FINDING HOME: RECLAIMING IDENTITY AFTER SUBSTANCE ABUSE AND TRAUMA

by

CLARE GENEVIEVE WILLIS

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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To my family
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Since I haven’t danced among my fellow initiates, following a looped procession from woods at the edge of a village, Tata’s people would think me unfinished—a child who never sloughed off the childish estate to cross the river boys of our tribe must cross in order to die and come back grown.

I was raised in a strange land, by small increments: when I bathed my mother the days she was too weak, when auntie broke the news and I chose a yellow suit and white shoes to dress my mother’s body, at the grave-side when the man I almost grew to call dad, though we both needed a hug, shook my hand.

If my alternate self, who never left, could see me what would he make of these literary pretentions, this need to speak with a tongue that isn’t mine? Would he be strange to me as I to him, frowning as he greets me in the language of my father and my father’s father and my father’s father’s father?

—Kayo Chingonyi
Kumukanda
ABSTRACT

FINDING HOME: RECLAIMING IDENTITY AFTER TRAUMA AND SUBSTANCE ABUSE

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The topic of this Clinical Case Study is the co-occurring disorders of substance use disorder (SUD) and post-traumatic stress disorder (PTSD). Raul (pseudonym) is a gay, Latino male in his mid-thirties who had been using methamphetamine for approximately seven years. The client had a traumatic childhood, and had been sexually assaulted twice in the two years prior to treatment.

The Literature Review examines the etiology, symptoms, and treatment of SUD, highlighting how differing theories on addiction present alternate treatment protocols, and also describes how traumatic stress affects the course of SUD and its treatment. Key concepts and major principles include the concept that SUD and PTSD are brain disorders; an alternate psychodynamic view that addiction begins with deprivations in early life; the sociocultural concept of the syndemic, in which multiple negative conditions converge to disproportionately affect already marginalized communities; the Jungian perspective that healing from addiction requires a spiritual union; and the Imaginal perspective that addiction is a consequence of the soul’s need for ecstatic states and participatory consciousness, essential human needs that are not being met by modern
Western societies. I found that the literature did not address whether early trauma treatment affects the incidence of addiction.

I was the client’s substance abuse treatment counselor, in conjunction with other, sometimes conflicting, treatment providers. Attempting to keep my center and serve my client echoed my client’s experience of trying to find his center and meet his own needs without illicit substances. Imaginal approaches such as writing, art making and active imagination, as well as the initiation rites provided by group therapy, helped the client to move from an intrusive obsession with self to a more expansive vision of wholeness and connection.

Viewing the case from the perspective of a syndemic allowed me to see how disparate structures of culture, such as the insurance industry, the health care system, the legal system, and even a gay male culture of San Francisco that valued a particular type of masculine physical appearance, all exerted pressure on my client’s view of himself and his self-worth as a gay Latino male. An archetypal and mythic backdrop was provided by the client in the form of the fairy tale *The Little Mermaid*. Many insights into Raul’s journey came from the story of the shape-shifting creature who abandons her home, her voice, and her body in a quest for acceptance and love.

The co-occurring disorders of substance use disorder and post-traumatic stress disorder, especially as they pertain to this particular client, have roots in biology, neurology, religion, racism, sexism, traditional gender roles, and the for-profit health care industry, to name but a few faces of the Gorgon that we must confront if we are to engage the entirety of this problem.
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CHAPTER 1

INTRODUCTION

Clinical Topic

This Clinical Case Study examines the topic of co-occurring disorders, in this case substance use disorder, also known as addiction, and post-traumatic stress disorder (PTSD). Thirty to fifty percent of people who suffer from PTSD will develop a substance use disorder (SUD), while only 8 to 25 percent of those without PTSD will abuse substances.¹ Bessel van der Kolk describes a “circular relationship” between trauma and substance abuse; while drugs or alcohol ease the symptoms of trauma, withdrawal from the substance intensifies the symptoms, so the rate of relapse is far higher for those with both conditions.² Addiction and trauma go hand in hand, with each condition having the possibility of causing or exacerbating the other.

