described her home life as dualistic. Cheryl recalled how people outside her family respected and adored her mother. She noticed the value of her mother’s reputation and how Cheryl often was silenced as a sacrifice to maintain mother’s pure reputation. In her home, she
felt abandoned. Cheryl described odd patterns of interaction, like how all family members would eat dinner in their bedrooms away from one another every night. When asked about moments when she liked or appreciated her mother, Cheryl was stumped and said she thought that this had never happened.

Cheryl’s relationship with her brother was described as ambivalent. She depicted her relationship with her mother as clean: she simply did not trust, like, or respect her. If her mother had not remained married to Cheryl’s father, Cheryl said, she likely would not have contact with her now. Cheryl’s brother, on the other hand, both perpetrated the rape and had been her savior. He taught her a great deal about how to be in the family. He was kind and he validated her. She was sad to have lost him and she was aware of the price of her honesty.

Cheryl adored her father and he adored her. She divulged that her father was soulful, vital, funny, electric, and real when he was not absent physically or high on marijuana. In contrast, she said her mother was plastic, like a Stepford wife/mother. Cheryl felt confused about what her father saw in her mother. After she reported the rape, her father confronted her brother. While her father was not able to get any clear answers, the fact that he tried greatly affected Cheryl and she felt loved. He was not willing to take any action about the situation, which she rationalized. Cheryl had been abandoned by her father but she was unable to see his parental failures throughout most of the sessions.

Cheryl was asked how she would describe her relationship with me and why she trusted me. Cheryl said that she watched how I related to others and when she observed that I was consistently real, honest, and trustworthy, she was willing to risk talking to me. Cheryl felt profoundly affected by watching me acknowledge my mistakes and take
responsibility for my actions when I went too far. Also, she said that my passion, integrity, and clear intention of wanting to help people alleviated doubts about my motives. We discussed several other clinicians and TLC staff and how they earned her trust. What it came down to for her was that each of us was a passionate person who did not hide behind an institutionally sterile façade.

Cheryl was asked how she learned to trust peers or romantic partners. She said that was confusing. The people she knew when she was in residential treatment were the people she trusted the most because they had known her when she was less adaptive and still loved her. In romance, she responded to a primal attraction. Cheryl was challenged about this because her new boyfriend was very different from others in her past. Cheryl deflected by teasing about his sexual prowess. She resisted admitting openly that he was a good person. She thought he was the perfect boyfriend but she was afraid to be a married housewife this early in her life. Her image of marriage was equated with imprisonment.

While it was important for Cheryl to explore her history, it was also important to guide her toward personal empowerment in the future. As she became more comfortable with the concept of imaginal structures, I frequently would ask her questions about aspects of herself. For example, I asked her to talk about the part of herself that wanted to use cocaine. She responded to this distancing technique by being able to describe the id-like aspect. She was encouraged to notice how the Friend and Gatekeeper each affected the part of her that wanted to use. Cheryl intuitively identified each aspect. The overall response was a prolonged and drastic reduction of demonizing her desire to use while simultaneously developing a respect for what she vitally needed and wanted.
The sessions in the middle of treatment flowed fairly smoothly as Cheryl confronted obstacles hindering goal completion. As she explored her dependence needs, Cheryl’s opinion about whether or not she had been dependent on cocaine vacillated. She thought it was serious, then she believed she had exaggerated. Next she thought she was addicted to intensity and the drug was simply one way she acted out this addiction.

In order to begin to get social needs met, Cheryl identified some activities she wanted to try. She then took risks to participate in various social events. We discussed specific risks she took. Many of her expectations about how she would be perceived were challenged and proven incorrect. With each step forward, Cheryl was more accurately able to imagine how others would receive her and she was able to imagine herself in their shoes. Her self-doubt decreased and she was better able to seek the connections she longed for. She became less interested in mind-altering drugs and her compulsions shifted to sex.

Cheryl took dance classes, participated in role-playing games, and began to study for a job she had previously been too intimidated to consider. She was amazed at the reception she received when she asserted herself. Cheryl drank or smoked marijuana during some social events and she periodically was sober to prove to herself that she did not need the intoxicants.

As she met people and they accepted her, she found herself sexually attracted to a large number of people. I felt hopeful when this happened because it seemed that her body was coming back to life. Also, it felt risky because she seemed to have found a whole new way to be stimulated. Cheryl was open with me about the attractions she felt and the sexual attention she received. She toyed with the idea of submitting to her
passions. Cheryl did not tell her boyfriend about her desires. She made excuses for not telling him. She eventually admitted that telling him meant she could not act on them. While she was clear she did not actually intend to violate his trust, she knew that telling him would make her accountable at a higher standard and would nullify the thrill she experienced. She liked the tension of being wanted, wanting someone she could not have, and recognizing the power she wielded. She realized that she was concerned she was unconsciously sabotaging her relationship out of her counter-phobic urge to avoid being either abandoned or pressed to be more emotionally intimate than she was comfortable being.

Cheryl’s boyfriend was emotionally available, which was why she had initially been attracted to him. Now, his depth and strength were intimidating even though she was clear that these qualities were what she wanted. Cheryl was repeatedly given the paradoxical intervention of being confronted about why she did not act on her sexual impulses. While she felt attracted to another person, she remained attracted to her boyfriend and felt overwhelmed by the depth of intimacy they shared. Cheryl’s ability to hold the entire picture was a newly developed capacity. She was given the observation that she was using her sexual attractions to keep an emotional distance from her boyfriend. Cheryl understood this and struggled with deciding how to respond for some time.

After approximately three and a half months, Cheryl increased the amount of social activities in which she engaged and she found social acceptance in all arenas she explored. She had begun to develop platonic relationships with people who reciprocated what she had to offer. Cheryl felt reduced desire to use cocaine and her sexual
temptations became less tempting. She believed she had recovered from cocaine dependence.

Cheryl appeared inflated and overconfident. She went out of town with a relative who was a known methamphetamine user. Prior to going, Cheryl explained that she did not feel tempted to use because it seemed disgusting to her. I confronted Cheryl by asking if she was needlessly sabotaging her recovery. Cheryl was dismissive of the question although she appeared to be thoughtful about the inquiry. I knew this was a red flag and I felt concerned about how to intervene. My concern stemmed from the knowledge that any response potentially could inhibit her from feeling the full weight of the choices ahead of her. In order to leave her to sit with the full experience, I asked questions and made comments about typical pitfalls of recovery. Cheryl listened and indicated she trusted herself.

During the following session, Cheryl complained about how horrible the trip had been. She complained that the family member had set her up by asking her to be in another city without anywhere to stay the night. She knew Cheryl did not have money for a hotel room. Cheryl said she was offered methamphetamine, which she resented, and she did not use it. While she complained, there was something about her disclosure that seemed distorted or forced. This occasion was the first time I had difficulty believing what she said about her experience. The way she depicted her reactions to the situation were consistent and coherent. What was inconsistent was an unidentified thread of guilt. Throughout the session, Cheryl was provided active listening to verify that I understood what she was communicating. When I deviated from pure mirroring, Cheryl became agitated and wanted to correct my interpretations. I shared the process comment that her
story was confusing and I did not fully understand how all the pieces fit together. She accepted this and tried to explain but became frustrated when I pointed out inconsistencies. Ultimately, the session ended with my asking Cheryl if she understood more about her choices than she had before the session. Cheryl said she did. She also said she felt even more assured that she could resist drugs in the future and that she did not want to put herself in a position with unethical people again.

Cheryl was militant as she defended her belief that she could resist drugs and it felt extreme to me. Other than asking a few curious questions, I did not press her to defend her position. Cheryl was encouraged to tend to her needs. The session ended with a rare awkwardness between us.

Cheryl began the next session enraged. It was the first session in which she emoted immediately, which felt uplifting to witness because she had been so controlled previously. She talked quickly and paced around the room. She began by saying that she refused to be enslaved to a drug. She talked about how she had gone to visit a friend the prior weekend. Shortly after arriving, he had offered her some cocaine. Cheryl immediately snorted the line of cocaine without thinking about her actions. A moment after she did that, she became frightened and angry about what she had done. She gathered her belongings to leave. He asked why she was leaving and she responded that she could not sacrifice everything that mattered to her. Cheryl proceeded home and told her boyfriend what had happened. He was kind, forgave her, and told her he appreciated how quickly she removed herself from the situation.

Cheryl was angry that the cocaine and her impulsivity determined her course of action. Then, she was angry that she had belittled herself by begging for forgiveness in
spite of the reality that she had momentously overcome something monumental to her. She explained that people do not use one line and then quit, which is accurate because it is typical for people to repeatedly abuse cocaine until the supply has diminished. She struggled to give herself credit because she was so angry that she had placed herself in the situation at all. She repeatedly stated, “I will not be a slave to any damn drug.”

Cheryl had known that her friend was likely to offer her cocaine and she had thought she could handle it. She ranted about how angry she felt for allowing the drug to determine where she could go, who she could be with, and whether or not she would consume it. Cheryl demonstrated improvement with all of her goals during this interaction. She overcame her fear of intimacy and talked to her boyfriend about what had happened. She did not stay and use more cocaine. While she had not remained sober, through this instance she had coupled the idea of cocaine with shame, rage, and disgust. Cocaine lost its powerful allure for her. She set limits with a peer even though it felt socially awkward. When the situation occurred, she did not abandon her needs for anybody else. She identified how she felt and what she needed, and took actions to get her needs met. She reported that something inside of her clicked and she took ownership of her life.

We continued to have sessions for two more months. The sessions focused on her desire for intimacy, friendships, and her ability to accept a promotion at work when she was not confident she deserved it. She continued to take steps to get her dependence needs met. Cheryl was educated about James Prochaska’s transtheoretical model of change: pre-contemplation, contemplation, preparation, action, maintenance, and termination. Cheryl had reached a plateau; she had not improved for a while. She was
generally focused on maintaining her new life style. She determined that she was in the termination stage because she had been maintaining sobriety and she needed to continue to establish a sober life style. By the time the treatment came to a close, Cheryl had become attached to this clinician even though she no longer required psychotherapy to help her maintain her sobriety. She wanted to continue psychotherapy. Cheryl appreciated and was willing to trust my belief that she no longer needed psychotherapy and she would be better served by creating a sober social network.

After six months of sessions, Cheryl had made her life as she wanted it to be. She had friendships and frequent activities in which to engage, and she had developed relationships with others she could authentically relate to without the use of cocaine. Cheryl had developed trust that she could share increasingly intimate details with safe people, get her dependence needs met while staying sober, and could take care of herself if others did not respond optimally to disclosures of tender information. She had also established self-trust and become increasingly honest with herself. During the last session, Cheryl made a scratch board image of Persephone standing in a powerful position. She had birds, a deer, and the sunrise coming from behind her. Cheryl was able to feel the power inherent in this image, power that she recognized had become an active part of her life. It was profound, considering she had had no concept of what this image would look like during the first session. Cheryl was sad that therapy was coming to an end because it meant we would not be seeing one another. Closure was done over several sessions and we discussed what she had learned, how she had grown, and the ways she had improved her life over the six months.
Cheryl initially had a poor sense of self-worth, largely because she did not know the value of her strengths. She was provided with modeling, guidance, and strategies the Friend could use to counter her Gatekeeper’s attacks. She developed tolerance for feeling emotions. She decoupled the feelings of vulnerability from inappropriate shame while she learned self-promoting thoughts and assurances. Cheryl was discouraged from continuing therapy beyond the six-month mark in order to help her learn to trust her abilities. While Cheryl and I enjoyed one another, it was very important for her to understand that I believed in her.

Melissa Schwartz taught, “Those wounded in relationship need to heal in relationship.” Since we had a history together, I was able to push, challenge, and appreciate Cheryl in ways I cannot with other clients with whom I have a shorter history. My enduring respect, appreciation, playfulness, and adoration of Cheryl were consistent and necessary. During times when our history could be explored, it was. This helped Cheryl learn to be herself without feeling inappropriate shame. Increased accurate reality testing allowed her to understand that she was not defective or deserving of shame. Self-acceptance led to the acceptance of imperfections in others as well.

**Legal and Ethical Issues**

No legal issues arose during the time I worked with Cheryl. No ethical concerns arose other than my occasional struggle to disengage from codependent tendencies and Cheryl’s use of intoxicants during the two sessions, both of which were previously explored. Cheryl’s desire for ecstatic experiences coupled with her potential to be impulsive was a concern. It was an ethical concern because codependent responses are
known to hinder therapeutic growth regardless of the intention behind the action. As I learned to trust Cheryl to take care of herself responsibly, Cheryl learned to trust herself also. While it is unclear if there is a causal relationship between my letting go of control and Cheryl’s developed self-trust, they appear to be connected.

Cultural issues were not of concern, although they were present. Cheryl’s godmother had the same ethnic background as I do, which facilitated a positive maternal projection. The projection deteriorated and before the sessions ended Cheryl began to see me as I was. As far as other cultural issues, Cheryl’s primary focus during these sessions did not relate to her cultural, ethnic, or spiritual background.

**Outcomes**

The therapeutic journey for Cheryl was overall beneficial. Her individual work served to improve her self-image, her ability to connect with others, her ability to feel her body, and her ability to accomplish the goals she hoped to achieve. Cheryl was able to learn how to efficiently seek connections with others who were worthy. Many of the coping techniques Cheryl used were identified through self-awareness as she recognized what was happening with her body, emotions, thoughts, and spiritual beliefs. The imagery was helpful also because she learned how to relate to her whole life in an integrated way. I believe that the trust she had in our relationship allowed her to process many vulnerable issues, including ones she had not risked in nearly 14 years.

Approximately a year after the last session, Cheryl called to talk because she wanted to tell me about changes she had made in her life. Cheryl first wanted to share that she had maintained her sobriety with cocaine. While she was proud of that, there was
something she had not told me that had been haunting her. Cheryl wanted to come clean
about the trip she had taken with the family member who used methamphetamines
approximately three months into treatment. Cheryl revealed that she had used
methamphetamines. She lied to me in the session following the incident. Most of what
she said during the subsequent session was accurate. She had felt duped into a bad
situation and she was unable to leave the area because she was high. Between that
experience and the one a week later when she used cocaine, she thought she could resist
the temptation of stimulants. She realized that she was acting as a slave to the drug. After
that, she fought to become free. Her decision not to use followed by her inability to resist
the drugs in both situations confronted her inflation.

Cheryl was asked if she knew why she lied. She indicated that she had lied to
avoid the shame of rejection or of being told, “I knew you would fail.” She also felt she
could not tell me the truth and lie to her boyfriend. She referred to the story about
Persephone and said the drug was the pomegranate seed that anchored her in hell. She
was able to talk about the cocaine immediately after she used because she had overcome
it. She had not overcome the methamphetamine and she felt humiliated, deflated, and
stupid. The shame about using methamphetamines combined with her shame about
cocaine caused a spark of anger and inspiration. Those feelings sparked a revolt against
the drug and helped her to break free from its chains. She indicated that the questions I
asked before the methamphetamine trip haunted her, so she knew what she was doing
immediately after she had done it. Even when she thought the questions were out of her
mind, exposure to stimulants unearthed them. She asked for this session to break what
she felt was the final bond the drug had on her: the shame of having lied. Cheryl was
praised for having the courage to tell the truth. She was very hard on herself about having lied.

Cheryl’s contention with her mother was built on her mother’s lie. She was not ready to forgive her mother, nor did she know if she ever would heal from that betrayal. During the final session, Cheryl began to feel compassion for the ways in which her mother was terrified to live. Cheryl came to understand that her mother hid behind her professionalism, alcoholism, and denial about experiences she believed she could not handle. Cheryl gave herself credit and she realized that the pain she had faced in the last eighteen months was more than either of her parents had likely ever faced.
CHAPTER 4

LEARNINGS

Key Concepts and Principles

The key concepts and major principles that helped inform my interpretations of the work Cheryl and I did together include the following: Erikson’s concept of identity development, Jung’s concept of archetypes, Rogers’s client-centered therapy approach to working with clients, Omer’s concept of imaginal structures and the Imaginal Approach, S. Brown and Wilkinson’s multiple perspectives on codependence, S. Powell’s Electra complex and related female development model, D. W. Winnicott’s theory of the false self and his development on Fairbairn’s object relations theory, and A. Beck’s theory on cognitive schemas and automatic thoughts.

Primary tasks in an imaginal psychotherapeutic journey are the explorations of the client’s imaginal structures and the exploration of the therapist’s own imaginal structures evoked during the context of the psychotherapy work with the client. The therapist must use discretion determining how, if, or when to address the therapist’s imaginal structures with the client. Throughout the sessions explored in this Clinical Case Study, we conducted on-going exploration of how her imaginal structures affected her life and the resulting compulsions to abuse intoxicants.
What Happened

When I first began working with Cheryl, we simultaneously worked with what was happening in the present as well as how the current situations were linked to the past. As a result of the isolation she endured before adolescence, she developed a false self. The defensive boundary between her true self and others had been something she had lived with for at least eight years prior to our meeting. The emotional neglect she experienced in her youth left Cheryl hyper-vigilant. During the sessions focused on in this Clinical Case Study, Cheryl developed an ability to trust others to be dependable. In response to our prior relationship, she reconnected quickly and began to expand her ability to trust others. She learned to trust that she could be resilient when mistakes were made. She grew to understand that people liked her for who she truly was. This understanding helped build her confidence so she could risk taking steps to get her dependence needs met.

Cheryl’s sense of self was unique because it was cohesive from the moment I met her. She withdrew or became verbally and subtly aggressive in relationships with others whom she did not trust. Uniquely, she did not alter the way she presented her identity in response to others. Her interpersonal struggles left her with unmet dependence needs that resulted in a variety of symptoms including physical pain (albeit not enough to qualify for somatization disorder), profound loneliness, emotional dysregulation, habituated behaviors, and chemical dependence. It was clear that her fears were irrational, which made it easy to provide unconditional positive regard. Cheryl accepted the unconditional positive regard. Cheryl built a variety of relationships, all of which affirmed the idea that she was loveable. The more risks Cheryl took, the more confident and socially successful
she became. She overcame her fears and lived life with activities that alleviated her lonely isolation.

Robert Dupont indicated that Cheryl’s pattern was typical when he described stimulants as having the “quickest bottom” when compared to any other substance.\(^2\) While this was the case, Cheryl was resistant to identifying herself as a cocaine addict. Glenn Walters addressed the resistance with his concept of stigmatization by a diagnosis.\(^3\) Walter challenged clinicians not to further align clients with the chemical dependence identity because it might be a distortion of reality.\(^4\) Cheryl was not encouraged to take a position one way or another and she remained responsive to treatment. I felt conflicted about this point because I wondered if denial about the label would put someone in unnecessary danger of relapse. When Cheryl described how her cocaine problem unfolded, she appeared to be enamored enough with cocaine that there was potential for relapse. It was difficult to understand the value and consequences of identifying oneself as an addict or denying the label. By the end of these sessions, I realized that it served the client to find ways to accept the deeper truth about her relationship to cocaine for herself without having to mediate or defend against the therapist’s position.

It was difficult to accept Cheryl’s attachment to continue use of other intoxicants while in treatment to discontinue cocaine abuse. It was clear that stimulants felt more urgently compelling to abuse than either alcohol or marijuana although it seemed that she was maintaining her pattern of using substances to avoid stressors. Also, the lowered inhibitions caused by those substances may have predisposed her unnecessarily to temptations. I felt myself in the role of the disciplinarian or limit setter and yet I knew it was her choice to use drugs or not. I found myself feeling incompetent, like a fraud,
because I was unable to impact her behavior. During these times, I experienced intense cravings for intoxication myself. As the sessions ensued, my ability to use counter-transference therapeutically improved, which allowed me to disengage from the personalization of the experience and from desires to control her actions. Cheryl asked my opinion at one point and I told her I thought daily use of any substance was excessive. She accepted my opinion and stated that we did not need to agree. We did not further explore this.

The second and third sessions involving Cheryl’s use of alcohol during therapy were similar to a case written by Donald Kalsched. He wrote about sessions with a woman struggling with an eating disorder. The sessions were marked by intimacy, hope, and tenderness followed by a relapse. Kalsched described the underlying dynamic as follows.

The first thing that helps us to understand this case is the nature of Mary’s anxiety. Both Winnicott and Kohut have pointed out that a certain level of “unthinkable” anxiety originates at the symbiotic state child development where the child is totally dependent of the mother as a kind of external metabolizing organ of psychological experience. The mother’s role is to help mediate experience and this means especially to help metabolize anxiety. It is as though the infant breathes in psychological oxygen through “lungs” supplied by the mother. What happens, then, when suddenly the mother is gone?

Kalsched wrote about feeling anger toward his client for sabotaging her success after their powerful session. My response to Cheryl was different. I felt afraid. She had been more fragile than I thought and it was frightening to recognize the impact I had on her. The power I had to hurt people frightened me.

One difference between Kalsched’s client and mine was that his client relapsed by doing what she wanted to stop and mine did not; she used other methods she thought were okay and she openly stated that she had no intention of controlling the use of those
substances (i.e., excessive nightly marijuana use and an alcoholic drink before the session). While my client did not sabotage her treatment goal, she did numb herself, use an intoxicant to avoid her emotions, and enact chemical dependence. The fear I experienced was a fear that I was incompetent to be entrusted with Cheryl’s safety. The image I had was that I had naïvely and inadvertently collaborated in causing a dam to break with my naïve, idealistic intentions. My personal responsibility in the situation felt unclear to me. I worried because I felt was unable to control the situation.

Prior work with Cheryl had been done when she was in a residential treatment facility. Other trained authority figures could observe, support, and assist her after poignant sessions. She had hurt herself in the past but others had been there to help her before her actions were excessively detrimental. This was the first time I had worked with her when she had the freedom to help or hurt herself.

After contacting both supervisors, I was assured that Cheryl had not actually put herself in an immediate crisis through her actions. This was validating and it alleviated my fears that I was responsible to control something I could not actually control. Av guided me to use process comments where I revealed my counter-transference to Cheryl, (i.e., involve her in solving the dilemma around offering therapy only when it could serve her) and to allow her to talk about her experience. Paula suggested that too much had been revealed at once and while the client trusted me, she did not yet trust herself to handle allowing another person to see this much vulnerability at one time. Both supervisors’ suggestions resonated and we progressed with treatment accordingly.