Gabor Maté says that addiction has “…biological, chemical, neurological, psychological, medical, emotional, social, political, economic, and spiritual underpinnings, and perhaps others I haven’t thought about.”³ This definition illustrates how important it is that the issue of co-occurring disorders be looked at from an Integral-Imaginal lens. Any singular approach to treatment, such as the brain disease model, leaves out other essential components of recovery. For example, anti-addiction medications generally focus on the brain, specifically the
mesolimbic pathway, colloquially called the brain-reward circuit, to correct the pathology that occurs there, but this does not take into account the multitudes of people who have “cured” themselves without drugs. How have they done this? Through Alcoholics Anonymous (AA), mindfulness techniques, substance abuse treatment, or cognitive-behavioral therapy—behavioral approaches that strengthen the prefrontal cortex and thereby increase that elusive characteristic we call “willpower.”

As Aftab Omer tells us, the imaginal realm is the realm of the soul, where authentic power emerges through experiencing and transmuting our vulnerabilities into capacities for action and self-transformation. Alcoholics Anonymous allowed addiction treatment to enter into the realm of the imaginal, to do soul work, because, as Schoen describes, working the 12 Steps enables “…the establishment of a conscious ego connection with the true Self (or Higher Power).”

Omer has described how when our attempts to do soul work are stripped of their numinousity, or their connection to the sacred, they become ritualized rather than ritual. At its worst AA can be ritualized, such as when its adherents act by rote rather than conscious choice, but at its best it can be transformative. An integral approach, which I believe the substance use treatment center where I worked was attempting to create, takes into account many of the contributing factors in this complex disease. This case study will take the same approach.

The subject of this Clinical Case Study, Raul, presented with substance use disorder as the main focus of his concern, but soon alluded to issues of trauma in both his childhood and recent past. The Literature Review chapter addresses
the concept of addiction from different theoretical perspectives, as well as the specific topic of co-occurring post-traumatic stress disorder (PTSD) and substance use disorder (SUD). The Literature Review chapter examines five different perspectives: Biological, Cognitive-Behavioral, Psychodynamic, Sociocultural, and imaginal approaches to understanding addiction and trauma.

The section on Biological Perspectives examines the evidence for viewing SUD as a disease of the brain, but also looks at the backlash against this approach. I will also discuss how cognitive-behavioral approaches to substance abuse treatment take the perspective that problematic behavior such as SUD can be extinguished by changing a client’s distorted thoughts or perceptions. In contrast, the Psychodynamic Perspectives section lays out the argument that addiction begins in early life. Psychodynamic theorists have seen addiction as related to pleasure drives; as a disruption of a subject’s infantile attachment behaviors; as self-medication; a variant of narcissistic personality disorder; or an effort to reverse feelings of intolerable helplessness. The Sociocultural Perspectives section presents research in areas related the client’s sociocultural location as a gay Hispanic male acculturated into the dominant culture. The section on Imaginal Approaches looks at addiction and trauma from the point of view of soul, discussing the innate human desire for ecstatic states, the quest for initiation that often goes awry in the Western approach to seeking ecstatic states, and the need to integrate what Jungian and Imaginal Psychology refer to as “the shadow”—the hidden aspects of the self that the conscious ego does not recognize—to embrace recovery.
Exploration of the Subject/Topic Choice

When I was seven years old our family moved to England for a year. My father, who is English, had graduated from Cambridge University and was invited back there for a yearlong sabbatical from his teaching job in California. I enrolled at Girton Glebe School, the local public school in the village where we lived. Many things were different about this school. We wore uniforms, we undressed for gym, and we played unfamiliar games like Conkers, which involved smashing two chestnuts from the local trees against each other until one cracked. We all ate lunch in the cafeteria, lumpy stews and rhubarb for dessert. Nobody brought a bag lunch from home. No one was allowed to have food allergies or preferences. I was casually and constantly teased. “Yank” was the favored term of endearment. I had to learn new money, new food, new sports, new games, and new curriculum. But most unsettling was the language. Yes, they spoke English, but with accents and word choices that made every sentence a challenge to understand, not to mention answer.

But being a child, and malleable, I adapted to my new environment. By the time we returned home a year later I had an English accent. My fashion sense and my food preferences, as well as all my cultural references for toys, movie stars, and television programs had changed. This was when the true dislocation began.

I started fourth grade in 1974. In 1968 the city of Berkeley had instituted the nation’s first non-court-ordered busing plan, a two-way system designed to
desegregate the elementary schools. I was bused to a school that previously had predominantly served black students. The combination of being white and being so obviously different singled me out for abuse. I was taunted, beaten, pelted with rocks, not allowed to go to the bathroom. I was called “proper, stuck-up, a stick in the ass.” I was afraid every day. I lost my English accent very quickly and tried to adapt in every way possible, but the experience of no longer being welcome in what I had thought of as my home, the experience of feeling like I didn’t fit in anywhere anymore, stayed with me throughout my childhood.

Raul and I looked very different on the surface, but I felt a kinship with him very early on. His anxiety around people and his difficulty in trusting that he could come forward and be his authentic self without being hurt was familiar to me. The specters of trauma, violence, and substance abuse lurked in both our histories and our psyches. I fear drawing false equivalencies, but I did feel that we shared an experience of standing on the outside, desperately wanting to be welcomed and seen for who we truly were, but afraid it would never happen. Raul had to find “home,” as I did. I was perhaps further down the road of healing, in finding my voice and my calling as a therapist, thus I saw myself as a useful guide to support Raul towards finding his voice and his “home.”

My identification with Raul was both helpful and hindering. My empathy for his experiences led to some misunderstandings and failures, when I took for granted that I understood things about Raul that I did not, and I discuss these below. Still, I feel that being aware of my own story helped me to engage Raul’s story more fully and authentically. Raul affirmed this at our last session when he
said, “You were the right person, at least for me.” I felt the same way, that Raul was the right client for me, which is the reason our shared journey is the topic of this Clinical Case Study.

**Framework of the Treatment**

For a period of one year in 2015-2016, I was one of six practicum interns at Ohlhoff Outpatient Services, an intensive outpatient substance abuse program in the Castro neighborhood of San Francisco, California. In addition to the interns there were three part-time clinical staff who worked alongside the interns, one administrative staff member, and two clinicians, an MFT and a psychologist, who supervised the interns. The outpatient program was part of the larger Ohlhoff agency, which included an inpatient residential program located in another building in San Francisco. There were six more practicum interns at the inpatient program, and we joined together weekly for didactic training and case presentations, which alternated location between the outpatient and inpatient sites. The inpatient site had additional clinical and administrative staff, as well as an on-site psychiatrist who occasionally treated clients of the outpatient program, and was available for consultation. Many of the clients of the outpatient program were graduates of the inpatient program.

Most of the clients at both programs were covered by private insurance, and part of the interns’ work was to secure benefits from the insurance companies and perform insurance reviews if the benefits ran out before the client had
completed the program. A few clients in the outpatient program, or their family members, paid out of pocket for the services, which averaged $160 per day. Because of the methods of payment the clientele at Ohlhoff were generally people with means—they were employed, recently unemployed, or had family members who could afford the cost of treatment.

Raul was in his mid-thirties at the time of enrollment at Ohlhoff, a Latino gay male who worked full time in health care administration. His drug of choice was methamphetamine, which he mainly smoked but occasionally snorted. He enrolled at Ohlhoff voluntarily, after his addiction caused him to be hospitalized and miss work to the point that his manager had become concerned. His diagnosis was acute amphetamine-type substance use disorder; 304.40 in the DMS IV.\(^7\)

Raul alluded in his intake interview to being sexually assaulted in his recent past, which was noted in the intake but not in his diagnosis, as Ohlhoff protocol was to only give substance use related diagnoses. Raul used his health insurance from his work to pay for his treatment, and the insurance company authorized only twelve initial sessions, which necessitated that I try to obtain further insurance payments in the middle of his treatment.

Raul was a client at Ohlhoff Outpatient for three months in the fall, and then reenrolled for two weeks in the spring. During his first enrollment he attended eleven individual sessions with me and six group therapy sessions that I co-facilitated, part of twenty-six group therapy sessions he attended in total. His first enrollment was disrupted when his insurance company abruptly cut off his benefits. After a relapse he reenrolled and received a new insurance authorization.
During the second enrollment he attended three group therapy sessions and one individual session with me before voluntarily withdrawing from the program.

The outpatient treatment facility offered two different programs—a coed program that occurred three evenings per week, and a women-only program that met on weekday mornings. In both cases the clients were expected to attend three group therapy sessions that lasted for three hours and one hour of individual therapy. They were also required to attend three AA meetings per week, obtain an AA sponsor, and work the first three steps of the AA program.  