Over the course of the sessions, it became clear that some of Cheryl’s cognitive schemas or structures were skewed. According to A. Beck, cognitive structures orient
people toward particular situations in which they find themselves. Cheryl’s youth entailed such a heightened state of anxiety caused by neglect and chaos that she developed what A. Beck referred to as a hypersensitive alarm system. Cheryl found vulnerability and shame intolerable after the earlier traumas. She avoided vulnerability and pain with patterns of self-injury. The self-injurious behaviors were her first developed habit for avoiding discomfort, a pattern of avoidance that endured throughout her youth in various manifestations. Eventually, she controlled her eating, suffered somatically, acted out sexually, and used intoxicants. These habituated patterns were addressed as she identified and confronted her manifestation of Beck’s automatic thoughts, including thoughts that others would reject or criticize her.

This work evoked a maternal, patient, and occasionally rescuing part in me. It also evoked some shame similar to what Cheryl went through, as though I were infected by the same poison. The intensity of the shame, defeat, and hopelessness she shared was overwhelming on several occasions. While I had done enough personal work to have the perspective to know it would pass, it evoked the aspects of my psyche that previously were rejected, avoidant, and angry. During the sessions, I felt balanced and centered. After the sessions, I occasionally had to manage my reactivity and self-doubt, and to trust in Cheryl’s ability to care for herself. Also, I had to seek supervision and consultation instead of avoiding problems when they arose. Like Cheryl, I felt this experience was both wonderful and humbling.

Cheryl’s mind-body split manifested in what L. McCullough called affect phobia, or an extreme avoidance of affects. Over the course of these sessions, Cheryl came to develop a tolerance for feeling her emotions and being guided by them. As she did this,
she realized that she had been a family scapegoat, which is another version of interpersonal splitting. Sylvia Perera’s scapegoat was an individual who took blame and punishment for the sins of others.\(^8\) This goat was then cast out or split off from the village. Cheryl had been raped and removed from her family home virtually identically to the mythic scapegoat who had been burdened with the villager’s sins and cast out of the village.

Cheryl enacted traits from Carol Pearson’s archetypes: the Orphan archetype, whose primary goal was to regain safety, which Cheryl did by distancing herself from others; the Destroyer, who fueled her inspiration to remain disconnected from others with the fear of annihilation; the Lover, who sought bliss; the Ruler, who demanded order and control because she was petrified of chaos; and the Sage, who sought the freedom of truth.\(^9\) Cheryl had cycles of binge eating and starving, which evoked a physiological high and appeared to be compelled by both the Destroyer and Ruler.\(^10\) These patterns were entrenched by the time the sessions of this case study occurred.

Cheryl had a history of demanding perfection from herself. She longed to have power and to know how to wield it. One of the frequent challenges she faced during these sessions was to identify when an impulse to abandon others was a counter-phobic response to her fear of being abandoned first. Through our work together, Cheryl came to understand how this assumption played a key role in her situation. Ultimately, she was able to recognize when she was compelled to strike preemptively. She shifted many of her impulses to flee into conscious attempts to challenge her assumptions by enacting the Friend with positive self-care. Cheryl naturally had charisma and when she was able to
absorb support and encouragement, she developed trust that others would respect and like her for who she was.

**Imaginal Structures**

**How I Was Affected**

Cheryl has always been someone of whom I have been fond. She was a feisty, witty girl and she had developed into a passionate woman with a playful, smart, and engaging flair. Cheryl was friendly, honest, and had a solid sense of integrity. She rarely showed her vulnerable side to others so when she allowed me to see her, it was an honor.

The struggle with chemical dependence evoked various responses in me. There were moments when I felt like an incompetent fraud. At other times, I felt competent and confident in my ability to provide a therapeutic and safe container. At yet other times, interpersonal boundaries blurred and I did not know when I used boundaries to defend myself against feeling the intensity of her struggle or when I crossed boundaries to rescue her. Cheryl has always been someone towards whom I felt maternal. During her periods of regression, it was painful for me to see her suffer. The most intense experience evoked for me was what has commonly been described as the empty nest syndrome. I had to learn to let go and let her make mistakes. While this was easy with other clients, it was not with Cheryl. The letting go began in the first session when our relationship changed from a relationship between an adult and a child to a relationship between an adult and an adult-child.

Over the course of the time we worked together, Cheryl became stronger and less defended. It was rewarding to see her resilience and self-acceptance develop. Cheryl
came home to herself, to her body, and she began to act in accordance with her core identity. As a result, she became powerful in her life. It was humbling to know how little power I had to make positive transformation occur while I had so much power to do harm. A great deal of the transformation occurred because of what she opted to do with the psychotherapy, not because I fixed her.

My response to Cheryl was pride. I felt this most powerfully in the follow-up session when she sought me out to tell me that she had used a stimulant on her trip out of town. While she had to sit with the wave of shame to let it go, I was present for her but did not share her experience. The boundaries were clear and I knew she felt supported and free simultaneously. I had the opportunity of being an elder who watched a youth become initiated while she was in my care. She was more beautiful, more courageous, and stronger than she knew.

There were difficulties during the time we worked together. The mistakes ultimately were beneficial because they challenged the expectation of perfection and assisted both of us with developing the capacity to be compassionate. This was not an enmeshed process; it occurred simultaneously. It assisted me with overcoming naïve mistakes like engaging in codependent power struggles, the belief that I was supposed to be the perfect therapist, and the belief that her improvement was my responsibility. As I admitted my mistakes, she was able to trust me enough to admit hers. Together we progressed with improved boundaries, confidence, humility, and improved reality testing. Ultimately, Cheryl maintained her sobriety from stimulants and learned to make wise choices supporting a sober lifestyle.
My Imaginal Structures

In many ways, Cheryl and I were quite similar although there were differences between us. The ways we had been wounded were different although our response to the traumas was to identify with the Orphan archetype. When she enacted aspects of her Gatekeeper, the imaginal structures I experienced were fear, suffocation, and protectiveness. I could relate to Cheryl’s notion that she had to intimidate others as a means of discouraging connections with the people whom she feared would ultimately abandon or hurt her. Also, I was able to relate to Cheryl’s belief that she had to be perfect to earn love from others. Since I was familiar with similar imaginal structures, it was easy to have compassion for what Cheryl was going through.

During the writing of this Clinical Case Study, I worked full-time as a program coordinator, and was a mother to a young child. It was impossible for me to simply disregard any of my obligations and I unconsciously fell into old, intolerant, and rigid patterns. It felt as if there were no space for reactions, no time to relax, and I felt exhausted and alone because there was no time for me in my life. The tighter I felt, the more reactivity I experienced in response to Cheryl’s struggles. Regardless of what the struggle was, I felt intensity.

In relationship to my life, I was attracted to several recurrent themes during this time period: the mermaid, Athena, Electra, The Triple Goddess, the Tree of Life, the Kabala, Yoda, pirates, prostitutes, and extensive Mother Earth imagery. Many of these imaginal structures seem to have been evoked by my rigidity, control, perfectionism, and constant enduring drive to manage all my jobs. Ultimately, my primal desires had to be acknowledged because they had been contained too long. These structures also seemed to
respond to loneliness, a need to connect, and the reality that life is not consistently predictable. While I had explored this concept prior to meeting Cheryl, I needed to re-member and re-visit what I had learned before.

Lee Hall’s translation of the myth of Athena, as well as the experience of becoming a mother, provided the most direct understanding of my imaginal structures. Hall described the process of a young Athena overcoming rash, impulsive decisions and transforming into a patient, thoughtful, confident force. I had to use daily disciplines to remind me that I was not in control and that there is something out there larger than me. Athena became wise as she learned patience, reverence, clarity, and to understand the big picture. Becoming a mother put me in my body in a way nothing else ever has. Between my experience learning to be in my body and Athena’s lessons, I was reminded that the struggles must be addressed in order to be overcome. Like Athena in her process of learning to transmute reactivity, I developed patience and a deep respect for the primal feminine experience. It was not possible for me to function endlessly in a rigid, racing, disciplined way. As I found balance in my life, I learned to make time for myself even though this meant it would take longer to complete my case study.

When I was younger, I experienced the primal part of myself as a disgusting, distorted, and horrific beast that required confinement. What I have come to understand is that the primal drives are much more akin to the mother tigress: beautiful, calculated, and capable of tremendous destruction and/or creation. Cheryl’s process of learning to see who she was reminded me of this lesson. This imaginal structure was much more dangerous to my life when I tried to control or confine her than it was when she was afforded dignity and respect. I saw this in Cheryl as well. The integration of these
characters into my psyche allowed me to become an authority figure capable of patience and worthy of trust, respect, and humility. In learning to relate to my primal aspects with reverence, I expanded my ability to sit with this aspect in Cheryl.

It is important to say that the depth of our connection was both inspiring and challenging. Having known Cheryl for five of her developmental years, I was emotionally invested in her treatment and I had to expand my interpersonal capacities to honor her natural adult need for separation. While I believed our connection made it easier for her to explore her wounds, it was more difficult for me to maintain professional boundaries. The temptation to rescue or control her actions were more powerful because I deeply cared about the choices she made. Since Cheryl had come of age, the nature of the interventions I provided needed to suit her development and treatment needs.

During our early sessions, Cheryl recognized that cocaine freed her from fears of rejection, freed her to accept the parts of her she rejected, and provided confidence to socialize with others. I was able to relate to her because I felt similarly. Due to the number of obligations in my life, my dependence needs were neglected and I needed to discontinue the confinement I had created in order to be successful with my responsibilities. While this was true, practicality dominated and I created this situation by rationalizing that this circumstance would be short-lived. Through my training, age, and personal therapy, I had done a great deal of work with my structures. Eventually, I accepted the consequences of not working myself to death. In essence, I accepted the extended amount of time it took to write this Clinical Case Study so I would not sacrifice getting my needs met throughout this process. This, as well as the similarities I had with
Cheryl, provided insights on how to help Cheryl see the beauty within her and to act with her best interest at heart.

As Cheryl became stronger, I found myself in the midst of a therapist’s version of the empty nest syndrome. When I worked with Cheryl prior to these sessions, I was able to alert an authority figure about problems with the ability to tend to her safety needs. I had to adjust to being unable to provide complete support. As she became stronger, I had to adjust to the reality that she did not need as much from me. Then I had to encourage her graciously to know that I trusted she could be successful without any professional help at all. I felt sad and simultaneously proud and hopeful. Interestingly, I experienced this structure more intensely than I had with any other client. In response to this relationship, I had to expand my capacities to be patient with myself, to trust in Cheryl, and practice the discipline of mindfulness in order to keep the situation in perspective.

When I was young, insecurity inhibited me from taking appropriate social risks. When I challenged Cheryl’s inaccurate assumptions about how she would be received, I did not tell her that I had used intoxication to assuage my social fears and insecurities of overwhelming others. Unlike Cheryl, I delved into the study of psychology, which genuinely inspired me. My inspiration allowed me to meet like-minded people, to learn that I was not as overwhelming as I feared, and to accept there were people I respected and admired who were as passionate as I was. During this stage of my life, it was excruciating when others validated my fears. I found myself feeling over-protective of Cheryl when I knew she faced similar fears. During those sessions, I did not act on these feelings. Rather, I used my supervisors to help me identify and manage the counter-transference and my reactivity so I could better support Cheryl in her process.
While writing this Clinical Case Study, the most suffocating imaginal structure I encountered was the taboo about chemical dependence. Chemical dependence was a topic I had avoided throughout my mental health career prior to the sessions addressed in this study. My resistance was ingrained in the belief that chemical dependence was incurable and likely to be resistant to treatment. Along the way, I learned that there are different types and degrees of suffering related to chemical dependence, including that understanding active use and being a “dry drunk” can be viewed as very similar psychological dynamics.\textsuperscript{12} The capacity to be resilient as it compares to the fragility typified by borderline traits demonstrates the potential difference between an individual with chemical dependence and one who is in remission or only a chemically dependent person by history. Facing the distorted female archetype that manifests as this symptom constellation should be respected because it is not for the faint hearted.

\textbf{The Client’s Imaginal Structures}

Cheryl’s imaginal structures included the Gatekeeper, Dionysus, Pentheus, a prisoner, warrior women, a fragile infant, seductress, mistrust of others, the scapegoat, the mega-beast, and the Good Mother. From the beginning, Cheryl was critical of herself and others. In order to avoid emotional pain, an active internal Gatekeeper frightened her away from risks associated with the potential suffering. She historically silenced her Gatekeeper by becoming intoxicated, fasting, harming herself, and using anxious, compulsive behaviors to avoid negatively stimulating issues. The Gatekeeper often attacked her with cognitive scripts and painful affects. These messages indicated she was worthless, defective, and otherwise unlovable so she should limit the possibility of having
other people discover these qualities by pulling back, restricting her actions, and keeping her real self a secret. These scripts were often evoked when Cheryl experienced moments of shame or incompetence, or felt the potential for these affects. Her reaction to the Gatekeeper was to comply with its expectations and to avoid growth risks, social connections, and feelings of pride. Cheryl was able to confront her imaginal structures when she was provided with acceptance, gentle encouragement, mirroring, and reality testing. Over time, she learned to question the limitations enforced by the Gatekeeper without requiring an external intervention.

Cheryl often vacillated between rigidity and ecstasy-seeking behaviors typical of the imaginal structures Pentheus and Dionysus. Cheryl embodied a rigid stance, adhering to the belief that she must follow rules that felt oppressive to her. The visceral experience of the rigidity was a compulsive, primal adherence to the rules. Violation of the rules evoked a primal, nonverbal fear. When she felt this fear, she became tearful, felt excessively out of control, was unable to sit still, lost her intellectual ability to be rational, and felt and expressed uncontained emotions. The violation of the rules came about when she realistically understood the irrational nature of her Gatekeeper. She would react to the rules and rebel by doing various things that contradicted her ideals. The reactions were both extreme responses and desperate attempts to have the experience of feeling alive. She had fantasies of acting on a whim sexually, socially, and interpersonally.

As she established balance between structure and unstructured aspects of her life, the imaginal structures became less exaggerated. The unstructured, playful aspects of her life included going to parties, participating in role-play games, and socializing with friends. In spite of her fear of rejection, Cheryl increasingly risked participating in events
that seemed as if they would allow her to be powerful, beautiful, confident, and wise.

There were times when Cheryl appeared to purposefully attempt to shock me with lewd comments or imagery, as if she were enacting Dionysian attempts to shatter rule makers. This appeared to be an unconscious reaction to a projection she had on me: the projection that I was enforcing oppressive rules. When I did not respond to her taunts, Cheryl often tried harder. I shared observations about this with Cheryl and I normalized her needs for both structure and freedom. Cheryl shifted from unconsciously channeling imaginal structures to consciously and collaboratively exploring underlying impulses.

Cheryl’s need for control, as it was depicted by Pentheus’s rigidity, was deeply ingrained. In the process of refining Cheryl’s reality-testing skills and personal expectations, the moments of learning prior to change were typified by extremely evocative affects. Cheryl abused marijuana and alcohol to avoid feelings evoked by the impending change. Cheryl was able to intellectualize that she was competent and in control but her self-criticism was very strong in this regard. Cheryl developed inner strength with each reparative social experience in which she was accepted. She also developed the internal sensations of permission and freedom to be herself. Cheryl became increasingly resilient as she accepted the mature understanding that intense emotions will pass. Her recognition that she was able to handle the emotions helped her to become less avoidant of emotions in general.

By the end of our sessions, Cheryl had clearly identified areas of her growth. She was in the process of learning how to transmute the impulses of her Gatekeeper. She did this by developing the capacity of reflexivity and compassion for herself. Reflexivity, as I
experience it and as Aftab Omer describes below, involves resilience and the ability to use an observing ego.¹³ (See Table 2 — Sample Reflexivity Scale.)

In our reactivity is hidden gold. What we do with it may or may not manifest the potential. We have to follow the reactivity to the fault line to reach the gold. Every turning point in development, or change in identity, will trigger a Gatekeeper. If you are callous, you will not be affected by things. If you are raw, you can’t be psychological; things feel very personal as if others are just ridiculing. But, if you can be crusty, you have a full range of capacities and are able to be present—this is called psychological reflexivity. Reflexivity is the capacity to engage and be aware of those imaginal structures that shame and constitute our experience.¹⁴

Cheryl spent a large portion of the therapeutic discussion exploring the concept of freedom. Her life had been dedicated to keeping herself emotionally safe. She had sacrificed freedom for safety on a consistent basis. The warrior women she chose to enact during her role-play games were a source of vitality for her. In the mid-point of treatment, Cheryl began to come into the sessions playfully enacting sword fights or hand-to-hand combat as she demonstrated how her characters acted in the role plays. It was a noteworthy turning point in the sessions because she held her body very differently: she embodied strength and the stealth of a warrior while she simultaneously demonstrated an integrated, mindful discipline. Prior to this point, she was rigid, defended, and small. While safety was still a concern, the sensory experience of her body movements and attitude was now lively, responsive, and playful.

Another poignant imaginal structure was the Scapegoat. She enacted all four of Perera’s aspects of the archetype: the victim, the wandering goat, the priest, and the accuser.¹⁵ In general, her Gatekeeper used the tactics of the priest and the accuser. Her Gatekeeper had a cold and aggressive style that indicated all the problems in her life were the result of her defective core, which was a message founded in an irrational lie. She was
used to being the IP, or identified patient, also known as the victim or wandering goat. In this role, she was blamed for her family problems. In her family of origin, she had been raped and literally cast out. The rape was not her fault and the family members denied the problem, acknowledged it could have happened without taking steps to keep her with a parent, and let her suffer the consequences as a child in the world alone. She toyed with the idea of retracting the rape accusation and accepting the burden of the lie in order to get her family back. She mentioned this once during the six months and she clearly had decided not to abandon herself.

Cheryl felt like a victim and often retreated into a lonely corner feeling hopeless and defeated. It was during these moments that she often avoided her pain through an addictive action. The more she blamed herself and refused to tell others about her shame, the more entrenched she became in her addictive habits. The only person I witnessed her be aggressive toward, besides herself, was her mother. Her attacks toward both herself and her mother were virtually identical. The perfectionism manifested like the image of an emotionally void priest who hits the table with a ruler any time an individual colors outside the line. It was relentless, unforgiving, and precise as it frequently compelled her to work harder, starve herself, not have feelings, and otherwise be vigilant. Often she would withdraw socially because she did not want others to know that she could not live up to the expectations. Granted, nobody could live up to the expectations. but she could not see the irrational nature of the expectations when she was defending against the Gatekeeper’s relentless attacks.

Regardless of the aspect of the Scapegoat complex she enacted, the counter-transference response was to control her by making her snap out of it. While it was a
challenge to assist Cheryl with identifying her experience, how it served her, and what she wanted to do with her feelings, assisting her to develop self-awareness and self-compassion were the most effective interventions.

The infant, or the nonverbal and fragile part that she had kept hidden, had begun to be protected by a dogmatic warrior. The entire process behind her limited responses was fear based and unconsciously enacted. When she began to comprehend what the rules were, how rational or irrational they were, and whether or not those rules served her, she was less controlled by her internal dogma. She began to notice feelings of inspiration and she let herself play. Cheryl enacted a variety of warriors and she often brought her favorite figurines. At this point in treatment, I primarily witnessed the changes and acted like a cheerleader as various risks were taken and accomplishments were achieved. Cheryl easily internalized the support.

Cheryl risked showing her vulnerability, which was a rare privilege to experience. When she was open, her openness was powerful and unguarded. I felt pulled to protect, contain, and nurture her. Had she been a young child, I would have scooped her up and held her. My inclination to protect her was inspired by her nonverbal, scared, and regressed presentation. It took a great deal of time for her to be able to show this part, which indicated that she was scared and she felt protective of it. I responded by providing a safe, secure, assuring container to assist her with the emotional risk of exposing this tender part. This imaginal structure was one of the last to surface. When it was present, there were moments where Cheryl clung to me wanting support, praise, and approval. Rather than acting defensively to defend a narcissistic lesion, she talked openly about her
internal sense of deflation and she actively risked healthy dependence in a courageous manner. The more she did this, the stronger she became.

A likely reason that the infant was one of the last imaginal structures to surface was that there were intermittent cameos from the mega-beast and the Good Mother. The mega-beast was virtually identical to the priest and it served to seem like there were two images providing the same controlling messages. Cheryl talked openly about her relationship with her mother and the ways she anticipated criticism, having her needs or requests ignored, and being nit-picked, disregarded, invisible, belittled, and never receiving an apology. Due to a prior experience when I had apologized to her for pressuring her around self-care and an eating disorder, Cheryl did not project the rigid bad-mother onto me. She did project a disciplinarian but she generally was able to see that I was responsive, which was something she was not used to. Cheryl indicated that she did not see me as being like her mother because I was not trying to be perfect nor was I expecting others to be.

Cheryl demonstrated efforts to overcome chemical dependence and to use what she learned to continue to develop. She strengthened increased capacities to be courageous, compassionate, reflexive, honest, and spiritual, and to use finely tuned discernment. She learned to acknowledge her emotions while she developed tolerance for the physical sensation of affects. She increased her ability to be informed by her feelings. She also learned to transmute her feelings into action, to connect with others, and to experience life at a deeper, more fulfilling level as a result of sacred suffering and active therapeutic work.
New Learnings about My Imaginal Structures

New learnings about my imaginal structures were most centrally connected to the concepts presented by Sheila Powell. My beliefs in my teen years were skewed toward the vilification of the archetypal feminine and glorification of the masculine; I did not know who I was because I so adamantly rejected my gender. It was through the process of embracing my feminine elders that I was able to integrate the feminine into my world. Learning the value of the archetypal feminine and the problems with exaggerated or distorted masculinity, and learning to simply be, has been very intense. It has been a central process in my life for over 20 years.

Two imaginal structures were evoked by counter-transference when Cheryl would rage about her mother’s cold calculation, then glorify her father’s minimal participation. The response to Cheryl’s hatred for her mother was to be collusively angry with Cheryl. I pushed myself to imagine what her mother must have gone through in order to see through the projections. This was helpful and it was not something I would have done instinctively. My training reminded me to remain curious about each person’s role in Cheryl’s life. Cheryl’s purified view of her father was easy to be collusive with as well. He was the one person who remained hers and kept her from being an orphan. Over time, I found myself feeling angry with him because he could have done more for her. Any comments I made in attempt to assist Cheryl with seeing his responsibility pushed Cheryl to defend him. Her response informed me about how to get out of the way so she could see the truth and stop defending her dad. My response was a complicated one. It had components of the truth, counter-transference, and it appeared to be an unconscious intolerant response to his being frozen by the archetypal devouring feminine. This
awareness helped me to see that I was angry with my father because he did not know how to be with powerful women without dominating or being dominated.