Group therapy consisted of an hour and a half process group followed by a psychoeducation session that included topics such as relapse prevention, recovering identity, stress management, spirituality, and family roles and codependence. Each client was asked to write their own drug and alcohol history and share it with the group, as well as sharing a “contemplation,” which is a poem, song, aphorism, or prayer that helps a client with his or her sobriety. Because of these contemplations a great deal of poetry, music and other art was shared in group therapy. Some of the group therapy sessions included art therapy, and Raul produced some artwork there. The art supplies were available to me for individual sessions but I did not use them.

The interns created the curriculum for group therapy, based on resources provided by the agency, although we were free to bring in our own ideas, which I did frequently. Some of the resources provided by the agency included books that contained worksheets that clients could complete. Most of these were from a cognitive-behavioral perspective, and I sometimes used these materials in
individual therapy, as on one occasion when I provided Raul with a DBT exercise called “Thought Defusion,” from the *Dialectical Behavior Therapy Skills Workbook.*

During Raul’s treatment I spoke to him on the phone on several occasions. We discussed his absences from group therapy, I informed him of the insurance denial of payment, and when he finally removed himself from treatment he did it by telephone. I also exchanged emails with him regarding logistical issues, such as inquiries about Ohlhoff’s hours of service and holidays.

I spoke to insurance representatives on Raul’s behalf on three occasions, and exchanged voicemail messages with Raul’s private psychiatrist. I also spoke to Raul’s sponsor on two occasions, as part of the protocol at Ohlhoff was to check up on clients to ensure that they were attending meetings regularly and working the steps of AA with their sponsor.

**Confidentiality and Ethical Concerns**

I have protected the confidentiality of my client through the use of a pseudonym, as well as altering certain demographic details, such as age, occupation, and geographic locations, that could potentially identify him. Protecting a client’s confidentiality is both a legal and ethical mandate for a therapist, but I was particularly concerned about safeguarding Raul’s privacy due to what I saw as the sensitive details of his case, such as the sexual assaults and the fact that his drug use involved illegalities. It turned out that my client was much less worried about confidentiality than I was.
Raul was not ambivalent about participating in this case study. After I described the process and how his identity would be protected, he replied, “I think it’s cool, I think it’s an honor that you chose me, and like you mentioned the whole identity thing, like I don’t even care, I’m just like, I’m ready to, it’s crazy all the things I’m able to do now.” He went on to describe engaging in activities that he had difficulty with before he began treatment, such as sharing his story at AA meetings. He equated this new freedom with letting go of the constraints of his past and opening up to a more expansive but also more self-chosen identity.

Had Raul not relapsed three months later and returned to Ohlhoff, he would have appeared to be a pure success story, at least with regard to the abstinence goals of the Ohlhoff program. Even if he had relapsed after six months and not three, I would no longer have been in that practicum and so I would not have known about the relapse, and the story in this case study would not have included this facet of his story.

I use the word **facet** intentionally. I have used the metaphor of a crystal in a later part of this case study, describing a way of **seeing** in social science research that Laurel Richardson describes as crystallization. She uses the metaphor of the crystal because a crystal is solid rather than amorphous, it is **fact**, and yet what we see in it depends on the angle of the viewer. She says, “…crystallization provides us with a deepened, complex, thoroughly partial understanding of the topic. Paradoxically, we know more and doubt what we know.” The fact of Raul’s relapse is an excellent example of this type of crystallization. Was Raul a success or a failure? Because I cannot answer this question it both deepens and makes
more complex my contemplation of Raul’s case. The metaphor of the crystal is also apt because of Raul’s drug of choice, crystal methamphetamine.

Raul was a client for three months in the fall of 2015, and then reenrolled for two weeks in the spring of 2016. During his first enrollment he attended eleven individual sessions with me and at least six group therapy sessions that I co-facilitated, part of twenty-six group therapy sessions he attended in total. His first enrollment was disrupted when his insurance company cut off his benefits. After a relapse he reenrolled and received a new insurance authorization. During the second enrollment he attended three group therapy sessions and one individual session with me, before voluntarily withdrawing from the program. During Raul’s treatment I spoke to him on the phone on several occasions, regarding his absences from group therapy, informing him of the insurance denial of payment, and when he finally removed himself from treatment. I also exchanged emails with him regarding logistical issues, such as inquiries about Ohlhoff’s hours of service and holidays.

I received individual supervision for one hour per week from Kenneth Gladstone, Psy.D., and two hours per week of group supervision from Faye Ocomen, LCSW. During group supervision we spoke about Raul on several occasions, and the other practicum trainees contributed insights that they had gathered from working with Raul in group therapy. I also discussed Raul in a case presentation for the entire Ohlhoff program, which included practicum trainees from the inpatient treatment facility. During the presentation I played audio of an individual session, and Raul’s diagnosis and treatment were discussed. Every
client of the Ohlhoff program is informed, as part of the admission protocol, that their cases will be discussed among the trainees during supervision.

Because all the clients participated in group therapy, we had an ethical duty to protect our clients’ identities within that milieu. We never used last names except in the password protected client records database, and we instructed the clients that everything that was said in group therapy needed to be contained within that group therapy session. Occasionally we would run into trouble when a participant in a group therapy session would bring up something that had been said by a participant in another group with different members. This necessitated that we speak to the person whose privacy had been violated as well as the person who had violated the rule, and sometimes facilitate a repair between the two people. I had to engage in some aspect of this procedure on several occasions, but not specifically with Raul.

I discussed Raul’s case with my individual supervisor on multiple occasions, and we discussed matters of both confidentiality and ethics. One of the topics we discussed included the issue of “split treatment,” defined as the concerns that arise when a psychiatrist and a therapist co-treat a patient. Raul had a private psychiatrist and an MFT licensed psychotherapist in addition to working with me. I explore more about the dilemmas that this created later in the Clinical Case Study. We also discussed the ethical dimensions of Raul’s sexuality, gender and ethnicity being different from mine, and my supervisor offered insights as well as practical guidance, such as support systems within the gay community that I could recommend to Raul.
It remains an open question whether Raul would have been better served by a therapist who more closely matched his sociocultural identity. The question is academic, because there wasn’t a therapist at Ohlhoff who exactly fit the bill, but it is also relevant. I note instances when I “dropped the ball” because of my lack of awareness of clinical factors that can affect clients like Raul, for example the existence of a type of body dysmorphia particular to gay men that could have shed light on the question of whether Raul had an eating disorder. My awareness of this area of clinical relevance only arose after I began research on this case study.

Several of my conversations with my individual supervisor centered on bridging the cognitive-behavioral focus of the agency with my more depth-oriented inclinations, as well as on understanding the dissonance I experienced from being both Raul’s counselor and also the enforcer of the rules that Ohlhoff imposed on clients as a condition of their participation in the program. These dual roles posed an ethical concern for me throughout my tenure at Ohlhoff.

Another ethical concern was my duty to interface with the insurance company on Raul’s behalf, which caused me to feel that I had personally failed him when they cut off benefits in the middle of his treatment. Conferring with them also raised confidentiality concerns, because during his insurance review I was required to report many details of Raul’s treatment, such as his medications and their dosages, and his meetings with his psychiatrist, his psychotherapist and his AA sponsor. I felt that the care manager was using this plethora of information to try to find something to bolster her case to discontinue coverage, and yet I felt
that if I did not answer her questions then they would deny coverage because of my lack of transparency. My interactions with the insurance companies were some of the most ethically questionable experiences of this internship.

**Client History and Life Circumstances**

Raul was married but had been separated from his husband for six years. At the time of the treatment he was living with relatives in a city south of San Francisco. He had a high school diploma and had attended two years of college. Raul had a full time job in health services administration, and had worked consistently through his drug use, although he stated that his use had made his work suffer and he had gotten in trouble at work because of it. In 2011 Raul was hospitalized for kidney failure as a result of malnutrition and dehydration caused by drug use. His longest period of sobriety during these years was six months in 2013. Raul used alone or with people he met through dating websites or apps, in which case he would use methamphetamine and have sex. He was sexually assaulted twice while using methamphetamine, once while unknowingly drugged with gamma hydroxybutyrate, a sedative commonly known as a “date rape” drug. As a result of these traumas he reported suffering from anxiety, sleep problems, and social isolation.