Like Cheryl, my mother was a teacher whom the community members adored. This was a struggle because I believed the people who adored her were stuck in a lie. It was a belief that confused me for a long time. In reality, others saw strengths in my mother that I simply could not see. While she was intricately involved in my life, I did not feel understood nor did I understand her. I did not ask my mother about things that confused me, largely because it did not occur to me to do so. We were simply so different that I could not imagine relating to her. Cheryl hated her mother for the betrayal, which made it easy to minimize other difficulties in their relationship. The similarity between Cheryl’s struggle with her mother and my struggle with my mother was based on the problems created when both Cheryl and I rejected the archetypal feminine.

At the opposite extreme, both Cheryl and I were very close to fathers who were often emotionally unavailable. I had moments with my father where I felt cherished, a sense of belonging, similar, and connected. Due to the ways I was seen and given a profound sense of belonging, I idolized my father and inflated his importance in my life. I wanted my relationship with my father to fill the void of the missing archetypal mother.

By the time the sessions in this case study began, my relationship to the feminine had healed tremendously. My mother had become a central part of my life in spite of the reality that I continued to feel different from her. During the course of this work, I learned to ask my mother questions about our differences and in doing so I found commonality and understanding with her. My relationship with my father had also progressed. It was important but not as inflated as it had been. As the purified projection
on my father peeled away, I was able to relate to him and to feel connected. A great many of the problems we had were caused by the projections and our inability to see one another as we really were.

At first, I felt conflicted about Cheryl’s relationship to the archetypal feminine. Cheryl’s hatred for her mother, in spite of how easy it was to rationalize hatred for a mother who betrayed her daughter the way she did, felt exaggerated to me. My concern stemmed from the understanding that Cheryl was a woman and if she hated women, I did not know how she could value herself. As my relationship with Cheryl deepened, she was eventually able to envision and transform into an embodied, respected, and interpersonally powerful woman. When the sessions came to a close, Cheryl transmuted some of her rage for her mother into compassion. She began to understand that her mother had done the best she could. She was not able to forgive the betrayal but she was able to find compassion about the fear and rigidity with which her mother lived.

Cheryl’s relationship with her father did not change much during this period of time. She recognized that he was not as involved as he could have been but that did not reduce his value in her life. As she became more realistic, she became more at peace with herself. As for my relationships with my parents, the same was true. The intimacy in the relationships with both of my parents deepened as I grew to accept them.

Primary Myth

The primary myth used as a backdrop for this psychotherapy case is Demeter and Persephone. The Greek myth tells of a young innocent girl, named Kore at the beginning of the story, who is picking Narcissus flowers when the earth suddenly opens up and she
is raped, kidnapped, and taken to underworld by her uncle Hades. According to Robert Graves’s version, Hecate, Greek Goddess of the Crossroads, was the only one to hear Kore’s screams during the abduction. Hecate was in a cave and unable to prevent the kidnapping. Demeter, the girl’s mother, refused to eat, drink, or rest as she searched desperately for her for nine days and nights.

On the tenth day, Demeter went into a village disguised and offered to become a nursemaid to the infant prince. In gratitude for the kindness she received from the people of the kingdom, Demeter tried to make the child immortal. She was interrupted during her spell and the baby died. Demeter became enraged because she could not keep him from death. Shortly thereafter, Demeter was told by a swineherd about the details of the kidnapping as he told how his swine were also swallowed by the earth. Armed with information, Demeter and Hecate confronted Helios, the sun who sees all, and forced him to admit what he saw. They forced him to admit how Zeus colluded with Hades’s crime through his silence, ignored Demeter’s grief, and allowed Demeter’s daughter to remain kidnapped. Zeus failed to help when directly asked, as did other gods. Demeter wandered the earth, and forbade trees to yield fruit and herbs to grow. When the human race was in danger of extinction, Zeus finally took action. He sent Hermes with a message telling Hades to return Kore to her mother and a message to Demeter that she would have her daughter back provided Kore had not tasted the food of the dead.

In the mean time, Kore had been witnessed eating seven seeds of an underworld pomegranate. In the process of overcoming being raped, kidnapped, and ingesting the fruit of the underworld, she became Persephone, a being of the underworld. Hades claimed her as his own because she had eaten the fruits of the underworld. Demeter
preparing to continue to shrivel the earth’s vegetation. Rhea, mother of Demeter, Zeus, and Hades, was asked to mediate the situation. The group came to the solution that Persephone would spend three months of the year with Hades reigning as queen of the underworld. During that time, the earth would be barren. The rest of the year, she would be with her mother and the earth would be fertile. Hecate oversaw the arrangement, assuring that the agreements were kept. In another version of the story, depicted by Kaela Kory, it is Baubo, a crone, trickster, fool goddess, who assists Demeter with recovering her daughter. Both versions of the story accurately depict imaginal structures found in contemporary women with chemical dependence.

Research done on two myths, Electra and Mother Earth, describe the psychological foundation of the myth Demeter and Persephone. Powell emphasized the profound importance of the enslavement of the feminine by masculine perpetrators. She recognized that preventing the connection between the girl and her feminine elders inherently retarded the girl’s ability to see herself inside of the big picture. Attempts by various aspects to compensate for one another caused an overall imbalance and created the manifestation of symptoms. The daughter’s idealized perception of her father was a key cause maintaining the disembodiment of the feminine. This was because she could not relate to him viscerally, i.e., he was not a woman, and because masculinity cannot compensate for femininity or vice versa. The story of Demeter and Persephone explains how a girl transforms into a woman. She cannot transform without the ingestion of the underworld’s pomegranate seeds and then needs her female elders’ assistance with digesting the poison. The role of the body is central for understanding how chemical dependence affects women.
Graves equated Demeter with Mother Earth, a character that enacted one of three guises: Kore, the youngest; Persephone, who was middle aged; and Hecate, the crone.\textsuperscript{22} The earth has been equated to a symbol for the body. Perera’s archetype, the Celtic Queen Maeve, depicts the reconnection of the mind and body with the assistance of the Mother Earth figure. The story of Demeter and Persephone was a road map depicting Cheryl’s process of reconnecting of her mind, body, and spirit, while “gradually becoming rooted in the deeper sense of her self as a woman.”\textsuperscript{23}

Demeter and Persephone is a myth that accurately depicts archetypal forces in contemporary adolescent girls’ and women’s lives and families. Kore was a girl who was stolen and betrayed; Cheryl was raped, blamed, unprotected, alienated, and trapped in her family home. After failures at school, self-harm, and hospitalizations, Cheryl finally revealed what she had endured. Without a mother to grieve, to become angry at the perpetrator of her daughter’s suffering, or to enact rage at the injustice, Cheryl remained trapped and alone in a lived experience of hell. Through the mentoring in which she felt her injustices were tended to, Cheryl transformed and began to believe that she deserved a joyful life.

Cheryl’s use of cocaine, starvation, binging and purging, self-harm, and other intoxicants pacified her hunger for dependence, just as the pomegranate seeds were ingested in attempt to satisfy hunger in Persephone. As a result of the ingestion of the food of the underworld, Persephone was unable to return to the earth’s surface. Cheryl’s use of cocaine transformed her. She saw an easy way out of her pain and she was seduced by the ease of it. She needed to break free from her projections, to be sober so she could see clearly, and to experience relationships as they actually were.
Many theorists believe it is a waste of time to provide therapy for clients who are not sober. Cheryl decided she needed to be sober for two months before believing she deserved help. After digesting the fruits and having several generations of mentors fight for her, Persephone was able to come home as the queen of the underworld. Likewise, Cheryl identified her capacity for soulful living and she discovered the ways her charisma inspired people to connect with her.

During the beginning of Kore’s captivity, she was treated as an object that Hades possessed. He did not ask her what she wanted or otherwise consider her needs or desires. Cheryl treated herself as an object that was only valuable when she actively strived for perfection. Those in her life, males and females, were able to control her with the mere implication that she had made a mistake. It took four months in treatment before she understood that she was worth enough to ask the question, “Are these people worthy of my time?” Shortly thereafter, she began to choose people to spend time with whom she benefited and enjoyed, and and whose company sustained her.

Once a person returns from a visit to the underworld, like Persephone, he or she has the potential to become more fully engaged in life than before. Potential can be either manifest or latent. To access the potential, assistance from a mentor is required to help make the latent potential manifest. Some people are able to assist themselves by changing their drug use patterns and others need assistance. Changing at a deeper level can be more complicated.
Personal and Professional Development

Working with Cheryl for an extended length of time was a gift to my personal development. Cheryl mirrored many of my aspects and I was aware of half of them. Through our journey together, I came to understand more of who I was and how I came to be that way. Because she and I both had endured isolation and longing resulting in a rambunctious adolescence, I was able to grow as a clinician by guiding her through this period of her life.

When Cheryl tempted herself by risking exposure to the stimulants, I found myself thinking, “No, don’t do it! I felt stupid when I did that.” It felt frightening to me that my story so closely overlapped with hers. I was afraid of the potential to project my story onto her. Rather than react, I used this as an indication of my increased reflexivity. Also, my increased reflexivity helped me to become curious rather than fixed in moments when I felt righteous about decisions or actions she took. It helped me realize that Cheryl needed to travel her own path while my responsibility was to help her develop awareness about the choices she made.

By the time these sessions began, I had become fairly comfortable with my development as a therapist. While that was true, I still felt naïve in terms of chemical dependence treatment. As I became comfortable holding Cheryl responsible for her use of therapy, I was able to accept that the therapeutic journey would move at its own pace as she was ready to progress. As this occurred, my anxiety, feelings of incompetence, and compulsions to be intoxicated dissipated. Eventually, I felt effective as a therapist and less caught up by my imaginal structure that I was not providing “good enough” treatment.
As I worked with Cheryl, I realized that my fears about rejection were surfacing. Cheryl was a courageous teacher as she took steps to attain the social acceptance she longed for. My ability to further accept who I was helped to cultivate my capacity of compassion. Professionally, I feel that my work with Cheryl further developed my ability to engage fragile topics. When I began my first internship, I felt confused about how to authentically be in relationship with others without alienating them or taking up too much space. My work with Cheryl provided me with the priceless opportunity to expand my clinical skills by working with someone I cared for deeply on a topic entrenched in boundary diffuseness and rigidity. Through this case study, I have come to feel competent and I have learned to enjoy working with this topic.

**Applying an Imaginal Approach to Psychotherapy**

The journey of writing this Clinical Case Study has provided me with a broader theoretical comprehension of imaginal approaches to psychotherapy. The depth was achieved by reviewing the literature on chemical dependence and comparing or applying it to a case in which I was personally involved. While the literature resonated with my experience, the use of imagery helped fill in the gaps. It helped me to understand the lived, integrated experience of chemical dependence and the recovery process. Imaginal therapists recognize that there are various ways a soul communicates and people must be tended to as whole beings. By attending to what surfaced, Cheryl expressed that she felt validated, cared for, and able to trust me to see her behind the wall of her defenses. When I presented an alternative way of looking at herself, Cheryl was able to see herself with more clarity, strength, and accuracy than she had before.
The use of the imaginal approach benefited my client. The main imaginal methods I used with Cheryl included educating my client about the concept of reflexivity, use of the imaginal approach with the Gatekeeper and Friend, working with her imaginal structures (characters she enacted during games with friends), and creative expression (art work). Clinically, these experiences included her acknowledging the power of old narcissistic lesions, developing awareness about how the imaginal structures impacted and were impacted by her development, recognizing her longing for connection, and the use of the myth Demeter and Persephone as a map identifying her place in recovery. After several months of open conversation, she began to feel the hope of spring and a deep sense of self-respect.

Cheryl was able to see that there was a connection between her fears, her longings, and her compulsions to use cocaine. I spoke with her about the imaginal structures of the Gatekeeper and Friend. She itemized ways in which the Gatekeeper was cruel and overly critical. She was invited to develop the use of a Friend to intervene on her behalf when the Gatekeeper was hyper-vigilant. Cheryl understood that the goal was to learn to help herself. Throughout the sessions, she was asked about the interplay between these two imaginal structures. She often teased that she had a “red-headed step-child named Synde” on her shoulder that put the judgmental voice “in check.” When she was unable to imagine a Friend, we role played responses and she became increasingly adept at intervening on her own behalf.

Cheryl was very attached to the images of female warriors during our process. She had a few different ones she enjoyed enacting and discussing. She came to identify ways to be powerful and while some of them were overtly aggressive, she came to
understand the impact of covert, indirect power, acceptance, silence, receptivity, and patience. Cheryl incorporated feminine power into her concept of embodied power.

This Clinical Case Study led me to supplement my knowledge of myths as I explored the stories that seemed to play a role in Cheryl’s story. The story of Persephone had been a central story evoked in both Cheryl and me. The isolation, shame, and suffering felt accurately depicted by Persephone’s struggle. The images Cheryl related to continually changed. She was very attached to female warriors and when she let herself enact them, she felt her power. Prior to therapy, Cheryl remained an uninitiated girl due to her rejection of womanhood. Accepting and wielding power helped her to own responsibility for her life. Cheryl’s perception of most males was fairly accurate, as evidenced by her ability to identify both positive and negative traits. She quickly began to have increasingly accurate perceptions of her father and brother while the perception of her mother remained largely fixed and vilified.

Cheryl was assisted with recognizing how rejection of various aspects of herself caused those parts to rebel. This was illuminated with the use of the story Sleeping Beauty. When she was given the awareness that the witch who caused the evil spell was offended because she was the only one not invited to the party, Cheryl identified ways she problematically rejected aspects of herself. She began to accept rejected parts and when she did, her perception of her mother began to shift.

These imaginal structures expanded my perspective of what Cheryl and I were working with even though it was not possible to fully know the greater story at that time. In my work with Cheryl, she began to explore abandonment fears and the vilified projection of females. She commented several times that improving in these areas was
what she was most grateful for. I also benefited tremendously from working with Cheryl regarding my self-doubt, my parental issues, and my personal power. It was powerful to witness therapy assist Cheryl with transformation. It was also powerful to witness how the imaginal approach inherently provided emotional containment in ways more traditional theoretical orientations typically do not.
CHAPTER 5

REFLECTIONS

Personal Development and Transformation

Working with Cheryl during our time together was very rewarding and it deepened my capacity as a clinician. There were times when I encountered intense emotions from Cheryl, in myself, and throughout my process of writing this Clinical Case Study. Had it not been for the history I had with this beautiful and vibrant client, I would have given in to my resistance and avoided the topic of chemical dependence altogether. Retrospectively, any number of topics would have facilitated a much quicker completion of my doctoral degree but none would have deepened my initiation as a psychologist to the degree that chemical dependence research has.

My resistance to the topic of chemical dependence stemmed from my personal history. Approximately 17 years prior to beginning these sessions, I abused stimulants for nearly two years after I took the California High School Proficiency Exam and left high school. While I never used stimulants again, my shame remained unresolved. While I knew I had lingering feelings about stimulants, I also knew it was time for me to learn about chemical dependence from a healing perspective. At the time, I was unable to label my hypersensitivity to the topic of chemical dependence but now I realize hypersensitivity and shame were precisely my experience. One of the most valuable learnings I gained from this study stemmed from the dissolution of my shame. My shame
dissolved as I developed compassion for the ways I suffered in my youth. It also
dissolved as my perception of chemical dependence transcended cultural taboos, allowing
me to see intoxication for what it was: a delight, a temptation, a trickster, and a cruel
enslaver for some.

Since this work began, I have periodically had times when I suffered from the
mind-body-soul disconnection. This process has taught me how to intervene on my own
behalf. It also has helped me minimize the episodes through the use of comprehensive
interventions like infusing patience, kindness, and meaning into my daily life.

One learning I had was in response to the counter-transference evoked during the
early sessions. While I was not “green,” I had not worked clinically with clients I had
known as long or as deeply as I did Cheryl. Identifying neurotic counter-transference, or
my issues, was much easier with clients I knew less intimately. I learned that I feel most
resistant, frightened, and self-conscious about seeking help when it was most imperative.
My ability to focus on the client notwithstanding, the intensity of my emotions was more
extreme than I had previously experienced in a therapeutic arena. As a result of my
struggle, I developed more compassion for Cheryl during the moments when she longed
to connect while simultaneously being frightened of rejection. I also discovered which
professional relationships in my life had the most trust because I intuitively migrated
toward them for help when I was confused about Cheryl’s case.

In the beginning, I found myself quite affected by the work during the early
sessions of this Clinical Case Study. While it is normal for therapists to occasionally
think about clients outside the therapeutic arena, I found myself thinking about Cheryl
more frequently than I thought was healthy. Noticing the frequency of these thoughts led
me to realize how much of my life involves the care of others. I came to understand that I needed to schedule time dedicated to my own well-being. This was a turning point for me. It initiated the practice of asserting my needs with the same power and protectiveness I have shown for others in my care. I began to spent time in nature, taking baths, learning to decorate cakes, painting murals in my home, and beautifying my life in general. The steps I took to improve my surroundings helped me to feel cherished, more worthy, and more deserving.

In addition to how I was affected by the clinical work, the writing process of the Clinical Case Study was personally challenging for me. A part of me appreciated the opportunity to learn about chemical dependence thoroughly. However, the integration of the information required more time than I wanted to spend. Many of my peers completed their doctoral papers in much less time. I frequently found myself triggered, overwhelmed, and confused about how the components of chemical dependence fit into the big picture. There were many times during my work on the Literature Review where I felt frustrated because the information failed to depict aspects of my experience. The majority of the first 18 months of work on this paper were fraught with feelings of shame, embarrassment about the topic, and frustration that I could not complete the paper more quickly.

Old imaginal structures were activated. I agonized over how long it was taking to complete this task. At the same time, fears that I was unworthy of the goal of becoming a clinical psychologist plagued me. Years ago, I dropped out of high school and while I had overcome aspects of this, this final step required that I confront my old demons. My relationship to authority figures, like Cheryl’s, had to be negotiated before I could
become an authority myself. Along the way, I developed the understanding that I am worthy of this responsibility.

Finally, I discovered that what has changed me the most is the knowledge I gained through the process of comprehending the big picture about chemical dependence. This research deepened my understanding of various primal experiences related to chemical dependence that I could not have gained otherwise. I feel more secure as a clinician and I find myself confidently assisting others who have sought my advice and collaboration. The most important lesson I have learned in terms of leadership is to help others trust themselves, a skill that took some time for me to develop. It is my plan to continue with this work as an imaginal psychologist.

**Impact of the Learnings on My Understanding of the Topic**

I can identify five new learnings that have changed my initial understanding of the topic of chemical dependence. The first learning is that chemical dependence is highly correlated with a false self: a mask that problematically entrenches its captives in the pervasive, all-consuming experience of isolation, shame, and alienation. The second is that intoxication is sought for the mystery, magic, beauty, and ecstatic state inherent in the experience. The third learning is that addiction, true to the original symbolism of enslavement, is deeply entrenched in the bastardization of the feminine principle through the mind-body-soul split. The fourth is that it is problematic to either be codependent, distanced, or adherent to rigid boundaries while treating a patient with chemical dependence. The fifth learning is after the development of chemical dependence, the
remaining benefit of the pattern of chemical dependency lies in the transformative potential of sobriety.

Originally, I thought chemical dependence was founded in an individual’s sense of inadequacy. I found the mechanics of cognitive psychology interesting because of the ways chemical dependence is inherently resistant to extinction. Further, understanding depth psychology’s theory that the systematic weaknesses can be attributed to early developmental issues was insightful. However, it was only after reading the explanations that imaginal psychologists gave pertaining to chemical dependence that I was able to form a complete and cohesive understanding of this form of suffering. Further, when I revisited various biological and socio-cultural facts and found they supported the imaginal theoretical understandings, I finally felt the picture was complete.

Viewing chemical dependence through the lens of Persephone’s story imbued this distinct form of suffering with humanity, dignity, and kindness in a way that was not addressed by other theoretical orientations. Most theories were unsuccessful in explaining the ways in which soul struggles to unfold, and how addictive rituals develop to compensate for the imbalance in the psychic system. It felt containing to understand there was a map that could explain, guide, and respect the struggles that an individual with chemical dependence endures. This process supported Cheryl and my sense of well-being, a remarkable feat considering the underlying shame inherent in this topic.

Utilizing myths and contemporary stories to help comprehend an individual’s struggle was beneficial. It was fascinating to see how the Persephone myth provided a meaningful frame for Cheryl’s experience. Trusting in the process and being patient with the unfolding were of central importance. Although chemical dependence can be treated,
it is not easily eliminated from one’s life. A person with chemical dependence must make a long-term commitment to the transformation his or her life must undergo to provide for need satiation, awe, self-respect, and humility. The payoff for this hard work is significant in every aspect of one’s life. Committing to a healthy lifestyle by honoring the body, dependence needs (including those of a spiritual nature), stress reduction, ecstasy needs, and therapeutic support can be a pathway to living without mind-altering drugs.

**Mythic Implications of the Learnings**

When Cheryl was able to allow herself to grieve, to be angry, to find her humor, and to be seen, she was able to rid herself of the compulsive obsession to use cocaine. Demeter and Persephone is a myth worthy of close attention when working with women with chemical dependence. This myth is especially useful when issues arise in women who have been alienated from their mothers. Cheryl sought the reconnection, re-parenting, and the re-mothering she missed. Her reconnection began with her spiritual process. She sought therapy around the beginning of spring and the sessions came to a close during the fall harvest. The spiritual connection, which she was initially too shy to talk about, was an important part of her foundation. Over the course of treatment, she became increasingly comfortable talking about and ritualizing her beliefs.

While she longed for mothering, she felt incarcerated by feelings of anger, shame, and grief caused by the betrayals she had endured in her youth. After we worked together for several months, Cheryl was able to talk directly about her insecurities from a raw, authentic, and receptive position. She came to understand the dignity of her experience without feeling that she was weak for having reactions in the first place. While the
primary focus of treatment was to discontinue cocaine use, establishing healthy ways of satiating dependence needs reduced the seductive power of intoxication and helped Cheryl develop the confidence to transform her life.

The story of Persephone and Demeter is significant in its ability to give explanation to the rise of chemical dependence in a woman who has been without the ability to make use of dignified female mentors. Cheryl’s inability to negotiate developmental stages likely was a direct result of her inability to trust a female elder during adolescence, an elder she admired, respected, and could look up to.

When Demeter was willing to be seen after her unsuccessful search for Persephone, she was in disguise as a beggar. People with chemical dependence, like Cheryl, often hide behind masks that depict them as being socially less worthy than they actually are. While Cheryl was attached to overt honesty, for the most part, she minimized her strengths, and enacted the belief that she was less worthy than her actual value. When intoxicated, she was extremely confident. It was both delightful and painful to witness this because of the beauty and power she typically kept hidden. Powell explains that the dark side of the personality, or the underdeveloped part of a female’s self, is released by the exclusive identification with the world through the father in the father’s world. While Persephone is trapped in the underworld, she remains stuck in her “dark side.”