Raul was born in the United States to parents of Mexican heritage; his father was born in this country while his mother was born in Mexico. He was the oldest child, with two younger siblings. His father owned a construction company and his mother worked in both the family business and in the financial services
sector. Initially the family lived in a working class Latino neighborhood, but moved to a predominantly white neighborhood when Raul was six, as the family began to be successful financially. In the new neighborhood Raul experienced cultural dislocation, bullied for being Latino and gay. Raul’s mother accepted his homosexuality, but his father did not. Raul witnessed frequent domestic violence in the household, perpetrated by his father on his mother. Raul’s mother also hit Raul. Raul was called to testify in court in a domestic violence case against his father, and was forced by his mother to lie on the stand and say that nothing had happened. The domestic violence, coupled with the trauma of being compelled to lie about it in order to protect the family, had a lasting impact on Raul.

While Raul was in treatment at Ohlhoff he also was under the care of a psychiatrist and a therapist. He had been seeing the therapist for two years and the psychiatrist for three years. Raul had been in inpatient substance abuse treatment twice in the previous decade and had also attended a dual diagnosis treatment program at a local hospital geared toward patients with significant mental health problems complicated by substance abuse.

At the beginning of the treatment Raul was living with family members. He socialized very little and expressed desires to be on a sports team and to do volunteer work, but was not engaging in any of those activities. By the end of his treatment Raul had moved into an apartment with roommates and had joined a sports team. After three months he relapsed and returned to Ohlhoff, spending one week in the program before voluntarily withdrawing, stating that he was confident he could stay sober without outpatient treatment.
Progression of the Treatment

Raul was my client at Ohlhoff Outpatient Services for three consecutive months, and then again for one individual session and three group sessions four months later after a relapse. During his first enrollment he attended eleven individual sessions with me and twenty-six group therapy sessions, including at least six that I co-facilitated. Group therapy consisted of an hour and a half process group followed by a psychoeducation session that included topics such as relapse prevention, recovering identity, stress management, spirituality, and family roles and codependence. Some of the sessions included art therapy and Raul produced some artwork. During individual sessions I provided DBT techniques to help Raul use mindfulness to cope with anxiety, and reality testing to analyze his fears about being in the groups, but mostly approached him in a humanistic way, treating him with unconditional positive regard and attempting to build a relationship where he felt safe and valued.

Raul left treatment before completion when, after an insurance review, his insurance company denied further coverage on the grounds that he was doing so well he could manage on his own with just support from AA. During his final session with me Raul professed to be much improved and stated that he felt he would be fine with his support system of therapist, psychiatrist and sober support from AA and his sponsor. His scores on the DASS (Depression, Anxiety and Stress Scales) indicated significant improvement in anxiety, stress and depression symptoms.
Raul relapsed and came back to the program in the spring and asked the program director to assign me to be his counselor again. His insurance company authorized twelve treatment days but Raul quit the program after three group sessions and one individual session. This time he did not complete the DASS or have any formalized termination process, he simply emailed me one day, followed by a short phone conversation. Raul gave a variety of reasons for quitting, stating that he had been too hasty in rushing back to Ohlhoff. He said the evening meetings interfered with his work and his sports team practices, and that he was confident he could stay sober with the support that he already had in place. He also said that there was really only “one reason” that he had relapsed, and that he was working on that issue with his psychotherapist. He never told me the exact nature of that one issue.

**Learnings**

The key concepts and major principles from the Literature Review that inform my conceptualization of this Clinical Case Study include the following: the conclusion of van der Kolk that a “circular relationship” between trauma and substance abuse exists, in that drugs or alcohol ease the symptoms of trauma while withdrawal from the substance intensifies those same symptoms, leading to a higher rate of relapse for those with dual diagnosis; Dodes’ concept of substance use as a means of fighting intolerable helplessness; Flores’ view of addiction as an attachment disorder treated by developing a capacity for healthy interpersonal relationships; González-Guarda, McCabe, Leblanc, De Santis, and Provencio-
Vasquez’s definition of a *syndemic* as “…co-occurring epidemics or conditions that interact with one another to disproportionately impact the morbidity and mortality of marginalized communities,” and their identification of a *syndemic* resulting from the combined effects of substance abuse, violence, HIV risk and depressive symptoms among Hispanic men; Gideonse’s description of the shaming and villainization of gay users of methamphetamine; Bruce, Ramirez-Valles, and Campbell’s depiction of the complex, intertwining relationship between stigmatization, substance use, and sexual risk behavior among Latino gay and bisexual men and transgender persons; and Anzaldúa’s literary interpretation of the borderland inhabited by gay Latinos and Latinas in the United States.12