Cheryl’s transition into womanhood occurred as she began to identify and relate to a woman she respected, in a woman’s world. Persephone attained freedom when Demeter kindled her power and revealed her actual identity. Demeter’s response to her daughter’s suffering is the idealized image of a devoted mother. She became angry,
fought for her, and took powerful action opposing the wrong her daughter had endured. All of these actions are evoked by understanding the horror her daughter endured. The understanding, compassion, and anger allowed Persephone to transform into divine royalty. As Cheryl risked being herself, her internal critic lost the power to shut her down because Cheryl discovered evidence that she was worthy, loveable, and soulful. In order for the transformation to be earned, Cheryl had to become angry about how she had been wronged, fight for herself, grieve, risk being who she was, and be willing to hold her ground in order to be freed from enslavement.

It is not surprising that a swineherd was the one who told Demeter what she required to find her daughter because of the symbolism inherent in the pig. The Chinese character for home in the West Zhou Dynasty, 1046 B.C, was a house with a pig inside of it. As Powell commented earlier, Cheryl needed to come home to herself. The imagery of home was of central importance. Cheryl had been searching for a home with several different boyfriends and each time, she recovered a part of herself. Even in the first session when she drew four images depicting Persephone’s enslavement, Cheryl was unable to imagine what returning home could be. She was attached to the idea of home and she was afraid of being suffocated or trapped in the wrong one. One significant reason she ended her relationship with the boyfriend she dated for the majority of the sessions in this case study was that she did not want to be a docile housewife. While it is unclear if that was what would happen, Cheryl’s fight for herself was a welcome change from her submissive acceptance of aspects she emotively rejected. Many of the images discussed in the client’s imaginal structures section appear to be a response to the
distortion of the feminine represented by a Stepford Wife. Part of Cheryl’s work was allowing herself to envision a home worthy of residence.

The swineherd, Eubules, disclosed Kore’s abduction just before Baubo the crone was introduced in the story. Baubo used lewd humor by exposing her genitals to Demeter, an action that snapped Demeter out of her daze with humor and allowed her to refocus her attention on recovering her daughter. Baubo disregards any social expectations of beauty in those who would objectify her because she has a deeper value. Walker suggests Baubo’s action is an invitation for Demeter to feel/know the divine power through a holy rite.

The pomegranate seed was an important aspect of the myth. Reminiscent of the symbolism of Addictus, Persephone’s actions caused her to remain in the underworld: she ate the seeds. Once she had the experience of intoxication, Cheryl could not remove the experience from her awareness. Cheryl was quite aware of her personal responsibility. Throughout the sessions, she vacillated between attributing her actions to external and internal loci of control. The source of shame, experienced as hell, appeared to be caused by Cheryl’s personal responsibility for her reactions to the trauma: reactive expression, self-harm, ambivalent attachment, loneliness, and her neurotic compulsions.

Regardless of the version of the story, three generations of female elders including Demeter (mother), Hecate/Baubo (grandmother), and Rhea (great-grandmother) were needed to facilitate Kore’s transformation into Persephone, queen of the underworld. Hecate symbolizes the reality that there are choices that will have different outcomes. In order to truly see herself, Cheryl required generations of women to see who she was and how she wanted to develop. As she aged and was able to be
mentored, her expectations for herself became more reasonable, and this process appeared largely due to the realistic qualities she found in respected elders. Baubo shatters the vanity of social expectation, leaving the reality of what actually is. Cheryl had to see past the lure, danger, and excitement of cocaine to be able to understand that it was acting as an enslaver. Rhea, Mother Earth, was the ultimate judge who played a key role in securing Persephone’s freedom. Cheryl had to feel her body, trust her insights, and mediate her freedom, which she did. Cheryl came into her power, as was depicted in her final art therapy image; she became freed from her incarceration.

Throughout Cheryl’s struggle, one aspect of her perfectionistic compulsion was to fit the societal image of being physically ideal. Baubo is a trickster who puts the competitive drive for vanity in perspective with humor, acceptance, and appropriate shame. Cheryl suffered from inappropriately having internalized shame because she had not been taught to experience the affect of shame for 30 to 60 seconds, then let it go. Humor that was lewd and honest played an important part in her life. Cheryl migrated to people she considered crass.

In order to heal, Cheryl had to look upon parts of herself that she did not think were beautiful, and eventually she was able to see how much she respected and appreciated her gumption. She transformed her belief that she needed to be excessively slim in order to be accepted. Cocaine provided her an easy, undisciplined way of maintaining her weight. She had to become disciplined, act with care for herself, and avoid mistreating her body with binging to be able to have a healthy body. She had begun to do this by the end of treatment. She made use of mentors who assured her she was
worthy. Her grandmother planted the seeds of belief she was worthy. Those seeds were then nurtured by several of Cheryl’s mentors.

**Significance of the Learnings**

As previously mentioned, there are five new learnings this study can contribute to the field of psychology. The first learning is that chemical dependence is highly correlated with a false self, the mask that problematically entrenches its captives in the pervasive, all-consuming experience of isolation, shame, and alienation. The second is that intoxication is sought for the mystery, magic, beauty, and interpersonal connection inherent in the experience. The third learning is that addiction, true to the original symbolism of enslavement, is deeply entrenched in the bastardization of the feminine principle through the mind-body-spirit split. The fourth is that it is problematic to be either codependent, distanced, or adherent to rigid boundaries while treating a patient with chemical dependence. The fifth learning is after the development of chemical dependence, the remaining benefit of the pattern lies in the *transformative* potential of sobriety.

The first learning is that chemical dependence is highly correlated with a false self, a mask that problematically entrenches its captives in the pervasive, all-consuming experience of isolation, shame, and alienation. The idea of the false self, while not new, continues to be an important concept. As the true self is sheltered, individuals suffer and grow to believe inaccurate perceptions of themselves. The safe haven behind the false self grows into a prison within which individuals cannot function. Chemical dependence was a compensatory function in Cheryl that she used to tolerate her repression.
The false self can be fueled by both personal and cultural Gatekeepers. The social rejection and overall taboo of chemical dependence can be oppressive. The second learning is that intoxication is sought for the mystery, magic, beauty, and interpersonal connection inherent in the experience. Recognition of the soul’s longing, hope, and desire significantly helped me to remember the deeper truth about the value of this work. Imaginal Psychology is about re-sacralizing life, an experience for which individuals with chemical dependence are desperate. Transmuting the disgust inherent in the paradigm of chemical dependence is imperative if a clinician hopes to successfully facilitate an individual’s transformation. The suffering caused by chemical dependence is associated with misperceptions, personal devaluing, and inappropriate shame. This horrid experience is pervasive and must be addressed so that clients may begin to feel they deserve to have a rich, vital life. Additionally, they must be given compassion rather than pity because pity is a version of shame that reinforces the belief they are defective.

The second learning is that intoxication is sought for the mystery, magic, beauty, and interpersonal connection inherent in the experience. It is this mystery, magic, connection, and beauty that chemical dependence people are starving for. This starving for beauty is the antithesis of shame. While the initial reason fades and is replaced with the horror of chemical dependence, its presence cannot be ignored. Chemical dependence is fueled by the compulsion to live fully: it is a desperate attempt by the soul to fight through helplessness, distrust, feelings of worthlessness, and loneliness.

The third learning is after the development of chemical dependence, the primary benefit lies in the transformative potential of sobriety. At this point, an individual stuck in chemical dependence does not experience pleasure from his or her experiences.
Unfortunately, the lack of mentoring leaves many people uninitiated and stuck in the psychological foundations that underlie chemical dependence. The concept of initiation has been explained by various writers throughout history. Robert Moore described the initiatory experience as “part and parcel of the universal spiritual journey, the pilgrimage of human life. Initiation is the process of dying and being reborn.”\(^5\) Hollis reminded us that “as far as 2500 years ago Aeschylus observed that the gods have ordained a solemn decree, that through suffering we come to wisdom.”\(^6\) The Celts had a similar belief, which was expressed by the Stewart Clan motto “*Virescit Vulnere Virtus,*” which has been translated as “Courage grows strong at a wound.”\(^7\) Viktor Frankl understood the deeper meaning of the historic motto. He emphasized that suffering can be transformed into *sacred suffering* when profound meaning is imbued into the perception of unavoidable incidents of horror, loss, or emotional wounding.\(^8\) Jean Houston elaborated on Frankl’s concept with what she called the *sacred wound.*\(^9\) Frankl suggested that an attitude toward or the meaning of an incident can be transformed. Houston professed that the wound itself is sacred because of its potential for transformation. “As seed making begins with the wounding of the ovum by the sperm, so does soul-making begin with the wounding of the psyche by the Larger Story.”\(^10\)

Failure to embrace a new story results in a repetition of the old story over and over again.\(^11\) For the purpose of substance abuse, failure to make the wound sacred results in chemical dependence, actions that literally move an individual toward death. The transformation begins when a move toward life and perceiving life through a new lens is risked. Carl Jung taught that if we look far enough and deep enough, all wounds have archetypal power with a mythic base that can challenge us to have a deeper life: “It
makes a difference whether we serve a ‘mania’ which is detestable and undignified, or a ‘god’ which is full of meaning.”

The fourth learning is that chemical dependence, which is perhaps most accurately reflected by the original symbolism of enslavement in addiction, is deeply entrenched in the bastardization of the feminine principal. The rejection of the body causes excessive misinterpretations of the world and leads to the fragility inherent in imbalance.

The lure to abuse substances is exacerbated by the alienation and inability to be “ideal.” The culture of individuals who abuse substances is inherently accepting of deviance as a norm; normalcy is very inviting to an individual who feels lonely, defeated, alienated, unaccepted, and inferior. Societal pressure to reject the body and bodily experiences begins at a very young age, particularly for those who are miserable.

When I began this work, I was stuck believing that people with chemical dependence would have to bear the burden of their symptoms for the rest of their lives. Today, I believe that overcoming chemical dependence is an initiatory, transformative process with a tremendous potential to teach people about soul, intimacy, spirituality, and becoming an open person capable of love and trust.

It would be unlikely to heal so completely from chemical dependence that a person could abuse the intoxicant again without risk of relapse. Even if an individual has been able to reconnect the mind-body-soul, repair all developmental deficits, and re-write dysfunctional scripts, the temptation to abuse pleasure is powerful for those who have been enslaved. The first use was already profound and that cannot be undone.
When Cheryl realized how she played out the myth of Persphone, she was able to be her own master, enslaved to no other ruler. She felt the Gatekeeper but she did not let it be the divine ruler of her psyche. The difficulty in the myth of Persephone, or Addictus, for that matter, was that she ate the pomegranate seeds and easily could get lost in self-blame. She also could have blamed Hades for enslaving her. Either way, the act of blame embeds the dynamic and hinders the necessary waves of grief, anger, and maturation from occurring. By allowing the waves of grief and anger to be experienced and digested, Persephone not only escaped from the underworld, but she became its queen. Once Cheryl realized that she was acting as if she were enslaved to cocaine, she was able to refocus without the distorted lens and to choose freedom. She recognized the subtle lies she used to believe that facilitated her prolonged enslavement to cocaine. She rejected the lies. Admitting to herself what she had done while simultaneously honoring her divine value broke the silent barrier her secret had maintained. Prin’s belief that authentic living, integrity, and rigorous honesty, in combination with Roger’s concept of unconditional positive regard and moving at her own pace, helped Cheryl mature, become whole, and heal.

Cheryl’s hatred for her mother shifted and she became compassionate about the ways her mother was unable to tolerate feelings. She continued to struggle with her mother’s denial about the rape although she was able to accept that it would be horrible to have something like that occur in the family where she was the mother.

Her relationship with her father also changed. In the beginning of treatment, Cheryl talked about her father in a way that indicated he was her savior. The inappropriate and inflated value she attributed to each of his actions became more
realistic as she realized the ways he also was not present for her. He provided validation, love, respect, and belief during a time when she most needed it, and that was honored for what it was. He also did not prevent her from being taken from the home through any actions of his own, which he could have done. Her desperate need to feel loved by someone caused her to overlook this. She did grow to realize that he, like her mother, could not tolerate his feelings because he felt more than he could tolerate, so he simply numbed out.

**The Application of Imaginal Psychology to Psychotherapy**

One positive effect of using imaginal approaches with Cheryl is that the learnings identified in this Clinical Case Study can contribute to Imaginal Psychology. Identifying Cheryl’s imaginal structures was a significant step in understanding what needed to be addressed, including how my imaginal structures affected my work with her. Until they were identified, it would have been difficult to find the underlying dynamics that fuel chemical dependence. Cheryl’s imaginal structures were so powerful in the beginning that her identity was saturated with them and she could not differentiate what was her and what was her Gatekeeper.

The concepts of the Friend and Gatekeeper made sense to Cheryl and we were able to work with them during our individual sessions. Although she ended up using different language such as “being mean to myself,” “having compassion,” or “taking care of myself,” the meaning was the same. Once we began working with her imaginal structures and she was able to allow her repressed aspects to come forth, she got in touch with what was underneath. Her ability to go through the dis-identification process
empowered her to begin to choose how she wanted to participate in life. Cheryl’s transformation exemplifies how Imaginal Psychology has its roots in transformative practices. Utilizing concepts, approaches, and methods from Imaginal Psychology when I worked with Cheryl was important and added depth to our work. In my experience, there are concepts in Imaginal Process that are easily understood by youth, such as the Gatekeeper, Friend, and characters from archetypal stories. Communicating in mythic terms seemed to ease the difficulty of conveying nuances about dynamics. There was never any problem with Cheryl’s ability, or mine when I was on the receiving end, to understand what was being communicated.

Cheryl’s response to this approach was to embrace it as a spiritual process. She was more open to doing “soul work” than she was to identifying herself as a recovering addict in psychotherapy. Cheryl was living proof that when she rejected bodily sensations, cravings for intoxicants and self-hatred attacked. When we began exploring repressed issues, identified imaginal structures, and working within the confines of unconditional positive regard, Cheryl’s cravings lost power and she felt more freedom in her life.

This Clinical Case Study demonstrates the usefulness of applying Imaginal Psychology when working with youth. Although the young adult and adolescent clientele I have worked with are primarily designated as emotionally disturbed, and often engage in behaviors characteristic of emotional disturbance, they have usually suffered from trauma and are emotionally very young. Imaginal Psychology offers alternative approaches that are not always verbal, sterile, or limited to a particular strategy.
Bridging Imaginal Psychology

Through the work I have done at TLC, I have utilized the imaginal approach with many of my clients. When referring to concepts from Imaginal Psychology with clients or colleagues, I often chose to use lay terms that are readily understandable in mainstream settings. I often would ask “Did it feel like [name of a character]?” or I used the term lens and the term imaginal structure interchangeably. In this way, the interactions were natural and easily communicated. Occasionally, people have asked what theoretical orientation I adhered to and it provided the opportunity for me to discuss Imaginal Psychology.

Working with youth has been a fantastic opportunity to utilize myths, contemporary stories, and fairy tales. I have explained to clients, their families, and other mental health care providers that the curriculum from which I received my graduate education drew from historic and modern fields of knowledge. The responses I received have been extremely positive. Many clients have grown up with these stories and can easily relate to their use in the therapeutic setting. The stories have been particularly useful with clients who have struggled academically and who developed a limited vocabulary. There is a curiosity that is evoked by suggesting specific mythic stories. This curiosity has developed an investment or buy-in from clients who otherwise have felt stigmatized by linear, mainstream concepts.

I believe that the main ways to bridge Imaginal Psychology’s terminology and concepts is through the use of parallel concepts and alternative words. Imaginal Psychology can become more familiar within the mainstream field of psychology. Given that Imaginal Psychology draws on ancient practices while integrating modern concepts,
it is a distinctly post-modern approach that can greatly contribute to the field of psychology.

**Areas for Future Research**

Given the results of this study, there are a variety of areas I would recommend for future research. I recommend exploring imaginal structures evoked among men as well as among women with distinct ethnic origins. It is probable that there are imaginal structures typical of specific intoxicants and I would recommend exploring what they are and how they unfold. Lastly, I would recommend identifying the specific benefits of recovering from chemical dependence.

Both Cheryl and I have white mothers, and we have fathers who each come from two different non-white ethnic backgrounds. We both related to our fathers and their impassioned, African American or Jewish lineage. The lack of depth in our understandings about our mothers’ white origins made it difficult to relate to them. The ethnic component is not a focus of this case study; however, it is a worthy notation and I recommend it to be researched in another paper.

Another matter worth mentioning is that Cheryl was raised by two chemically dependent parents in a society where the majority of her peers used drugs socially. Some of this was by virtue of being raised in residential treatment, but some was about the zeitgeist of today’s California culture. Cheryl had a liberal perspective about what was a socially acceptable use of intoxicants. In my opinion, her perspective was skewed and she excused excessive use of marijuana, alcohol, and prescription pain medications as a direct result of her perception that intoxication was socially acceptable. The distinction between
cocaine dependence, binge drinking, and marijuana dependence is very important. The lack of compulsions to use marijuana often makes its dependence appear non-existent, particularly when compared to the intense cravings experienced with cocaine withdrawal. It would be worthwhile to explore various cases in different cultures to learn how the culture impacts use and the manifestation of symptoms.

The lived experiences of intoxication from cocaine, marijuana, heroin, caffeine, and alcohol are distinct from one another. The groups of people dependent on a specific substance have a sense of connection, commonality, and understanding of one another that others can only witness from an outsider vantage point. The choice to use one or another of the drugs, I believe, is about the specific nuance of what is missing in an individual’s life. It would be worthy to study the similarities of experience, dreams, longing, and pain to identify the calling to a particular kind of intoxication.

Lastly, it would be wonderful to research the capacities, traits, and skills that are common among women who have overcome chemical dependence. Erikson identified generativity and wisdom as potential developmental goals. It would be beneficial to learn how recovery could assist people with progressing towards those ends. My unreasearched hypothesis is that recovery not only benefits the individual by the discontinuation of the problem, but likely causes an individual to be soulfully richer and wiser than he or she would have been otherwise.

Pamela Sue Hartman explained,

Wisdom is conceptualized as a life-span personality development enabled by continued structured personality integration and resulting in a set of personality attributes considered most characteristic of the prototypical wise person. The attributes include insight and introspection, complex cognitive processes, and social judgment and integrity- wisdom is distinct from other competency indicators as it includes creativity and encompasses generativity/the capacity to
care/be concerned with others- associated with religious/spiritual endeavors, coming to terms with early adulthood life choices/difficulties through self evaluation and self acceptance- they possess ego-resiliency. Wisdom is a multidimensional yet unitary construct born out of the specificities of an individual life and a particular social moment yet encompassing universal features of structured personality integration.\textsuperscript{14}

In conclusion, future research could benefit the field of Imaginal Psychology in further linking the experience of those who suffer from chemical dependence with recovery. The use of myth, imagery, and symbolism can assist soul to unfold when working with clients who have suffered from trauma. Given what I have learned writing this Clinical Case Study, I believe that Imaginal Psychology has much to offer those who work with clients suffering from substance-related diagnoses.
APPENDIX
APPENDIX 1

INFORMED CONSENT

To Cheryl Dean (pseudonym):

You are invited to be the subject of a Clinical Case Study on the topic of chemical dependence treatment. The study’s purpose is to better understand chemical dependence and its treatment.

For the protection of your privacy, all of my notes will be kept confidential and your identity will be protected. In the reporting of information in published material, any and all information that could serve to identify you will be altered to ensure your anonymity.

This study is of a research nature and may offer no direct benefit to you. The published findings, however, may be useful to those who struggle with chemical dependence and the clinicians and counselors working in the field of chemical dependence treatment.

The Clinical Case Study does not directly require your involvement. However, it is possible that simply knowing you are the subject of the study could affect you in ways which could potentially distract you from your primary focus in the therapy. If at any time you develop concerns or questions, I will make every effort to discuss these with you.

If you decide to participate in this Clinical Case Study, you may withdraw your consent and discontinue your participation at any time and for any reason. Please note as well that I may need to terminate your being the subject of the study at any point and for any reason; I will inform you of this change should I need to make it.

If you have any questions or concerns, you may discuss these with me, or you may contact the Clinical Case Study Coordinator at the Meridian University, 47 Sixth Street, Petaluma, CA 94952, telephone: (707) 765-1836.

I, ______________________, understand and consent to be the subject of the Clinical Case Study written by Synde Acks, on the topic of addiction. I understand private and confidential information may be discussed or disclosed in this Clinical Case Study. I have had this study explained to me by Synde Acks. Any questions of mine about this Clinical Case Study have been answered, and I have received a copy of this consent form. My participation in this study is entirely voluntary.

I knowingly and voluntarily give my unconditional consent for use of both my clinical case history, as well as for disclosure of all other information about me including, but not limited to, information which may be considered private or confidential. I understand that
Synde Acks will not disclose my name or the names of any persons involved with me, in this Clinical Case Study.

I hereby unconditionally forever release Synde Acks and the Institute of Imaginal Studies (and all of its trustees, officers, employees, agents, faculty, successors and assigns) from any claims, demands, and legal causes of action whether known or unknown, arising out of the mention, use and disclosure of my clinical case history, and all information concerning me including, but not limited to, information which may be considered private and confidential. The Meridian University assumes no responsibility for any psychological injury that may result from this study.

The terms and provisions of this consent shall be binding upon my heirs, representatives, successors and assigns. The terms and provisions of this consent shall be construed and interpreted pursuant to the laws of the State of California.

Signed this ____ day of ____________, 2007, at ___________________, _________.

Day Month City State

By: ____________________________________________________________

Client’s signature

____________________________________________________________

Print Client’s signature legibly and clearly on this line.
**APPENDIX 2**

**CHERYL’S DIAGNOSES**

Over the course of treatment at TLC, Cheryl was given four diagnoses. The first two were given by TLC’s intake director and TLC’s psychiatrist. The final two diagnoses given at ages 20 and 22 were provided by me. The diagnoses developed as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>Axis I Clinical Disorders</th>
<th>Axis II Personality Disorders</th>
<th>Axis III General Medical Conditions</th>
<th>Axis IV Psychosocial &amp; Environmental Problems</th>
<th>Axis V: GAF</th>
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</thead>
<tbody>
<tr>
<td>Age 15: Intake into residential treatment</td>
<td>309.51 Posttraumatic Stress Disorder 313.89 Reactive Attachment Disorder</td>
<td>V71.09 No diagnosis, borderline personality traits</td>
<td>Some allergies, mild asthma</td>
<td>A, C: Problems with primary support and education</td>
<td>45</td>
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<tr>
<td>Age 18: Discharge from Residential Treatment</td>
<td>296.32 Major Depressive Disorder Recurrent 309.81 Posttraumatic Stress Disorder 307.1 Anorexia Nervosa, Binge eating/purging type 300.81 Undifferentiated Somatoform Disorder</td>
<td>301.83 Borderline personality disorder</td>
<td>Some allergies, mild asthma</td>
<td>A, C: Problems with primary support and education</td>
<td>55</td>
</tr>
<tr>
<td>Age 20: Intake for CCS Sessions</td>
<td>309.81 Posttraumatic Stress Disorder 304.20 Cocaine Dependence 305.20 Cannabis Abuse 305.00 Alcohol Abuse 305.5 Opioid Abuse 307.1 Anorexia</td>
<td>301.83 Borderline personality disorder, in partial remission</td>
<td>Some allergies, mild asthma</td>
<td>A, B: Problems with primary support &amp; social environment</td>
<td>55</td>
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<td>Diagnosis</td>
<td>Age 22: Discharge for CCS Sessions</td>
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<td>Nervosa, Binge eating/purging type, in partial remission</td>
<td>309.81 Posttraumatic Disorder, in full remission</td>
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<td>300.81 Undifferentiated Somatoform Disorder</td>
<td>300.02 Generalized Anxiety Disorder, in partial remission</td>
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<td>304.20 Cocaine Dependence, in full remission</td>
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<td>305.20 Cannabis Abuse</td>
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<td>305.5 Opioid Abuse</td>
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<td>307.1 Anorexia Nervosa, in full remission</td>
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<td>300.81 Undifferentiated Somatoform Disorder, In partial remission</td>
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<td>A, B: Problems with primary support &amp; Social Environment,</td>
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**APPENDIX 3**

*Diagnostic and Statistical Manual of Mental Disorders, 4th ed., rev., Summary of Chemical Intoxication, Withdrawal, Abuse, and Dependence.*

The following directly quotes from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision.*

**Substance Abuse Summary**

The essential feature of Substance Abuse is a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. In order for an Abuse criterion to be met, the substance-related problem must have occurred repeatedly during the same 12-month period or been persistent. There may be repeated failure to fulfill major role obligations, repeated use in situations in which it is physically hazardous, multiple legal problems, and recurrent social and interpersonal problems. Unlike the criteria for substance dependence, the criteria for substance abuse does not include tolerance, withdrawal, or a pattern of compulsive use and instead include only the harmful consequences of repeat use.

The individuals may repeatedly demonstrate intoxication or other substance-related symptoms when expected to fulfill major role obligations at work, school, or home. There may be repeated substance-related legal problems. Lastly, the person may continue to use the substances despite a history of undesirable persistent or recurrent social or interpersonal consequences.

**Criteria for Substance Abuse**

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)

2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)

3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
(4) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

**305.00 Alcohol Abuse**  
**307.50 Amphetamine Abuse and 305.60 Cocaine Abuse**

Notation: Legal difficulties are significant to track due to the aggression typical in amphetamine and cocaine abusers and due to the illegal nature of obtaining the drug.

**305.20 Cannabis Abuse**

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**Criteria for Substance Dependence**

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12 month period:

1. **Tolerance**, as defined by either of the following:
   - (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect;
   - (b) markedly diminished effect with continued use of the same amount of the substance

2. **Withdrawal**, as manifested by either of the following:
   - (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances);
   - (b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms

3. The substance is often taken in larger amounts or over a longer period than was intended

4. There is a persistent desire or unsuccessful efforts to cut down or control substance use

5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain smoking), or recover from its effects.

6. Important social, occupational or recreational activities are given up or reduced because of substance use.
(7) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

Specify if:
With Physiological Dependence: evidence of tolerance or withdrawal
(i.e., either item 1 or 2 is present)
Without Physiological Dependence: no evidence of tolerance or withdrawal
(i.e., neither item 1 or 2 is present)
Early Full Remission
Early Partial Remission
Sustained Full Remission
Sustained Partial Remission
In a controlled Environment

303.90 Alcohol Dependence Note: Due to the unpleasant and intense alcohol withdrawal symptoms which occur 4-12 hours after the reduction of intake following prolonged, heavy alcohol ingestion. Many people with alcohol dependence continue to abuse the substance to avoid or minimize their discomfort. Sleep disturbance can persist at lower intensities for months. Only about 5 percent of individuals with alcohol dependence ever experience the more severe symptoms (e.g., grand mal seizures or delirium).

305.70 Amphetamine Dependence and 304.20 Cocaine Dependence
The patterns of use and course of Amphetamine Dependence and Cocaine Dependence are similar because both substances are potent central nervous system stimulants with similar psychoactive and sympathomimetic effects. However, amphetamines are longer acting than cocaine and thus are usually self-administered fewer times per day. As with Cocaine Dependence, usage may be chronic or episodic with binges (“speed runs”) punctuated by brief drug free periods. Aggressive violent behavior is associated with Amphetamine Dependence, especially when doses are smoked, ingested or administered intravenously. As with cocaine, intense but temporary anxiety resembling Panic Disorder or Generalized Anxiety Disorder, as well as paranoid ideation and psychotic episodes that resemble Schizophrenia, Paranoid Type, are often seen, especially in association with high-dose use. Withdrawal symptoms are often experienced as temporary.

304.30 Cannabis Dependence
Often, this dependence pattern is typified by use of potent cannabis throughout the day over a period of months or years. They may spend several hours a day attempting to acquire the substance. The substance or acquisition of the substance often interferes with family, school, work, or recreational activities. The substance abuse may persist despite knowledge of physical problems (excessive sedation, chronic cough related to smoking, and a decrease in goal-oriented activities resulting from repeated use of high doses).
Criteria for Substance Withdrawal

A. The development of a substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy and prolonged
B. The substance-specific syndrome causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Use of multiple substances: Substance Dependence, Abuse, Intoxication, and Withdrawal often involve several substances used simultaneously or sequentially. Often individuals with a particular kind of dependence often utilize another substance which counteract the lingering symptoms of intoxication: e.g., a stimulant dependent person may use a depressant to allow them to sleep or a depressant dependent person may use a stimulant to help them become alert. Polysubstance Abuse or Dependence only applies to the simultaneous use of three substances or more repetitively. When different substances are abused in separate incidents, the diagnosis should individually list each substance abused or depended upon.

291.81 Alcohol Withdrawal
Diagnostic Criteria
A. Cessation of (or reduction in) alcohol use that has been heavy and prolonged.
B. Dysphoric mood and two (or more) of the following physiological changes, developing within a few hours to several days after Criterion A:
   (1) Autonomic hyperactivity (e.g., sweating or pulse rate greater than 100)
   (2) Increased hand tremor
   (3) Insomnia
   (4) Nausea or vomiting
   (5) Transient visual, tactile, or auditory hallucinations or illusions
   (6) Psychomotor agitation
   (7) Anxiety
   (8) Grand mal seizures
C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

292.0 Amphetamine Withdrawal and Cocaine Withdrawal
Both diagnosis have the same diagnostic criteria. Diagnostic Criteria:
A. Cessation of (or reduction in) amphetamine (or a related substance) use that has been heavy and prolonged
B. Dysphoric mood and two (or more) of the following physiological changes, developing within a few hours to several days after Criterion A:
   (1) Fatigue
(2) Vivid, unpleasant dreams
(3) Insomnia or hypersomnia
(4) Increased appetite
(5) Psychomotor retardation or agitation
C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Cannabis Withdrawal* This information is not listed in the DSM-IV-TR. The symptoms are based on Alan Budney and Roffman & Stephens research. They proposed the following Cannabis withdrawal Syndrome criteria:

(1) Anger or aggression.
(2) Decreased Appetite/weight loss
(3) Irritability
(4) Nervousness/anxiety
(5) Restlessness
(6) Sleep difficulties/strange dreams

Criteria for Substance Intoxication

A. The development of a reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. **Note:** Different Substances may produce similar or identical syndromes.
B. Clinically significant maladaptive behavioral or psychological changes that are due to the effect of the substance on the central nervous system (e.g., belligerence, mood lability, cognitive impairment, impaired judgment, impaired social or occupational functioning) and develop during or shortly after use of the substance.
C. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Below are additional criteria to Criteria A, B, and C listed above for all Substance Intoxication diagnoses.

**303.0 Alcohol Intoxication**
Diagnostic Criteria
A. Recent ingestion of alcohol
B. Clinically significant maladaptive behavioral or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood lability, impaired judgment, impaired social or occupational functioning) that developed during, or shortly after, alcohol ingestion.
C. One (or more) of the following signs, developing during, or shortly after, alcohol use:
(1) Slurred speech, incoordination
(2) Unsteady gait
(3) Nystagmus
(4) Impairment in attention or memory
(5) Stupor or coma
D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

292.89 Amphetamine Intoxication or Cocaine Intoxication
Both diagnosis have the same diagnostic criteria. Diagnostic Criteria:
A. Recent use of amphetamine or a related substance (e.g., methylphenidate)
B. Clinically significant maladaptive behavioral or psychological changes (e.g., euphoria or affective blunting, changes in sociability; hypervigilance; interpersonal sensitivity; anxiety, tension, or anger; stereotyped behaviors; impaired judgment; or impaired social or occupational functioning) that developed during or shortly after, use of amphetamine or related substance.
C. Two (or more) of the following, developed during, or shortly after, use of amphetamine or a related substance:
   (1) Tachycardia or bradycardia
   (2) Papillary dilation
   (3) Elevated or lowered blood pressure
   (4) Perspiration or chills
   (5) Nausea or vomiting
   (6) Evidence of weight loss
   (7) Psychomotor agitation or retardation
   (8) Muscular weakness, respiratory depression, chest pain, or cardiac arrhythmias
   (9) Confusion, seizures, dyskinesias, dystonias, or coma
Arnold Washton’s list of common cocaine dependence traits:

- Increasing irritability
- Severe depression
- Panic attacks
- “High-crash” cycle consistent with bipolar cycles
- Being short-tempered
- Distractible
- Unmotivated
- Reclusive
- Unreliable
- Asexual
- Suicidal
- Ultimately incapable of functioning of performing daily responsibilities.

- Aggressiveness
- Manipulative
- Demand ing
- Hostile
- Argumentative
- Unsociable
- Erratic
- Lethargic
- Paranoia
- Volatility
- Significant increase of a user’s proclivity toward physical violence.

Cocaine psychosis is another possible condition caused by cocaine abuse, which is virtually indistinguishable from classic paranoid psychosis:

Traits:

- Extreme paranoia
- Suspiciousness
- Agitation
- Irritability
- Social withdrawal
- Potential suicidal behaviors
- Possible violent behaviors
- Delusions and hallucinations

The primary psychiatric problem with cocaine use is that the cocaine induced symptoms of depression, psychosis, panic attacks and “high-crash” emotional roller-coaster are not symptoms responsive to anti-depressants or anti-psychotics. All symptoms are temporary and the only treatment for them identified by Washton is abstinence from cocaine use.

**305.90 Caffeine Intoxication**

A. Recent consumption of caffeine usually in excess of 250 mg (e.g., more than 2-3 cups of brewed coffee).

B. Five (or more) of the following signs, developing during, or shortly after, caffeine use:

1. Restlessness
2. Nervousness
3. Excitement
4. Insomnia
5. Flushed face
6. Dieresis
7. Gastrointestinal disturbance
8. Muscle twitching
(9) Rambling flow of thought and speech  
(10) Tachycardia or cardiac arrhythmia  
(11) Periods of inexhaustibility  
(12) Psychomotor agitation  

292.89 Cannabis Intoxication  
A. Recent use of cannabis  
B. Two (or more) of the following signs, developing within 2 hours of cannabis use:  
   (1) Conjunctival injection  
   (2) Increased appetite  
   (3) Dry mouth  
   (4) Tachycardia
# APPENDIX 4

## THERAPEUTIC INTERVENTIONS USED DURING PSYCHOTHERAPY

<table>
<thead>
<tr>
<th>Clinical Interventions</th>
<th>Biological</th>
<th>CBT</th>
<th>Psychodynamic</th>
<th>Socio-cultural</th>
<th>Imaginal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body</td>
<td>Identifying physical cues</td>
<td>Identify specific cues for coordinating affects, identify feelings about specific affects</td>
<td>Developed tolerance with intimacy</td>
<td>Develop matched attunement to read other’s bodily cues</td>
<td>Identify and experience body, translate experience into images</td>
</tr>
<tr>
<td>Cognition</td>
<td>Recognizing cravings, feeling triggered, and observing self enact distraction techniques like cleaning, desire for self-harm, or cravings to use</td>
<td>Tracking family of origin patterns</td>
<td>Identifying dependence needs or libidinal desires</td>
<td>Identify personal beliefs about social, gender, and cultural expectations of her experience, Take Risks toward social connections</td>
<td>Redefine self-image to include strengths, see herself according to her potential at birth, track thought patterns</td>
</tr>
<tr>
<td>Imaginal</td>
<td>Identify images evoked by her body sensations and universal experiences</td>
<td>Explored Gatekeeper, Friend, Subject interactions to identify internal scripts, beliefs, and tensions</td>
<td>Identify images evoked by fantasies, CBT scripts, family of origin mores, and affects as viewed through the lens of the observing ego.</td>
<td>Explored Gatekeeper, Friend, Subject interactions to identify internal tensions</td>
<td>Develop mutually entailed capacities: courage, compassion, reflexivity</td>
</tr>
</tbody>
</table>
APPENDIX 5

ALCOHOLICS ANONYMOUS 12 STEPS

Step One
We have admitted we were powerless over alcohol (or substance of choice)—that our lives have become unmanageable.

Step Two
Come to believe that a Power greater than ourselves could restore us to sanity.

Step Three
Make a decision to turn our will and our lives over to the care of God—*as we understood Him*.

Step Four
Make a searching and fearless moral inventory of ourselves.

Step Five
Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

Step Six
Were entirely ready to have God remove all these defects of character.

Step Seven
Humbly asked Him to remove our shortcomings.

Step Eight
Make a list of all persons we had harmed, and become willing to make amends to them all.

Step Nine
Made direct amends to such people whenever possible, except when to do so would injure them or others.

Step Ten
Continued to take personal inventory and when we were wrong promptly admitted it.

Step Eleven
Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.
Step Twelve

Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.
APPENDIX 6

CHERYL’S ART
Illustration 1. Kore’s Abduction

Illustration 2. Demeter’s Suffering
Illustration 3. Pomegranate Poisoning  

Illustration 4. Demeter's Rage
Illustration 5. Persephone, Queen of the Damned
## APPENDIX 7

### TABLES

Table 1. The Story of Chemical Dependence: A Cross Comparison of Theories - 3 Steps: The Beginning, The Middle, The End

<table>
<thead>
<tr>
<th>Theorist/focus</th>
<th>Name of Stage</th>
<th>Symptom</th>
<th>Treatment Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Beginning</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pita, Jellinek&lt;sup&gt;†&lt;/sup&gt; Alcohol</td>
<td>Prealcoholic</td>
<td>Social use, tolerance is developing.</td>
<td>Explore vulnerable connections capable of meeting dependence needs in a healthy manner</td>
</tr>
<tr>
<td>Nakken,&lt;sup&gt;‡&lt;/sup&gt; p. 20 Universal, All addictions</td>
<td>Internal Change</td>
<td>Mood change caused by excitement of addictive behavior (gambling, intoxication, spending money, sex), develop the illusion of control and addiction logic/rationalizations for use (32-34) Susceptible moments for CD: After the loss of a loved one, the loss of status, loss of ideals or dreams, loss of friendships, facing new social challenges or social isolation, or when leaving one’s family (14).</td>
<td>Accepting and taking responsibility for the presence of an addictive personality/dual personalities: self &amp; addict</td>
</tr>
<tr>
<td>Theorist/focus</td>
<td>Stage Name</td>
<td>Symptom</td>
<td>Treatment Strategies</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------</td>
<td>-------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>The Beginning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washton,(^2) p. 56 Cocaine</td>
<td>Early Stage</td>
<td>Brain chemistry is altered, addictive thinking begins, obsessive thoughts, compulsive urges, conditioned cravings, lifestyle changes, withdrawal from normal activities, subtle physical &amp; psychological consequences (jitters, irritability, mood swings, etc.).</td>
<td>Abstinence, social networking</td>
</tr>
<tr>
<td>Washton and Boundy,(^4) pp. 31-33, 38 Universal-All addictions</td>
<td>Infatuation</td>
<td>Early addiction experiences become physically imprinted: addictions become associated with euphoria, visceral mood elevations, a thrill, and adrenaline rush. Individuals experience the illusion of being more attractive, at ease, less isolated, more productive, powerful, removed from problems, and so forth.</td>
<td>Since there are no negative consequences, treatment is often not sought. If it is, addressing the trigger and allowing healthy emotion processing could potentially prevent addiction from becoming a crutch.</td>
</tr>
<tr>
<td>Washton and Boundy, pp. 31, 36-37.</td>
<td>Honeymoon</td>
<td>In times of stress, individuals seek out previously soothing and uplifting experiences to escape the momentary suffering. Only positive effects are experienced. The stress may be a specific trauma or trigger, which causes a cascade effect.</td>
<td>Since there are no negative consequences, treatment is often not sought. If it is, addressing the trigger and allowing healthy emotion processing could potentially prevent addiction from becoming a crutch.</td>
</tr>
<tr>
<td>Theorist/focus</td>
<td>Stage Name</td>
<td>Symptom</td>
<td>Treatment Strategies</td>
</tr>
<tr>
<td>---------------</td>
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<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>The Middle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pita, Jellinek, p. 30</td>
<td>Prodromal</td>
<td>Signals disease onset: blackouts, binge drinking, may develop a “big shot” complex, inflated behaviors, hidden drinking, chronic hangovers.</td>
<td>See Table 7, Doyle Pita’s Recovery Treatment Plan.</td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pita, Jellinek, p. 30</td>
<td>Crucial</td>
<td>Loss of control consumption after first drink, rationalizations are created to excuse/justify behavior. Drinking in the morning occurs to start the day, ease jangled nerves, medicate a hangover. Guilt/remorse develops about use. Behavior crosses personal, moral, ethical beliefs. Others begin to pressure use to stop, failed attempts to quit occur, and relationships are lost.</td>
<td>See Table 7, Doyle Pita’s Recovery Treatment Plan.</td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nakken, pp. 36-55</td>
<td>Lifestyle Change</td>
<td>Regular occurrence of addictive behavior, behavioral loss of control, behavioral dependence develops, addictive personality establishes control mentally and emotionally, behavioral commitment to addictive process is all encompassing, individual isolates or attaches to others with similar addictive beliefs. Traits: lies, blaming others, ritualized use, withdraw from relationships, hiding use, rationalizations, “I’m in pain, I need relief,” others begin to reject or disregard person because of use, tolerance is developed, energy is drained, spiritual emptiness.</td>
<td>Develop healthy rituals with others, honesty.</td>
</tr>
<tr>
<td>Universal-All addictions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theorist/focus</td>
<td>Stage Name</td>
<td>Symptom</td>
<td>Treatment Strategies</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------</td>
<td>-------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><em>Washton and Boundy, pp. 32,</em></td>
<td>Betrayal</td>
<td>Problems mount, hunger for gratification intensifies, greatest fear of inadequacy occurs in many life arenas. Moral, legal, and/or personal ethics lines are crossed. Pleasure is not experienced during addictive behaviors.</td>
<td>See Table 7, <em>Washton Recovery Stages</em></td>
</tr>
<tr>
<td><em>Universal-</em></td>
<td><em>All addictions</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Washton and Boundy, p. 32</em></td>
<td>On the Rocks</td>
<td>Individuals ignore mounting evidence of the drug or activity’s negative side effects. Individual attempts to recapture the honeymoon phase by increasing involvement with it. Desire to avoid withdrawal increases. Conditioning has developed and cravings occur when the individual encounters conditioned stimulation. Brain functioning is altered; tolerance has developed.</td>
<td>See Table 7, <em>Washton Recovery Stages</em></td>
</tr>
<tr>
<td><em>Universal-</em></td>
<td><em>All addictions</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theorist/focus</td>
<td>Stage Name</td>
<td>Symptom</td>
<td>Treatment Strategies</td>
</tr>
<tr>
<td>---------------</td>
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<td>----------------------</td>
</tr>
<tr>
<td>Pita, Jellinek, p. 30</td>
<td>Chronic</td>
<td>Prior to this stage, an alcoholic can opt to drink the first drink or not. In this stage they must drink. They are blindly, helplessly drunk for days during benders; hopelessly in search of alcoholic euphoria; they disregard everything including family, job, food, and even shelter; tremors and withdrawal symptoms occur quickly after intoxication; They desperately protect their supply; Unreasonable resentments cause excessive hostility toward others; constant of fear and anxiety is felt without identifiable cause; irrationality becomes obvious and they become realistic about drinking; Surrender process: if they are unable to seek help at this level, death likely will result from extensive and irreversible brain damage, alcoholic psychosis, cirrhosis of the liver, pancreatitis, hemorrhaging varices of the esophagus, or suicide. Amnesia and confabulation of Karsakoff’s syndrome can occur as well as coma and convulsions from Wernicke’s disease.</td>
<td>See Table 7, Doyle Pita’s Recovery Treatment Plan.</td>
</tr>
<tr>
<td>Theorist/focus</td>
<td>Stage Name</td>
<td>Symptom</td>
<td>Treatment Strategies</td>
</tr>
<tr>
<td>---------------</td>
<td>------------</td>
<td>---------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Nakken, p. 55 Universal/ All addictions</td>
<td>Life Breakdown</td>
<td>Addictive personality is in total control of the self through pain, fear, shame, loneliness, and anger. The person does not care about self or others. Addiction no longer produces pleasure. Addictive logic breaks down. Addictive behaviors continue because of the security found in ritualized behaviors. Connections are broken down so that the addict either isolates or only socializes with other addicts. Clingy with others and overly sensitive fear of abandonment occur. Physical breakdown occurs. Suicidality.</td>
<td>Reach out to others/discontinue isolation.</td>
</tr>
<tr>
<td>Washton, p. 56 Cocaine</td>
<td>Late Stage</td>
<td>Failed efforts to stop; severe financial problems, work/school dysfunction, relationship problems; plummeting self-esteem, chronic severe depression, cocaine psychosis, death.</td>
<td>See Table 7, Washton’s Recovery Treatment Plan.</td>
</tr>
<tr>
<td>Washton and Boundy, pp. 32, 42-43 Universal - All addictions</td>
<td>Trapped</td>
<td>The more an individual struggles to break the addiction by will power alone, the tighter its grip becomes. They are desperate, obsessed by the activity to the exclusion of almost everything else. “Descent into despair”/ they can see no way out. They’ve lost other ways to cope. They are trapped between engaging in the addiction, which fails to bring relief or pleasure, and terror or despair.</td>
<td></td>
</tr>
</tbody>
</table>
Notes