The meaning of recovery to a client such as Raul can be examined through the lens of Jung’s concept of addiction as a search for wholeness that can only be fulfilled by a union with God, and Schoen’s expansion of Jung’s assertion to include a non-dual perspective on a higher power as the cure for addiction.13 Raul had two other clinicians working with him besides me, and the experiences of triangulation, such as power struggles and replication of parent-child dynamics, that therapists have when working with a client who has relationships with other clinicians, such as a psychiatrist, are described by Goin; Imhof, Altman and Katz; Gould and Busch; and Meyer and Simon.14

Raul’s anxiety and depression increased during the first few weeks of his treatment, consistent with van der Kolk’s description of how withdrawal from substances can intensify trauma symptoms, reaching intolerable levels that caused him to call in sick and miss sessions, and then ebb and allowed him to
participate and have periods of connection with me and the other clients in
treatment. The domestic violence that he witnessed as a child, the bullying and
abuse he received in school, and the incident in which he felt coerced to lie in a
court of law about the domestic violence, all created an atmosphere in which Raul
was forced to deny his own needs and the reality of what was an untenable
situation, in the service of maintaining relationships with his loved ones. As van
der Kolk describes it, “Erasing awareness and cultivating denial are often
essential to survival, but the price is that you lose track of who you are, of what
you are feeling, and of what and whom you can trust.”

Another developmental trauma that Raul experienced was a cultural
dislocation. He acknowledged the difficulty of his move at age six from a deeply
interconnected Latino community to a white neighborhood and a predominantly
white Catholic school, where he was bullied both for being Latino and for being
gay. Yet his nostalgia for his early life was tempered by the knowledge that the
culture of his birth created its own dislocations for him as a homosexual, stating
that his parents were ashamed of him for being gay, and alluding to them trying to
“beat the gay” out of him.

Another concept that informed my work with Raul was that of projective
identification, a concept developed by Melanie Klein, and described by Waska as
“…an intrapsychic and interpersonal phenomenon that draws the analyst into
various forms of acting out. The therapist struggles to use understanding and
interpretation as the method of working through the mutual desire to act out the
patient's core fantasies and
feelings.” During a session when Raul recounted to me the specifics of the two sexual assaults he suffered, I felt overwhelmed and imagined myself running out of the room. This projective identification caused me to experience an enactment of what Peter Levine describes as a natural response to trauma—the desire for a “discharge of energy” to complete the physiological response to threat. I felt in my own body Raul’s incomplete action of running away, or fighting back, and somehow reclaiming the power lost in this interaction.

One of the enduring images I have of Raul is of watching him in one of the early group therapy sessions, zipping and unzipping his jacket over and over again. I imagined him as a turtle, sticking his head out and then withdrawing it, unable to decide whether to move forward or stay in safety. This image aptly describes Raul’s progress in treatment, with moments of progress alternating with moments of regression. This is considered a natural progression of recovery from addiction, as addicts learn to, as Flores describes it, “...balance between affect release and affect containment.”

Raul continued to see a private psychiatrist and psychotherapist while he was in treatment at Ohlhoff. I communicated with the psychiatrist, but not with the psychotherapist, although I received information from Raul about the psychotherapist. I was affected by the diagnoses that the psychiatrist gave me, as well as feeling torn by Raul’s reports of being angry with his psychotherapist and his psychiatrist for things they were telling him. Raul took a number of different psychiatric medications during his treatment, one of which was forbidden by
Ohlhoff, and I felt inadequate to mediate between these two authority figures who held differing opinions from each other and from me.

During treatment Raul found a measure of acceptance within the community of his peers at Ohlhoff, within the sober community of AA, and from me as his therapist. He experienced a period of sobriety and was able to create some independence by moving into his own apartment, a move that he had long desired. He joined a sports team and contemplated doing volunteer work and perhaps changing jobs. His world seemed to be expanding.