<table>
<thead>
<tr>
<th>Rating</th>
<th>Attributes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I am reactive, self-involved, unaware of my behavior and its effects on my responses to my environment, self-important and blaming others. I have no awareness of my projections. Learning opportunity? Are you kidding?? I am in victim consciousness!</td>
</tr>
<tr>
<td>2</td>
<td>I react to what other people say. I think that other people are out to get me or misunderstand me. I feel the need to protect myself accordingly. I am shut down, withdrawn, or closed to feedback. I rationalize and I know I am right. I deny the existence of the validity of the feedback I am receiving.</td>
</tr>
<tr>
<td>3</td>
<td>I am self-involved and unaware of my behavior and its effects on my responses. I am moody and withdrawn and resistant to looking at my experience from the lens of reflection. When others reflect that back to me, I collapse inside.</td>
</tr>
<tr>
<td>4</td>
<td>I am self-involved but beginning to realize that my experience is being affected by my behavior and attitude. I’m demonized my shadow parts and don’t want to look or be accountable for myself.</td>
</tr>
<tr>
<td>5</td>
<td>I am able to reflect on my emotional experience and see the trails into my shadow work or my reactivation. Although I can see what I am doing, I am still not able to stand outside of my pathologizing enough to experience myself objectively.</td>
</tr>
<tr>
<td>6</td>
<td>I’m starting to see that my emotional responses are linked to what’s happening in the classroom and to my life’s issues. I begin taking a learning approach to my issues when present. I begin to take ownership of my demonized parts and I begin to experience the seeds of integration. There is a glimmer of strength and “response-ability” growing inside me.</td>
</tr>
<tr>
<td>7</td>
<td>I’m recognizing that my reactivity is triggered by my internal imaginal structures and memories. I’m fully involved in embracing the feedback I’m receiving and learning about my shadow. I’m deep in the work of discovery. Sometimes I still get activated but I can hold my own with my own reactivity.</td>
</tr>
<tr>
<td>8</td>
<td>I am enjoying the process of owning and accepting my projections. I take responsibility for my reactions to situations around me, and I am showing greater acceptance of my experience. I experience greater integration of the aspects I formerly demonized, and find myself able to share and experience all parts of me with greater flexibility and ease.</td>
</tr>
<tr>
<td>Rating</td>
<td>Attributes</td>
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<tr>
<td>--------</td>
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</tr>
<tr>
<td>9</td>
<td>I am for the most part conscious and aware. I enjoy the process of owning and accepting my shadow - I accept all of my behaviors and actions as opportunities to learn and grow. I express my experience authentically and am not afraid of sharing and discovering places of darkness inside and bringing them to the light for healing and growth. I feel safe and secure in myself. I experience integration and maturity in my consciousness. I have facility in working with myself such that I move easily into compassion and friendship with myself on all levels.</td>
</tr>
</tbody>
</table>
### Table 3. Socio-Cultural Facts\(^1\)

<table>
<thead>
<tr>
<th>Why did you start using? 310 interviews</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Wanted to fit in with peers</td>
<td>58%</td>
</tr>
<tr>
<td>A family member or caretaker used</td>
<td>12%</td>
</tr>
<tr>
<td>Emotional or mental issues</td>
<td>12%</td>
</tr>
<tr>
<td>Fun/Experimental/curiosity</td>
<td>10%</td>
</tr>
<tr>
<td>Problems at home or school</td>
<td>9%</td>
</tr>
<tr>
<td>Traumatic/stressful event</td>
<td>4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When asked how they chose to stop, 189 individuals reported:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12-step/self-help groups</td>
<td>45%</td>
</tr>
<tr>
<td>Treatment</td>
<td>34%</td>
</tr>
<tr>
<td>Cold turkey/will power</td>
<td>30%</td>
</tr>
<tr>
<td>Competing activity</td>
<td>11%</td>
</tr>
<tr>
<td>Dealt with mental health issues</td>
<td>3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When asked what was happening inside of them when they relapsed, 79 individuals reported:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lonely/bored</td>
<td>31%</td>
</tr>
<tr>
<td>Craved/wanted to use</td>
<td>31%</td>
</tr>
<tr>
<td>Negative emotion (sad, angry)</td>
<td>17%</td>
</tr>
<tr>
<td>Managing mental health symptoms</td>
<td>12%</td>
</tr>
<tr>
<td>Stopped Treatment</td>
<td>7%</td>
</tr>
<tr>
<td>Denial, questioning sobriety</td>
<td>7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When asked what was happening outside of them when they relapsed, 79 individuals reported:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Temptations</td>
<td>28%</td>
</tr>
<tr>
<td>Stress/responsibilities</td>
<td>28%</td>
</tr>
<tr>
<td>Relationship problems</td>
<td>16%</td>
</tr>
<tr>
<td>Bored, too much time</td>
<td>7%</td>
</tr>
<tr>
<td>Negative feelings, confusion</td>
<td>5%</td>
</tr>
<tr>
<td>Unresolved recover issue</td>
<td>5%</td>
</tr>
<tr>
<td>Mental Health Symptoms</td>
<td>2%</td>
</tr>
</tbody>
</table>
### Table 3--Continued

| Nothing | 12 |

**Notes**

Table 4. Relapse Warning Signs

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Listed by Prin(^1) (pp. 251-252)</th>
<th>Listed by Marlatt(^2)</th>
<th>Listed by Washton(^3) (pp. 119-121)</th>
<th>Listed by Other Theorists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impatience</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Argumentativeness</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>Nowinski, Baker, and Carroll(^4) (p. 83)</td>
</tr>
<tr>
<td>Depression</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Pity/Blaming others</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>Wei-Fin Lin(^5)</td>
</tr>
<tr>
<td>Cockiness or arrogance</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Complacency</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of self care</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Dishonesty</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Unrealistic expectations</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Forgetting gratitude</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Difficulty managing emotions</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>Perera(^6) (p. 153)</td>
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<td></td>
<td></td>
<td>Nowinski, Baker, and Carroll (p. 83)</td>
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<td></td>
<td>Beck(^7) (p. 23)</td>
</tr>
<tr>
<td>Difficulty managing stress</td>
<td>√</td>
<td></td>
<td>√</td>
<td>Beck (p. 23)</td>
</tr>
<tr>
<td>Refusing Problems</td>
<td>√</td>
<td></td>
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</tr>
<tr>
<td>Negative Attitude/Stink thinking</td>
<td>√</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Rigid beliefs/attitudes/Control issues</td>
<td>√</td>
<td></td>
<td>√</td>
<td>Washton and Boundy(^8)</td>
</tr>
<tr>
<td>Waiting to be rescued/codependence</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life’s not fun without drugs</td>
<td>√</td>
<td></td>
<td>√</td>
<td>Leonard(^9)</td>
</tr>
<tr>
<td>Inaccurate reality testing</td>
<td>√</td>
<td></td>
<td>√</td>
<td>Wei-Fin Lin</td>
</tr>
<tr>
<td>Symptoms</td>
<td>Listed by Prin (pp. 251-252)</td>
<td>Listed by Marlatt</td>
<td>Listed by Washton (pp. 119-121)</td>
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<tr>
<td>--------------------------------</td>
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<tr>
<td>Trauma</td>
<td></td>
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<td>√</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td>√</td>
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<tr>
<td>Bored</td>
<td></td>
<td></td>
<td>√</td>
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</tr>
<tr>
<td>Lonely</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
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<tr>
<td>Urges</td>
<td></td>
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<td>√</td>
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<tr>
<td>Desire to test self control</td>
<td></td>
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<td>√</td>
</tr>
</tbody>
</table>

Notes

Table 5. Imaginal Structures Related to Chemical Dependence

<table>
<thead>
<tr>
<th>By Name</th>
<th>Addictive Quality</th>
<th>Unconsciously Sought</th>
<th>Response to Problem</th>
<th>Steps to Achieve Transcendent Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictus/The Hostage</td>
<td>Hedonism, seek pleasure/avoid pain</td>
<td>All-encompassing Overview Primal desires</td>
<td>Avoidance, humiliated by the shadow</td>
<td>Develop self, reunify mind-body-soul connection, develop trust &amp; interdependence</td>
</tr>
<tr>
<td>(Leonard,(^1) pp. 4-9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queen Maeve (Perera(^2))</td>
<td>Hedonism, seek pleasure/avoid pain</td>
<td>Relief from bodily restraints</td>
<td>Intellectualization</td>
<td>Reunify mind-body-soul, development of self, develop trust &amp; interdependence</td>
</tr>
<tr>
<td>The Gatekeeper</td>
<td>Compulsion, avoid pain</td>
<td>Safety</td>
<td>Prevent problems by avoiding unnecessary risks</td>
<td>Challenge fears with reality testing and identifying the soul’s desire</td>
</tr>
<tr>
<td>Lover/ The Romantic</td>
<td>Tunnel vision, rose-colored lens/failure to accurately see reality</td>
<td>Bliss, seduction</td>
<td>Focus on object of affection, seeking ecstasy, inaccurate perceptions</td>
<td>Attend to the big picture, improve accurate reality testing, discipline</td>
</tr>
<tr>
<td>(Pearson,(^3) pp. 10-11; Leonard, pp. 48-49)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Innocent (Pearson, pp. 10-11)</td>
<td>Excessively trusting/undefended</td>
<td>To remain safe</td>
<td>Denial or seek rescuing</td>
<td>Fidelity, courage</td>
</tr>
</tbody>
</table>

\(^1\) Leonard, 1986. 
\(^3\) Pearson, 1990.
<table>
<thead>
<tr>
<th>By Name</th>
<th>Addictive Quality</th>
<th>Unconsciously Sought</th>
<th>Response to Problem</th>
<th>Steps to Achieve Transcendent Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fool/Moneylender</td>
<td>Inflation/deflation cycles</td>
<td>Enjoyment, ease</td>
<td>Plays tricks on it, manipulative</td>
<td>Trust in the process, authentic living; transform humiliation with humility</td>
</tr>
<tr>
<td>(Pearson, pp. 10-11; Leonard, pp. 14-36)</td>
<td></td>
<td></td>
<td></td>
<td>Trust, facing struggles with wisdom</td>
</tr>
<tr>
<td>The Trickster</td>
<td>Shape-shifter, immediate gratification of opposing desires</td>
<td>Entertainment, inspiration, the transcendent function or 3rd thing.</td>
<td>Manipulation, trickery, avoidance</td>
<td></td>
</tr>
<tr>
<td>(Leonard, pp. 98-113)</td>
<td>Excitement, thrill</td>
<td>Shortcut to ecstasy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Gambler</td>
<td>Cynicism, control through fear, avoiding powerlessness, self-destructiveness</td>
<td>Power, freedom</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Leonard, 91-94; Pearson, p. 19)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Outlaw</td>
<td>Craving something outside of self for fulfillment</td>
<td>Relief of resentment, anger</td>
<td>Anger, shut down, defeat</td>
<td>Restraint, moderation, affirmation of inner struggle: sacrifice one’s ego and instead apply one’s unique creativity to larger solution</td>
</tr>
<tr>
<td>(Leonard, pp. 70-82)</td>
<td></td>
<td></td>
<td></td>
<td>Redemption comes from willing every moment, take responsibility</td>
</tr>
<tr>
<td>The Underground Man</td>
<td>Avoiding power/others are mean</td>
<td>Purity/innocent goodness</td>
<td>Deflation, passive compliance</td>
<td>Fidelity, discernment, assertion</td>
</tr>
<tr>
<td>(Leonard, pp. 42-47)</td>
<td>Excessively guarded, unyielding</td>
<td>To regain safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scapegoat; Victim</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orphan (Pearson, pp. 10-11)</td>
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</tbody>
</table>

Table 5--Continued
<table>
<thead>
<tr>
<th>By Name</th>
<th>Addictive Quality</th>
<th>Unconsciously Sought</th>
<th>Response to Problem</th>
<th>Steps to Achieve Transcendent Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver (Pearson, pp. 10-11)</td>
<td>Transcendent Development Caregiver (Pearson, pp. 10-11)</td>
<td>Protects others without discernment</td>
<td>To avoid pain/help others</td>
<td>Give without maiming self or others</td>
</tr>
<tr>
<td>Creator (Pearson, pp. 10-11, 165)</td>
<td>Unconsciously Sought</td>
<td>Difficulty accepting external locus of control</td>
<td>Acceptance/belonging</td>
<td>Self-creation, self-acceptance</td>
</tr>
<tr>
<td>Transcendent Development Caregiver (Pearson, pp. 10-11)</td>
<td>Protects others without discernment (Pearson, pp. 10-11)</td>
<td>Difficulty accepting external locus of control</td>
<td>Acceptance/belonging</td>
<td>Give without maiming self or others</td>
</tr>
<tr>
<td>The Madwoman (Leonard, 117-139)</td>
<td>Madness, insanity, Kali, Hecate, Ereshkigal, Oya (Borderline type behaviors)</td>
<td>Acceptance, kindness, to be seen, to be spiritually whole, trust someone trustworthy</td>
<td>Extreme unpredictable reactivity</td>
<td>Self-acceptance, humility, digesting trauma/humility</td>
</tr>
<tr>
<td>The Judge/Scapegoat’s Priest/Moneylender (Perera, pp. 23-24; Leonard, pp. 36, 140-164)</td>
<td>Perfectionism &amp; dominance; hides shadow qualities righteously; alienated from inner world</td>
<td>Control &amp; power, denial of humanity/creativity</td>
<td>Colludes with Azazel, avoids being blamed by blaming others, buckling down and doing better</td>
<td>Discern between judgments that honor growth/ wholeness and those that condemn us to stagnation. Experiences emotion and physical experiences</td>
</tr>
<tr>
<td>The Killer, Scapegoat’s Azazel (Perera, pp. 18-19; Pearson, pp. 10-11; Leonard, p. 165)</td>
<td>Kill’s vulnerability to avoid deflation/narcissistic lesions; blames, avoids shame</td>
<td>Discharge emotions, metamorphosis</td>
<td>Slay or confront problem</td>
<td>Pick battles, humility</td>
</tr>
<tr>
<td>By Name</td>
<td>Addictive Quality</td>
<td>Unconsciously Sought</td>
<td>Response to Problem</td>
<td>Steps to Achieve Transcendent Development</td>
</tr>
<tr>
<td>----------------------------------------------</td>
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</tr>
<tr>
<td>The World’s Night/Archetype, which is enacted in the larger culture: (Leonard, p. 197)</td>
<td>Monomaniacal will to control life for the purposes of power, security, comfort, and victory</td>
<td>Control &amp; Power, denial of humanity/creativity</td>
<td>Everything that threatens control is warded off and objectified</td>
<td>Mind-body connection, remain own witness/judge, use inner guide to help determine right, wrong, and soulfulness</td>
</tr>
<tr>
<td>The Abyss/Dark Night of Soul (Leonard, pp. 213, 229)</td>
<td>Fighting the struggle, giving up</td>
<td>Recognition that the individual is not invincible</td>
<td>This is the archetypal hitting bottom</td>
<td>Spiritual renovation, finding meaning, courage, surrender, acceptance, compassion for personal suffering,</td>
</tr>
<tr>
<td>The Battleground (Leonard, p. 243)</td>
<td>Hiding in familiarity, inaccurate reality testing, fantasy perceptions instead of reality</td>
<td>Psychological death</td>
<td>Longing for comfort/Facing shame, self-doubt, self-hatred</td>
<td>Allow the transformation to happen, try new tactics and risk connection</td>
</tr>
<tr>
<td>Soul on Fire (Leonard, p. 259)/The Creation (Leonard, pp. 292-252)</td>
<td>This is a raw, new place; reaching for the old may be a response but so is reaching for the new</td>
<td>Psychological rebirth</td>
<td>Seeking new solutions, having to risk incompetence and unfamiliarity; problems have cracked individuals open so they can begin to find themselves again</td>
<td>Asking for help, trying new responses, being vulnerable, feeling the body, mind, and soul reintegrate</td>
</tr>
</tbody>
</table>
Notes


   Claire-Voss stated, “In my view, the greatest mistake one can make in approaching spiritual alchemy is to come to it with a set of preconceived doctrines concerning the nature of things, which is allowed to function axiomatically. The task then becomes no longer that of trying to understand, but of attempting to valorize or to vilify. While one thing such an approach to spiritual alchemy lacks is subtlety, but there is an alternative approach that is potentially very subtle indeed, because it may easily function as a disguised form of the first, albeit unintentionally. This second approach runs the risk of subjecting the materials being examined to the tacit, and hence unexamined, criteria embedded in a mentality, a world view, a conceptual framework, which are such that the materials appear as rattling, dry bones, devoid of meaning, perhaps thereby even faintly ridiculous. This often occurs when we utilize an approach found in much late-twentieth-century scholarship, comprised of idiosyncratically (hence, arbitrarily) selected elements from the analytic philosophical tradition, together with the tattered, tired (thought still feebly twitching) remnants of ideas of ‘objectivity’ that were developed in the late nineteenth century. Great care must be taken when utilizing such contemporary methodological tools to examine materials like alchemy. Instead, one should try to become intimately familiar with the pre-modernist worldview that gave rise to spiritual alchemy and to develop a genuinely empathetic grasp of both the world-view and its manifestation. Without these two efforts we cannot hope to understand the materials. This approach is not to be confused with advocacy or with depreciation; rather, it is related to a third thing: it requires courage. For a scholar, bracketing experience is much easier, and certainly much safer, than to confront it head on. Put very simply, the approach I am using here leaves one open to the possibility of experiencing wonder: of coming to know something we did not know previously, or of deepening our knowledge of something we were already acquainted with. That is my understanding of what being a scholar is essentially all about, and I confess that it is a process that brings me not only pleasure, but joy.”
<table>
<thead>
<tr>
<th>Stage</th>
<th>Characteristics</th>
<th>Techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contemplation</td>
<td>Not currently considering a change, ignorance is bliss</td>
<td>Validate lack of readiness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clarify: decision is theirs</td>
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<tr>
<td></td>
<td></td>
<td>Encourage re-evaluation of current behavior</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encourage self-exploration, not action</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Explain and depersonalize the risk</td>
</tr>
<tr>
<td>Contemplation</td>
<td>Ambivalent about change: sitting on the fence</td>
<td>Validate lack of readiness</td>
</tr>
<tr>
<td></td>
<td>Not Considering change within the next month</td>
<td>Clarify: decision is theirs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encourage evaluation of pros and cons of behavior change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify and promote new, positive outcome expectations</td>
</tr>
<tr>
<td>Preparation</td>
<td>Some experience with change and are trying to change</td>
<td>Identify and assist in problem solving obstacles</td>
</tr>
<tr>
<td></td>
<td>“Testing the waters”</td>
<td>Help patient identify social support</td>
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<tr>
<td></td>
<td>Planning to act within a month</td>
<td>Verify that patient has underlying skills for behavior change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encourage small initial steps</td>
</tr>
<tr>
<td>Action</td>
<td>Practicing new behaviors for 3-6 mo.</td>
<td>Focus on restructuring cues and social support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bolster self-efficacy for dealing with obstacles</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Continued commitment to sustaining new behavior</td>
<td>Combat feelings of loss and reiterate long-term benefits</td>
</tr>
<tr>
<td></td>
<td>Post- 6 months to 5 years</td>
<td>Plan for follow-up support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reinforce internal rewards</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discuss coping with relapse</td>
</tr>
<tr>
<td>Relapse</td>
<td>Resumption of old behaviors: “fall from grace”</td>
<td>Evaluate trigger for relapse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reassess motivation and barriers</td>
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<tr>
<td></td>
<td></td>
<td>Plan for stronger coping strategies</td>
</tr>
</tbody>
</table>
Notes

Table 7. Recovery Treatment Plans

<table>
<thead>
<tr>
<th>Stage 1: Stabilization &amp; Crisis Intervention: 2 Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immediately stop all drug/alcohol use</strong>&lt;br&gt;Break off contact with dealers/users&lt;br&gt;Recover from acute aftereffects/drug withdrawal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 2: Early Abstinence: 1-2 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Learn about addictive disease</strong>&lt;br&gt;Admit that the addiction exists</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 3: Relapse Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Progress from verbally admitting to emotionally accepting that the disease exists</strong>&lt;br&gt;Learn about relapse: process, warning signs, risk factors, counteracting risk factors&lt;br&gt;Make positive, lasting changes in lifestyle</td>
</tr>
</tbody>
</table>
### Table 7--Continued

<table>
<thead>
<tr>
<th>Washton’s Recovery Stages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 4: Advanced Recovery</strong></td>
</tr>
<tr>
<td>Achieve more lasting changes in attitude, lifestyle, and behavior</td>
</tr>
<tr>
<td>Change addictive thinking styles and personality traits</td>
</tr>
</tbody>
</table>

**Doyle Pita’s Recovery Treatment Plan**

### Stage I: Initiating Treatment

**Process:** Psychosocial crisis = Trust versus mistrust  
Potential strengths = hope and trust versus withdrawal  
Therapeutic process = Asking for and accepting help  
Task: Admitting, “I cannot control use of alcohol/drugs”  
Goal: Agreement on treatment goal: stopping compulsion  
Strengths needed to move on to next stage: Trust and hope

### Stage II: Stopping the compulsion

**Process:** Psychosocial crisis = Autonomy versus shame, doubt  
Potential strengths = will versus compulsion  
Therapeutic process = “I am willing to try”; “I trust you”  
**Tasks:** Follow treatment plan  
Separating from active loved ones and friends  
Working on Step One: Admitting loss of control, “I will not use drugs/alcohol”; “I will attend individual and group therapy and A.A.”; “I will get a sponsor”.  
Goal: To stay sober one day at a time  
Strengths needed to move on to next stage: Trust, hope, and will
<table>
<thead>
<tr>
<th>Table 7--Continued</th>
<th>Doyle Pita’s Recovery Treatment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage III: Working and Playing Sober</strong></td>
<td></td>
</tr>
<tr>
<td>Process: Psychosocial crisis = Initiative vs. guilt/industry vs. Inferiority</td>
<td></td>
</tr>
<tr>
<td>Potential Strengths = Purpose vs. Inhibition/competence vs. Inertia</td>
<td></td>
</tr>
<tr>
<td>Therapeutic Process = “I admit that I have the disease”; “My purpose is to stay sober”; “I am a worthwhile person”</td>
<td></td>
</tr>
<tr>
<td>Tasks: Psycho-education,</td>
<td></td>
</tr>
<tr>
<td>Working on the first three steps,</td>
<td></td>
</tr>
<tr>
<td>Returning to work as a recovering person,</td>
<td></td>
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<tr>
<td>Learning to parent sober and non-codependently,</td>
<td></td>
</tr>
<tr>
<td>Learning to play, enjoy leisure time, relax, have fun</td>
<td></td>
</tr>
<tr>
<td>Goal: Learning to work and play sober</td>
<td></td>
</tr>
<tr>
<td>Strengths needed to move on to next stage: Trust, hope, will, purpose, competence</td>
<td></td>
</tr>
<tr>
<td><strong>Stage IV: Identity Development Specific to Sobriety</strong></td>
<td></td>
</tr>
<tr>
<td>Process: Psychosocial Process= Identity versus Identity confusion</td>
<td></td>
</tr>
<tr>
<td>Potential strengths= Fidelity versus repudiation</td>
<td></td>
</tr>
<tr>
<td>Therapeutic Process= Faith in recovery, sober self, higher power</td>
<td></td>
</tr>
<tr>
<td>“I am trustworthy”; “I am worthy of respect”</td>
<td></td>
</tr>
<tr>
<td>Tasks: Identify and challenge irrational beliefs about self</td>
<td></td>
</tr>
<tr>
<td>Accepting, “I am a recovering alcoholic/addict”</td>
<td></td>
</tr>
<tr>
<td>Learn to accept and care for the self</td>
<td></td>
</tr>
<tr>
<td>Work on self-esteem and express feelings about self.</td>
<td></td>
</tr>
<tr>
<td>Working on steps Two and Three</td>
<td></td>
</tr>
<tr>
<td>Goal: To admit and accept, “I am an alcoholic”; to begin to identify a spiritual self.</td>
<td></td>
</tr>
<tr>
<td>Strengths needed to move on to next stage: Trust, hope, will, purpose, competence, faith</td>
<td></td>
</tr>
</tbody>
</table>
### Table 7--Continued

**Doyle Pita’s Recovery Treatment Plan**

<table>
<thead>
<tr>
<th>Stage V: Intimacy Development Specific to Sobriety</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process:</strong> Psychosocial Process = Intimacy (in friendships) versus isolation</td>
</tr>
<tr>
<td>Potential strengths = Love versus exclusivity</td>
</tr>
<tr>
<td>Therapeutic Process = Learning about relationships, honesty and trustworthiness, expressing feelings to others, taking risks, giving and getting needs met.</td>
</tr>
<tr>
<td><strong>Tasks:</strong> Working on Relapse Prevention</td>
</tr>
<tr>
<td>Getting honest</td>
</tr>
<tr>
<td>Joining a self-help group</td>
</tr>
<tr>
<td>Joining a step group</td>
</tr>
<tr>
<td>Expressing feelings in a therapy group</td>
</tr>
<tr>
<td>Asking for something</td>
</tr>
<tr>
<td>Learning assertion skills</td>
</tr>
<tr>
<td>Making new sober friends</td>
</tr>
<tr>
<td>Socializing with friends, family, relatives</td>
</tr>
<tr>
<td>Recognizing and giving up codependent behaviors</td>
</tr>
<tr>
<td><strong>Goal:</strong> To gain socialization and relationship skills</td>
</tr>
<tr>
<td><strong>Strengths needed to move on to next stage:</strong> Trust, hope, will, purpose, competence, faith, love</td>
</tr>
</tbody>
</table>
## Table 7--Continued

### Doyle Pita’s Recovery Treatment Plan

<table>
<thead>
<tr>
<th>Stage VI: Identity Development</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process:</strong> Psychosocial Process = Identity versus Identity Confusion</td>
</tr>
<tr>
<td>Potential strengths = Identity/sense of self; fidelity vs. repudiation</td>
</tr>
<tr>
<td>Therapeutic Process = Learning about self: self in relationship to family of origin, immediate family, and relevance of roles to present identity.</td>
</tr>
<tr>
<td><strong>Tasks:</strong> Giving up other obsessive-compulsive behaviors: food, cigarettes, workaholism</td>
</tr>
<tr>
<td>Identifying family of origin issues: alcoholism, sexual abuse, etc.</td>
</tr>
<tr>
<td>Identifying feelings about childhood issues</td>
</tr>
<tr>
<td>Giving up old family role: scapegoat, mascot, hero</td>
</tr>
<tr>
<td>Identifying career related goals and strengths, furthering education, making career changes.</td>
</tr>
<tr>
<td><strong>Goal:</strong> To discover who I am now, my strengths and needs.</td>
</tr>
<tr>
<td><strong>Strengths needed to move on to next stage:</strong> Trust, hope, will, purpose, competence, faith, love, identity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage VII: Intimacy in Love Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process:</strong> Psychosocial Process = Identity versus Identity Confusion</td>
</tr>
<tr>
<td>Potential strengths = Identity/sense of self; fidelity vs. repudiation</td>
</tr>
<tr>
<td>Therapeutic Process = Learning about self: self in relationship to family of origin, immediate family, and relevance of roles to present identity.</td>
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<tr>
<td><strong>Strengths needed to move on to next stage:</strong> Trust, hope, will, purpose, competence, faith, love, identity</td>
</tr>
</tbody>
</table>
Notes


Table 8. Rational Emotive Therapy: Treatment Stages

<table>
<thead>
<tr>
<th>Phase</th>
<th>Major Focus/Goal</th>
<th>Probable Cognitive Issues/Strategies</th>
<th>Probable Behavioral Issues/Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiating Treatment</td>
<td>Establishing a noncondemning relationships, collaborating on defining the problem and setting goals, and teaching client to use treatment</td>
<td>Assessment of clients’ views of discomfort, of alcohol and drug effects and of themselves or having the problem to begin with; correcting client’s incorrect or irrational beliefs about treatment, their problems with alcohol, and the process of recovery.</td>
<td>Accurate assessment of the frequency, amplitude, and duration of dysfunctional alcohol and/or substance abuse; direct instruction on the limit of therapy and how to use it to change behavior, beginning with honest definition of the problem</td>
</tr>
<tr>
<td>Stopping</td>
<td>Conditional acceptance that there is a problem and action toward the initial steps required to inhibit abuse (i.e. a decision to change and action to implement this decision)</td>
<td>Disrupting discomfort anxiety and helplessness. Establishing realistic expectations about time and effort required for change; while change is difficult, it isn’t too hard to accomplish and while stopping, will make one uncomfortable and it is tolerable.</td>
<td>Establishing incompatible alternatives to alcohol or substance abuse; establishing self-reinforcement strategies for not using and/or penalties for use; keeping behavioral records</td>
</tr>
<tr>
<td>Phase</td>
<td>Major Focus/Goal</td>
<td>Probable Cognitive Issues/Strategies</td>
<td>Probable Behavioral Issues/Strategies</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Staying Stopped</td>
<td>Emotional and behavioral self-management to avoid the triggers for dysfunctional use.</td>
<td>Didactic and dialoging techniques of the ABC-D of RET; disputing shoulds for self, others, and the world; disputing dichotomous reasoning, exaggeration of frustration and self-damnation for imperfections; basic rational-emotive problem solving skills.</td>
<td>Teaching behavioral stress management (e.g., relaxation training, self-hypnosis); assertiveness training and behavioral rehearsal for saying no to use; social skills training and/or social problem solving training and rehearsal.</td>
</tr>
<tr>
<td>Changing Personal Philosophy</td>
<td>Developing a more rational philosophy self-acceptance and a more stress-resistant life style</td>
<td>Didactic and dialogic teaching of philosophy of self acceptance and tolerance for human imperfections, disputing self-rating while encouraging a rational appraisal of the consequences of decisions to think, feel, and act in a given way toward self and others</td>
<td>Instruction, encouragement, and direct reinforcement of expanded experiences for personal pleasure and vocational accomplishments.</td>
</tr>
</tbody>
</table>

Notes

Table 9. Erikson’s Psycho-Social Stages and Developmental Challenges

<table>
<thead>
<tr>
<th>Stage</th>
<th>I: Infancy</th>
<th>II: Early Childhood</th>
<th>III: Play Age</th>
<th>IV: School Age</th>
<th>V: Adolescence</th>
<th>VI: Young Adulthood</th>
<th>VII: Adulthood</th>
<th>VIII: Old Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freudian Psycho-Sexual and Libidinal Stages/ Modes (Bodily Sensations)</td>
<td>Oral, Respiratory, Sensory, Kinesthetic (Incorporative Modes)</td>
<td>Anal-Urethral, Muscular (Retentive-Eliminative)</td>
<td>Infantile-Genital, Loco-motor (Inclusive, Exclusive)</td>
<td>“Latency”</td>
<td>Puberty</td>
<td>Genitality</td>
<td>(Procreativity)</td>
<td>(Generalization of Sensual Modes)</td>
</tr>
<tr>
<td>Basic Strength</td>
<td>Hope</td>
<td>Will</td>
<td>Purpose</td>
<td>Competence</td>
<td>Fidelity</td>
<td>Love</td>
<td>Care</td>
<td>Wisdom</td>
</tr>
<tr>
<td>Basic Antipathies/ Core Pathologies</td>
<td>Withdrawal</td>
<td>Compulsion</td>
<td>Inhibition</td>
<td>Inertia</td>
<td>Repudiation</td>
<td>Exclusivity</td>
<td>Rejectivity</td>
<td>Disdain</td>
</tr>
<tr>
<td>Stage</td>
<td>I: Infancy</td>
<td>II: Early Childhood</td>
<td>III: Play Age</td>
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</tr>
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<td>-------</td>
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</tr>
<tr>
<td>Radius of Significant Persons</td>
<td>Maternal Person</td>
<td>Parental Persons</td>
<td>Basic Family</td>
<td>“Neighbor- hood” School</td>
<td>Peer Groups and Out groups; Models of Leadership</td>
<td>Partners in friendships, sex, competition, and cooperation</td>
<td>Divided labor and shared household</td>
<td>“Mankind,” “My Kind”</td>
</tr>
<tr>
<td>Related Principals of Social Order</td>
<td>Cosmic Order</td>
<td>“Law &amp; Order”</td>
<td>Ideal Prototypes</td>
<td>Technological Order</td>
<td>Ideological World View</td>
<td>Patterns of Cooperation and Competition</td>
<td>Currents of Education and Tradition</td>
<td>Wisdom</td>
</tr>
<tr>
<td>Binding Ritualization</td>
<td>Numinous</td>
<td>Judicious</td>
<td>Dramatic</td>
<td>Formal (Technical)</td>
<td>Ideological</td>
<td>Affiliative</td>
<td>Generational</td>
<td>Authoritism</td>
</tr>
<tr>
<td>Ritualism</td>
<td>Idolism</td>
<td>Legalism</td>
<td>Moralism</td>
<td>Formalism</td>
<td>Totalism</td>
<td>Elitism</td>
<td>Philosophical</td>
<td>Dogmatism</td>
</tr>
</tbody>
</table>

Notes

NOTES

Chapter 1

1. American Psychological Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition Text Revised. (Washington, D.C.: American Psychiatric Association, 2000), 191-285, 338-343, 405-409, 479-483, 562-564, and 655-661. Substance-induced disorders include substance-induced delirium, substance-induced persisting dementia, substance-induced persisting amnestic disorder, substance-induced psychotic disorder, substance-induced mood disorder, substance-induced anxiety disorder, substance-induced sexual dysfunction, and substance-induced sleep disorder. Additionally, many diagnoses like mood disorders, anxiety, insomnia, borderline personality disorder, or histrionic personality disorder have identical criteria to substance related disorders with an exclusion in the criteria that typically states, “The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.”


While this Case Study is limited to studying psychological implications of substance abuse, it is universally accepted that sociological implications affect individuals psychologically. Research regarding the legal repercussions, percentages of specific legal violations, and social trends has substantial implications. It appears that cocaine had at least two cycles in the last 125 years where the cocaine was expensive was used by educated or famous crowds and ended up inexpensive, associated with crime, used by impoverished people, and was associated with extreme withdrawal symptoms, as indicated by Dominic Streatfild, Cocaine: An Unauthorized Biography (New York, St. Martin’s Press: 2001), 105-134, 195-472. Authors of Hooked: Illegal Drugs and How they Got That Way, cited above, indicated that heroin was popular before and after cocaine was but not simultaneously. While the assertions about trends were identified in non-academic arenas, the implications are noteworthy. Understanding about social trends could benefit because clinicians by helping them understand when clients are seeking social acceptance, rebel against authority, punish themselves by acting against their morals, rejecting societal rules, or attempting to identify as a deviant. Academic research in this area is highly recommended.

6. County of Sonoma Department of Health Services, http://www.co.sonoma.ca.us/health/aods/druguseinfo.htm [accessed October 10, 2010]. In Sonoma County, 49 percent of 11th graders and 80 percent of students attending nontraditional schools had tried marijuana. These percentages of use were higher for marijuana than cigarettes: 41 percent for 11th graders and 76 percent of students in nontraditional schools. Web site was recommended by Timmen Cermak to remain updated on Sonoma County statistics.

Drug abuse populations are expanding. While traditionally 15 to 25 year olds have had the highest rate of drug abuse, a recent trend in methamphetamines use indicates age 35 is the average age, according to Patrick Zickler interview with Nora Volkow, “Methamphetamine Abuse Linked to Impaired Cognitive and Motor Skills Despite Recovery of Dopamine Transporters,” NIDA Publications 17, No. 1 (April, 2002). The most common demographic for substance abuse is 18 to 25 years of age (County of Sonoma Department of Health Services, http://www.co.sonoma.ca.us/health/aods/druguseinfo.htm [accessed October 10, 2010]).

According to a self-report study about alcohol abuse done by Carol Prescott, a higher prevalence was found among males and younger birth cohorts (Carol Prescott et al., “Genetic and Environmental Influences on Lifetime Alcohol-Related Problems in a Volunteer Sample of Older Twins,” Journal of Studies on Alcohol 55, no. 2 (Mar, 1994): 184-202). They also found significant associations between severity of alcohol abuse and the age of drinking onset, parental history of alcohol problems, and lower educational attainment (Ibid). NIDA’s NSDUH Report states that males over age 21 were more likely to report having used alcohol before age 15 (National Institute of Drug and Alcohol Abuse, “The NSDUH Report, October 22, 2004,” http://www.oas.samhsa.gov/2k4/ageDependence/ageDependence.html). People using before age 15 were five times more likely to report alcohol dependence or abuse than those who first used alcohol after age 21 (Ibid.). Also, 95 percent of the 14 million adults classified as having alcohol dependence or abuse in the last year began using alcohol prior to age 21 (Ibid.).

In a National Institute on Drug Abuse (NIDA) funded research project, 1,253 out of 3,401 college students used cannabis five or more times in a year, according to K. M. Caldeira et al., “The Occurrence of Cannabis Use Disorders and Other Cannabis-Related Problems Among First-Year College Students,” Addict Behaviors 33, no. 3 (December 1, 2008: 397-411). Of those 1,253 students, one in ten met the criteria for cannabis dependence and 14.5 percent met the criteria for cannabis abuse. When under the influences, 24.3 percent regularly put themselves in danger and 10.6 percent continued to use despite problems with friends or family. According to Rose Milbrath, Director of National Alliance on Mental Illness (NAMI)’s Sonoma County Chapter, dual diagnosis treatment is necessary for all people suffering from a mental health issue because people seek relief from their suffering any way they can during desperate moments. In tracking the pattern of substance use and recovery, Alexandre Laudet et al. collected the self-report results about substance abuse presented in Table 3—Sociocultural Facts (Laudet et al., “Perceived Reasons for Substance Misuse Among Persons with a Psychiatric Disorder”). Additionally, Table 4—Relapse Warning Signs, provides information about relapse warning signs identified by various theorists.


11. Having facilitated groups for at-risk teens between the ages of 12-19 years of age for over 11 years, I have found that the teens who have participated in groups with me have consistently expressed this opinion. The teens I have worked with generally express the belief that adults exaggerate the degree of danger posed by substance abuse.

12. Rob Neiss, Santa Rosa Junior College supervision session, author’s notes, September 18, 2002.


14. TLC Child and Family Services Connections Treatment Philosophy.

15. Meridian University handout defining Aftab Omer’s Imaginal Process concepts. Received May 4, 2011 from Melissa Schwartz. “Empathic Imagination: Imagination integrates and amplifies the somatic, affective, and cognitive dimensions of experience. Imagination may be further differentiated into various modes of imagining that are sense, capacity, and context specific. Empathetic imagination refers to the mode of imagination most relevant to relatedness between humans as well as human relatedness to the more than human.”

16. Ibid.


20. Ibid.

21. Ibid.

22. Ibid.

23. Meridian University handout defining Aftab Omer’s Imaginal Process concepts.

24. Ibid.
25. Ibid.

26. Ibid.

27. Ibid.


29. Meridian University handout defining Aftab Omer’s Imaginal Process concepts.


### Chapter 2


32. Ibid., 356, 362, 368, 381, 392, 400, and 476.

33. Laudet et al., “Perceived Reasons for Substance Misuse.”


36. Aftab Omer, *Imaginal Process II* course at Meridian University, author’s notes, January 17, 1999; Meridian University handout defining Aftab Omer’s Imaginal Process concepts.

37. Meridian University handout defining Aftab Omer’s Imaginal Process concepts.

38. Ksir, Hart, and Ray, 437-438. “Alcohol continues to be the most widely abused drug and is unique because it is one of the only mind-altering drugs that can be used socially and without consequences for some people.”

psychosis), and ‘epilepsy’ (probably seizures seen during withdrawal) . . . Rush also concluded that hard liquor damaged the drinker’s morality, leading to a variety of antisocial, immoral, and criminal behaviors. . . . Rush believed that a direct toxic action of distilled spirits on the part of the brain responsible for morality. Rush introduced for the first time the concept of addiction to a psychoactive substance describing the uncontrollable and overwhelming desire for alcohol experienced by some of his patients. For the first time, this condition was referred to as a disease and he recommended total abstinence from alcohol for those who were dependent.”


44. Perera, Celtic Queen Maeve, 117.

45. Ibid.

46. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 191-295.

47. Ibid.

48. Timmen Cermak, Understanding Addiction: Focus on Adolescents & Young Adults seminar presented by the Drug Abuse and Alcohol Council September 17, 2008, Mary Agatha Furth Center, Windsor, CA. Cermak described the seductive qualities of the ecstatic experience inherent in intoxication. He clarified that he had not encountered clients who had negative emotional and physiological experiences of their first intoxication.


50. Dupont, 97.

51. Ibid.

52. Ibid.

53. Dupont, 93.

54. Dupont, 93.
55. Cermak, _Advanced Topics in Addiction Treatment_.

56. Dupont, 96, 104-106.

57. Ibid.

58. Ibid.


61. Ibid.


63. Ibid.

64. Dupont, 159.

65. Ibid.

66. Dahl.

67. Ibid.

68. Volkow, “Dopamine in Drug Abuse and Addiction.”


70. Michael Riera, _Uncommon Sense for Parents with Teenagers_ (Berkeley, CA: Celestial Arts, 1995), 12.

71. Ibid.

72. Ibid.


80. Dupont, 98, 100.


82. Dupont, 97.

83. Weil, 10; Cermak, *Advanced Topics in Addiction Treatment*.

84. Nora Volkow, video recording of Volkow’s presentation to Harlem High School students about the topic of addiction and the effect of drugs on the body, available from drugabuse.gov/blog/dr-nora-volkow-shakes-up-harlem/.


86. Dominick Streatfield, *Cocaine: An Unauthorized Biography* (New York: St. Martin’s Press, 2001), 9. “Perhaps cocaine was just an accident from nature. Historical commentators, however, report all sorts of other tales to account for its origins. Although these vary widely from culture to culture, there is common ground: coca is always seen as a gift from the gods to man, usually to enable him to bear some hardship, and often following a terrible tragedy. In one myth, a mourning mother, wandering heartbroken on the sierra, is so distraught that she plucks a leaf from the nearest bush and puts it into her mouth. The gods take pity on her and feed her through the leaf to enable her to bear her grief.”


88. Ibid, 27.

89. Ibid, 13, 37.

90. American Red Cross, First Aid Skills Card, Revised March, 2006, Item # 656692. “The symptoms of hypothermia include: shivering, clumsiness or lack of coordination; slurred speech or mumbling; stumbling, confusion or difficulty thinking, poor decision making, such as trying to remove warm clothes; drowsiness or very low energy; apathy or lack of concern about one’s condition; progressive loss of consciousness; weak pulse; slow, shallow breathing. The symptoms of heat exhaustion include: cool, moist, pale or flushed skin; heavy sweating; headache; nausea; dizziness; weakness; confusion or difficulty thinking; poor decision making, such as to remain in the heat; and exhaustion.”

92. Ibid.

93. Ibid.


96. Ibid.


98. Ibid.


105. Freud, “Cocaine Papers.”
106. Ibid.


110. Ibid.


112. Ibid.

113. Ibid., 20-21.

114. Ibid.

115. Ibid.

116. Ibid.


118. Hartmann.

119. Ibid.

120. Dupont, 110-114.


122. Ibid. Drug-related associations have unpredictable outcomes and can range from extremely pleasurable to excruciating.


125. Ibid., 2, 37-61

126. Ibid., 65-66.
127. Ibid., 106-107.


132. Ibid., 85.

133. Ibid.

134. Ibid., 95.

135. Ibid., 95.

136. Beck, Emery, and Greenberg, 38-39, 227-228. Examples of negative self-concepts are, “I am helpless (because I can’t control using), I am weak (because I can’t resist cravings), I am unlovable, I am defective, I am worthless/disgusting (because I have a dirty habit), I am a failure, and I am trapped.” Examples of negative views about the past are, “I have never done anything right, nothing works out for me, I have always been unhappy, and my whole life is a big failure.” Examples of negative present views are, “People despise me because of my addiction, my family has given up on me, there are so many demands on me and I can’t handle them, and my job is dull and depressing.” Examples of negative views about the future include, “If I try something, it won’t work out, I will never get what I want, I don’t deserve anything better in life, and my future is hopeless.”

Underlying components of the above concepts may include permission giving beliefs such as, “Since I’m feeling bad, it’s okay to use, I’ve been having a hard time; therefore I’m entitled to some relief, If I take a hit, I can get away with it, The satisfaction is worth the relief of relapsing, or If I give in this time, I will resolve to resist the temptation next time” (Beck, Emery, and Greenberg, 38).

The negative self-concepts also are based on the following maladaptive beliefs. “(1) Things should always go smoothly for me or things should not go wrong; (2)When I am blocking in what I am doing, it is awful; (3) I cannot stand being frustrated; (4) other people are to blame for my being thwarted; (5) people deliberately give me a hard time” (Beck, Emery, and Greenberg, 39).


138. Ibid.


140. Ibid., 39, 251-267. Catastrophizing, as the term was used by Beck, was similar to the theoretical concept in Ellis’s theory about over-generalizing.

141. Ibid., 27, 51.


145. Ibid.

146. Donald Nathanson, *Shame and Pride: Affect, Sex, and the Birth of the Self* (New York: W.W. Norton & Company, Inc., 1992), 355-356. “The relationship between shame and alcohol has been known since antiquity. (I have heard it said that, save for two isolated aboriginal cultures, every society on the planet has spontaneously found caffeine, nicotine, and alcohol. It seems as if the biological nature of the affect system leaves us vulnerable to certain recurrent noxious experiences that are ameliorated by these chemicals). The Latin proverb, in vino veritas, (in wine there is truth), indicates both that shame affect can teach us to hold our tongue and that alcohol can unleash it. Booze is forever ‘allowing’ us to say what we ‘shouldn’t’ . . . . Physiologists say that alcohol has a ‘disinhibiting effect,’ that it acts as a ‘releaser’ of emotion or of action. People are more likely to get angry with drunk, more likely to fight, to speak with feeling. It seems reasonable to assume that one of the primary actions is to release us from the bonds of shame, that it is a ‘shamolytic’ agent. We can take courage from a bottle because whatever reticence prevents us from action will be reduced by booze. Perhaps, to some degree, fear also is soluble in alcohol. But to the greatest extent, it is the shame-based painful inhibition of action that is soothed by alcohol...It is the cultures that are most afflicted by shame that we see the greatest amount of personality change with alcohol. The rules of the Japanese society require absolute control over affective display lest any leak of feeling cause loss of face and therefore great shame. Yet, when drunk, Japanese are effusive.”


148. Ibid.

149. Ibid.


152. Ibid.

153. Ibid.

154. Ibid.


156. Ibid., 22.
157. Stephanie A. Brown et al.


159. Ibid.

160. Ibid., 17.


162. Streatfield, 9-10, 16.

163. Ibid., 16.


165. Ibid.


168. Ibid., 126.


170. Julian Rotter, “Interpersonal Trust, Trustworthiness, and Gullibility,” *American Psychologist* 35, no. 1 (Jan. 1980): 3, 1-7. Trust was defined as the act of believing communication in the absence of clear or strong reasons for not believing. This was distinct from gullibility because that was defined as believing when most people of the same social group would consider belief naïve and foolish; trust is independent of gullibility.

171. Ibid.

172. Ibid.

173. Ibid.

174. Ibid.

175. Ibid.
176. Perera, *Celtic Queen Maeve*, 125. “We are finding that many psychotherapy clients with early structural damage to their psyches use various addictive behaviors and substances to soothe and enliven their fragmented, enfeebled, and alienated selves and to replace the absent and deformed parental introjects. Both the solace and stimulation created through addictive habits provide a substitute for the effective self-soothing, self-esteem, and self-motivation that were not sufficiently fostered during early development and/or that are not again currently available due to the catastrophic stress of present circumstances.”


178. Ibid.


181. Ibid.


184. Freud, “Cocaine Papers.”


186. Ibid.


188. Ibid.


190. Brown.


193. Ibid., 159. Here, Powell references de Shong Meador.

194. Powell, 155-173.

195. Ibid.


197. McCullough et al., 13-14.

198. Ibid.

199. Ibid., 14.

200. Ibid.

201. Ibid., 299.


203. Ibid.


205. Ibid.

206. Ibid.

207. Ibid.

208. Ibid.

210. Ibid.


212. Ibid.

213. Ibid.


215. Washton and Boundy, 87.


221. Powell, 162.

222. Samuels, 68.

223. Ibid.

224. Powell, 165.


226. Washton and Boundy, 53.

227. Ibid., 50-52.


229. Neiss.

231. Dupont, 103.

232. Ibid.


234. Ibid.

235. Examples of the deities are as follows: Silenus was the ancient Greek god of beer and was generally imaged as drunk, fat, and carried by donkeys or satyrs; Dionysus was the ancient Greek god who was dedicated to the joyful seeking of ecstasy through the intoxicating power of alcoholic drinks; Tezcatzontecatl was the Aztec god of pulque (a substance like beer) and was known for drunkenness and fertility; Bast was the Egyptian and Tameran cat goddess who ruled over hemp and marijuana and was depicted as full of the power of sensuality; Yasi, the African goddess of beer, was generally seen dancing behind masks with a beer ladle in her hand; Ninkasi, the Sumerian beer goddess, was known for her ability to satisfy human desire.

236. Aegir was the Norse god of the sea and beer and controlled the storms and turbulent seas, symbolically a passionate god associated with emotions. Mbabamwana Waresa was a Zulu goddess known for creating the first beer and she was celebrated for her search for true love. Radegast was the Czech god of hospitality and mutuality and was credited with the creation of beer. In Ancient Baltic and Slavic mythology, Rauogupat was known as the god of fermentation and his partner Rauogutien was known as the goddess of beer. Osiris, the Egyptian god of agriculture, taught the people how to make beer. The Greek god Dionysus, also known as Bacchus, lord of fruitfulness and wine, was associated with the harvest and origins of life. Mama Coca, a Peruvian deity popularly worshipped roughly 1500 years ago, was believed to have brought the gift of the coca leaf to her people and coca was equated with the essence of life itself. Incan Indians knew her as “Lady Coca” and she was the “living manifestation of the divine” as explained by Emma Carlson Berne, A History of Drugs: Cocaine (Farmington Hills: Greenhaven Press, 2006), 24. Lastly, there was the Celtic Queen Maeve known most completely as mother earth and endowed with all traditional goddess qualities (Perera, Celtic Queen Maeve and Addiction).


239. Ibid.

240. Ibid., 15-16.


242. Ibid.

243. An anonymous guest speaker invited to address the Introduction to Substance Abuse course at Santa Rosa Junior College; he had earned his 65-year chip and had begun attending AA meetings when AA was first founded.

244. Cermak, Understanding Addiction: Focus on Adolescents & Young Adults.

246. Ibid.

247. Aftab Omer, *Imaginal Process* course at Meridian University, author’s notes, July, 2000. “The more pleasure-less a society, the more obsessed it is with sex, drugs, and rock and roll.”

248. Ksir, Hart, and Ray, 209. Sixty percent of males and fewer than 45 percent of women report having consumed alcohol within the past months; Streatfield, 119. He commented about all of the effeminate names given to cocaine such as belladonna, Lady Coka, and white snow, which represent his experience that cocaine was most associated with women and sex.


254. Dupont, xxii.


257. Ibid., 22, 23, 27, 168.

258. Ibid., 27.


262. Jim Amirkhan, Personality Psychology class, Psychology 356, California State University, Long Beach, author’s notes, March, 1993. Amirkhan pointed out that the similarity in gender, power of the person modeling the behavior, and the interpersonal bond all played key roles in modeling or inspiring mimicked behaviors. Likely, the similarity of gender he referred to was gender identity.


265. Brown, 238.


269. Ibid.; American Academy of Pediatrics Committee on Public Education.

270. Mr. & Mrs. Smith. DVD, directed by Doug Liman (2005; Burbank, CA: Twentieth Century Fox Film Corporation). Starring Brad Pitt and Angelina Jolie; National Institute on Alcohol Abuse and Alcoholism, “NIAAA Counsel Approves Definition of Binge Drinking,” NIAAA Newsletter 3 (2004): 3. Author defines binge drinking as “a pattern of alcohol consumption that brings the blood alcohol concentration (BAC) to 0.08 percent or more. This pattern of drinking usually corresponds to five or more drinks on a single occasion for men or four or more drinks on a single occasion for women, generally within about 2 hours.”


272. Ibid.


275. Ibid., 91-92.

276. Grof, 94.

277. Ibid., 113.

278. Omer, 186.

279. Ibid., 235-266.

280. Ibid., 257.

281. Ibid.

282. Ibid.


286. Ibid.

287. Ibid.


289. Ibid.


291. Cermak, Understanding Addiction, Power Point presentation, available from Substance Abuse and Mental Health Service Administration, http://www.oas.samhsa.gov/2K4/ageDependence/ageDependence.htm [accessed October 10, 2010]. Percentages of past year alcohol use disorder (abuse or dependence) among adults aged 21 or older, by age of first use: 16 percent at <12, 15 percent 12-14 yrs, 9 percent 15-17 yrs, 4.2 percent 18-20 yrs, 2.6 percent 21+ yrs.

292. Ibid. Percentages of past year cannabis use disorder by age among recent cannabis onset users (prior 2 years): 6 percent, 17.4 percent for 13 yrs, 14.1 percent for 14 yrs, 16.4 percent for 15 yrs,
15.4 percent for 16 yrs, 10.6 percent for 17 yrs, 12.8 percent for 18 yrs, 8 percent for 19 yrs, 6.9 percent for 20 yrs, 4.4 percent for 21 yrs, 3.0 for 22-26 yrs.


294. Melissa Schwartz, Psychopathology course at Meridian University, author’s notes, September, 1998.

295. Meridian University handout defining Aftab Omer’s Imaginal Process concepts.


297. Omer, Integrative Seminar course at Meridian University, author’s notes, July, 2000.

298. Omer, Group Process II course at Meridian University, author’s notes, July, 2000.

299. Henry Corbin, Alone with Alone: Creative Imagination in the Sufism of Ibn’ Alrabī (New Jersey: Princeton University Press, 1969), 80. “The active imagination guides, anticipates, molds sense perception; that is why it transmutes sensory data into symbols. The Burning Bush is only a brushwood fire if it is merely perceived by the sensory organs. In order that Moses may perceive the Burning Bush and hear the Voice calling him ‘from the right side of the valley’ in short, in order that there may be a theophany—an organ of trans-sensory perception is needed.”

300. Moore, xi.

301. Ibid.

302. Meridian University handout defining Aftab Omer’s Imaginal Process concepts.

303. Aftab Omer, Psychopathology course at Meridian University, author’s notes, September, 1998.

304. Ibid.


307. Meridian University handout defining Aftab Omer’s Imaginal Process concepts.

308. Omer, Imaginal Process II course at Meridian University, author’s notes, January, 1999. Handout and discussion about Imaginal Structures; Meridian University handout defining Aftab Omer’s Imaginal Process concepts.

309. Hillman, 9, 38.
310. Ibid.


312. Moore, xiii; Hillman, 25. Hillman defines soul as “that unknown human factor that makes meaning possible and turns events into experiences.”


315. Ibid.

316. Meridian University handout defining Aftab Omer’s Imaginal Process concepts.

317. Ibid.; Aftab Omer and Melissa Schwartz, Psychopathology course at Meridian University, author’s notes, September, 1998.

318. Ibid.

319. Ibid.

320. Meridian University handout defining Aftab Omer’s Imaginal Process concepts.

321. Ibid.

322. Ibid. Omer explained that Accountability refers to the ability to make, keep, and renegotiate implicit and explicit agreements as well as the remediating of broken agreements. Accountability as a practice may be accomplished through the following steps: 1. Description and acknowledgement of one’s actions and the harm caused by those actions; 2. Apology as an expression of regret and remorse about the harm caused by one’s actions; 3. Commitments to actions that prevent future harm and remedy previous harm; 4. Undertaking actions that provide reparation and restitution for harm already done.”

He noted that Responsibility is the ability, constituted by distinct capacities, to respond to specific domains of life experience. For instance, courage responds to danger, humility responds to failure, and so on.

323. Carl Jung, The Archetypes and the Collective Unconscious (New York: Bollingen Foundation, 1959, 1990), 81. “This archetype is often associated with things and places standing for fertility and fruitfulness: the cornucopia, the plough field, the garden. It can be attached to a rock, a cave, a tree, a spring, a deep well . . . .”; ibid., 107. “Semele herself seems to have been an earth-goddess just as the Virgin Mary is the earth from which Christ was born. This being so, the question naturally arises for the psychologist: what has become of the characteristic relation of the mother-image to the earth, darkness, abysmal side of the bodily man with his animal passions and instinctual nature, and to ‘matter’ in general?”

324. Aftab Omer and Melissa Schwartz, Psychopathology course at Meridian University, author’s notes.

325. Ibid. Omer, Psychologists as Community Makers course at Meridian University, author’s notes, June, 2002.
One way to describe the mind-body split would be through psychodynamic language. If the id becomes encapsulated and unable to express itself because of the dominating superego, the buildup created by the id functions as poison in the overall the system. The poison effectively saturates the entire system and it functions to prevent a person from feeling uplifted or relieved of pain. When an addict or chemically dependent person engages in his or her dependent habit, it vents some of the poison and lowers the pressure level of the overall system.

Simultaneously, as the pressure is reduced by allowing the id a temporary period during which it can be expressed, another pressure is simultaneously created. The most significant aspect of chemical dependency or addiction I have experienced is the shame inherent in the taboo of being out of control, dependent, or lazy. This is taboo because the larger American culture glorifies strength, autonomy, and independence. The abundance of superheroes in our contemporary media is vast and they are depicted as an ego ideal. The heroes in our stories are generally witty, cunning, and uniquely do not need anybody else to achieve their heroic accomplishments. Our failure to live up to the ego ideal creates the second kind of pressure. As a person continues to use, and does so more frequently, profoundness of the shame increases. So, when the venting of the id’s pressure occurs and the pressure of shame builds, it is possible that the cycle could become so entrenched that a person would have to consistently be under the influence of his or her particular “romantic” or seductor to be able to tolerate his or her lived experience. When people become dependent on a chemical or another addiction, they inherently experience their inability to succeed autonomously. In this private moment, a person experiences feeling like a fraud, because of the belief that others do not really know about his or her failing, and like an unloveable failure. The window of relief grows increasingly narrow over time and people who are addicted depend on their addictions with increasing frequency. “She gives us an image of multiplicity within a while from a time before divine attributes or functions were split among a pantheon of deities that were then regrouped together under some hierarchical order that likely represented the social structures of the narrator’s time, leaving each one disperse and depotentiated through excessive discrimination” (Perera, *Celtic Queen Maeve*, 326).

Queen Maeve’s spiritual followers recognized her in natural structures including caves, rivers, and mountains. My awareness of this concept was most intense for me during my pregnancy with my son Zeth. Through the sensory experiences of drinking water and eating fresh fruits, vegetables, and meats I felt my lips become full and my body replenished of nutrients. I also felt life force vibrating through the trees and shimmering in each of the leaves with its brilliant and captivating color. The nonverbal, bodily understanding of her, which can be comprehended through many ways including mine, is central to the conceptualization of who Queen Maeve is.


328. Ibid.

329. Ibid.


331. Ibid.

332. Ibid, 159.


334. Ibid.

335. Perera, *Celtic Queen Maeve*, 29-68.
336. Ibid.


339. Ibid.

340. Ibid., 58.


342. Ibid.

343. Ibid.

344. Dupont, xxiii.

345. Zoja, 29. “The Dutch root word *droog* meaning “dry goods” a word generally used to depict articles at a traveling market.”


347. Perera, *Celtic Queen Maeve*, 44.


349. Ibid., 13-16.

350. Ibid., 164.

351. Ibid., 172-181.

352. Ibid., 16.


354. Nakken, 44.


358. Perera, Celtic Queen Maeve, 29-69, 106-162.


360. Ibid.; Perera, Celtic Queen Maeve, 62-98.


362. Ibid.

363. Woodman, 55, 60.

364. Perera, Celtic Queen Maeve, 29-42.

365. Ibid., 65.


367. Ibid. “Jungian Psychology, as well as much of the rich religious and mythological tradition from which it draws many of its insights, avers that it is the swamplands of the soul, the savannas of suffering, that provide the context for the stimulation and the attainment of meaning. As far as 2500 years ago Aeschylus observes that the gods have ordained a solemn decree, that through suffering we come to wisdom. Without the suffering, which seems the epiphenomenal requisite for psychological and spiritual maturation, one would remain unconscious, infantile and dependent. Yet many of our addictions, ideological attachments, and neurosis are flights from suffering. One in four North Americans identify with fundamentalist belief systems, seeking therein to unburden their journey with simplistic, black and white values, subordinating spiritual ambiguity to the certainty of a leader and the ready opportunity to project life’s ambivalence onto their neighbors. Another twenty-five to fifty percent give themselves to one addiction or another, momentarily anesthetizing the existential angst, only to have it implacably return on the morrow. The remainder have chosen to be neurotic, that is to mount a set of phenomenological defenses against the wounding of life. . . . An old saying has it that religion is for those who are afraid of going to hell; spirituality is for those who have been there. Unless we are able to look at the existential discrepancy between what we long for and what we experience, unless we consciously address the task of personal spirituality, we will remain forever in flight, or denial, or think of ourselves as victims, sour and mean-spirited to ourselves and others.”

368. Perera, Celtic Queen Maeve, 61.


371. Ibid.


374. Hope Edelman.


376. Ibid.

377. Ibid., xxv.

378. Ibid.

379. Ibid.

380. Ibid.

381. Ibid., 7.

382. Ibid., 86.

383. Ibid.

384. Ibid., 86-88.

385. Ibid.

386. Reis, 71; Moore, xi.; Perera, *Celtic Queen Maeve*, 450; Edelman, 170.


388. Reis, 71.


391. Linda Schierse Leonard, *Witness to the Fire: Creativity and the Veil of Addiction* (Boston: Shambhala Publications, Inc., 1989). During the Flight, Leonard employed the imaginal structures she called the Hostage, the Moneylender, The Gambler, The Romantic, the Underground Man, the Outlaw, and the Trickster. During the Fall, she describes the Madwoman, the Judge, the Killer, and the World’s Night. During the Creation, Leonard conceptualizes the Abyss, the Dark Night of the Soul, the Battleground, the
Chapter 3

1. Meridian University handout defining Aftab Omer’s Imaginal Process concepts. Omer refers to the core identity as the unique endowment of particularities that unfold, mature, and guide transformations of identity through a life span; it is the unique endowment of particularities that makes individuation a possibility.

2. Azure Acres Alcohol and Drug Treatment Facility’s Phyllis Haig presentation, “Chemical dependence: an Overview” at Journey High School, 1800 North Gravenstein Highway, Sebastopol, CA 95472, February 15, 2005, author’s notes. The speakers were anonymous and they talked about their experiences with treatment. They offered the stages as it was taught to them in their treatment facility. Stage 1: Curiosity, Stage 2: Experimenting, Stage 3: Social User, Stage 4: Habitual User, and Stage 5: Addiction.


4. I had been contacted by the baby’s mother, who asked if I would attend the funeral. At the time, I consulted with my supervisor and was encouraged to go if I felt open to it. Due to the reality that many of my former students likely could have been affected by this event, I opted to go to provide support.
5. Carl Rogers, *On Becoming a Person: A Therapist’s View of Psychotherapy* (New York: Houghton Mifflin Company, 1961), 47-48. Components of treatment associated with unconditional positive regard were as follows: “(a) the degree of empathetic understanding of the client manifested by the counselor; (b) the degree of positive affective attitude (unconditional positive regard) manifested by the counselor toward the client; (c) the extent to differential characteristics have to do primarily with the attitudes of the helping person on the one hand and the perception of the relationship by the ‘helpee’ on the other.”

6. Brown, 32-44.


8. PETS was the abbreviation for a process I developed in approximately 2005. The clients I worked with often talked about thoughts without awareness about the rest of their experiences. On a white board, I wrote that the clients needed to describe how they felt Physically, how they felt Emotionally, where their Thoughts centered, and how they felt Spiritually. After writing this on the board, I saw the capital letters “PETS” in a vertical position and I thought of the Mary Oliver Poem *Wild Geese*: “Let your soft body like what it likes.” I thought it was funny to call the assessment PETS because the activity, much like petting a dog, directly evoked an awareness of the soft body experience, and I have this kind of quirky humor. The name PETS stuck and this grounding activity has been used in my groups often.


**Chapter 4**

1. Winnicott, 10.


4. Ibid.


6. Ibid., 95.

7. McCullough.


10. Ibid.


12. Dry drunk, definition. http://www.aasoberliving.com/drydrunk.html [accessed October 10, 2010]. The definition of a dry drunk: a colloquial term generally used to describe someone who has stopped drinking, but who still demonstrates the same alcoholic behaviors and attitudes. Dry drunk” traits consist of:

* Exaggerated self-importance and pomposity
* Grandiose behavior
* A rigid, judgmental outlook
* Impatience
* Childish behavior
* Irresponsible behavior
* Irrational rationalization
* Projection
* Overreaction

13. See Table 2—Sample Reflexivity Scale. The form was provided by Lily Goodman, during an Imaginal Process tutorial, Institute of Imaginal Studies, Winter, 1999; Meridian University handout defining Aftab Omer’s Imaginal Process concepts.


16. Sam Kimbles, *Self Injurious Behaviors* training at TLC Child and Family Services, author’s notes, October, 2010. Here, Kimbles explained the difference between borderline personality disorder symptoms and healing from narcissistic wounding without enacting axis II symptoms.

17. *Drop Dead Fred*.

18. Victor Frankl, *Man’s Search for Meaning: An Introduction to Logotherapy* (New York: Washington Square Press, Inc.: 1959), 178-183. Sacred suffering is the act of consciously facing the ways we suffer through ritual and active attention which allows our suffering to transform us, heal us and return to living our lives.


Chapter 5

1. Powell, 168. “For a woman who has exclusive identification with the world of the ‘other,’ with father in father’s world, such identification seems to release the dark side of her personality, and the undeveloped part of herself. Hence, she is cut off from the full range of intensity of human emotions, and from being fully in her body. Here I find Jung’s animus theory too narrow and stereotyped and not to be based on women’s experiences. Men’s own arcaic fears, taboos, fear of engulfment, and deep-seated generalized terror of women’s power reinforce women’s own fears of their own aggression, and so this is projected onto men. Cultural fears and taboos, are expressed at the cost of women’s autonomy.”


5. Robert Moore, The Archetype of Initiation (Xlibris Corporation, 2001), 78.


10. Ibid., 104.

11. Ibid., 105.


13. Prin; Rogers, Client-Centered Therapy, 24, 208.

Appendix 3


3. Ibid.

4. Ibid., 33-34.

5. Ibid.

6. Ibid., 34.

Appendix 5

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*Mr. & Mrs. Smith*. DVD, directed by Doug Liman. Burbank, CA: Twentieth Century Fox Film Corporation, 2005.


_________. “Generalized Expectancies for Internal Versus External Control of Reinforcement” *Psychology Monographs* 80, no. 609 (1966).


_________. drugabuse.gov/blog/dr-nora-volkow-shakes-up-harlem/ Video presentation of Volkow presenting to Harlem High School students about the general topic of addiction and how drugs affect the body.