Treatment ended unexpectedly for both of us, as Raul and I were buffeted by forces beyond our control, the forces of the for-profit insurance industry. I underwent an hour-long interrogation by an insurance representative, after which they denied any further service for Raul, because in their opinion he was doing so well that he did not need outpatient treatment but could rely on Alcoholics Anonymous instead. I felt powerful feelings of failure and guilt; I felt responsible for Raul’s sobriety and thought I had failed him during my interview with the insurance representative. This could be attributed to countertransference, but there was also my natural response to a clinically inappropriate decision by the insurance company that I knew could, and did, lead to negative consequences for Raul. The nameless, faceless bureaucrats at the insurance company managed, with their questioning, to turn my anger back toward myself.

In Imaginal Psychology, the concept of *imaginal structures* is used to describe unacknowledged aspects of the self in both the therapist and the client
that may be affecting and interpreting our perceptions and interactions in the moment. Meridian University defines imaginal structures in this way:

Imaginal structures are assemblies of sensory, affective, and cognitive aspects of experience constellated into images; they both mediate and constitute experience. The specifics of an imaginal structure are determined by an interaction of personal, cultural, and archetypal influences. These influences may be teased apart by attending to the stories that form personal character and the myths that shape cultural life.  

Imaginal structures are individual to each person. The imaginal structures that Raul manifested during our work together included the Hurt Child, the Rebel, and the Adept Traveller. The Hurt Child, a remnant of his traumatic childhood, sought to limit Raul’s experiences in order to protect him from harm. The Rebel was a manifestation of Raul’s desire for freedom from the expectations of parents, bosses, lovers, and society. Like the Hurt Child, the Rebel was protective, but sometimes led him into counterproductive or dangerous behaviors. The Adept Traveller was the imaginal structure that allowed Raul to navigate the intersectionality of his identity, to cross back and forth between the multiple worlds that he inhabited. The Adept Traveller was successful, but that success came at a cost. The Traveller had to hide certain aspects of his identity to be accepted in the different worlds, so the Traveller had to be bifurcated, not integrated.

Several of my own imaginal structures revealed themselves during my work with Raul. These were The Hurt Child, the Perfect Mother, and The Wise Woman. The Hurt Child sided with Raul against authority figures such as the psychiatrist and the Ohlhoff agency, which created solidarity between us but
limited our power and efficacy. The Perfect Mother conceptualized her clients as her children. She believed that her actions alone would secure their success or failure, and so was unable to recognize and validate the client’s power and autonomy. The Perfect Mother perceived the loss of insurance benefits as a personal failure. The Wise Woman was a positive imaginal structure that allowed me to be comfortable with my expertise and to act with authority and responsibility while understanding that the future was not in my control.

A mythic dimension was revealed when Raul told me that his favorite movie was *The Little Mermaid*. Upon exploring the ancient origins of this mythic creature, and the nineteenth century fairy tale by Hans Christian Andersen upon which the Disney movie is based, I found many connections and resonances with Raul’s journey. The painful transition that the mermaid makes in order to achieve her dream of becoming human echoes Raul’s struggle to be accepted in the various worlds in which he travels but does not feel wholly accepted. In the fairy tale the mermaid’s desire to acquire a human soul and her willingness to give up everything, including her body and her voice, to achieve it, is indicative of Raul’s struggle with substance use, which Imaginal and Jungian Psychology, as well as AA, see as a search for union with a higher power.

Working with Raul provided numerous opportunities for personal and professional development, both during our work together and in the process of writing this case study, although I have felt regret that the insights accrued during the writing of the case study happened too late to affect the therapy. My attunement with Raul’s distress created an opportunity for me to develop what
Meridian University refers to as the capacity for *reflexivity*. Meridian sees the capacity for reflexivity as progressing across seven levels:

1) The ability to be affected  
2) The ability to be aware of how one is affected  
3) The ability to describe how one is affected  
4) The ability to express how one is affected  
5) The ability to be aware of, describe and express the imaginal structures that have been engaged  
6) The ability to describe and express the personal, cultural and archetypal dimensions of the relevant context  
7) The ability to move forward with creative action

I became aware of my internal subjective experiences as they manifested themselves in affect. With the help of my supervisor I learned to identify them clinically as countertransference or projective identification when that was warranted, and to use them to help create meaning both about and for my client.

Working with Raul, who was different from me in many sociocultural aspects, gave me the opportunity to deepen my understanding of how each person’s subjective experience of race, gender and sexuality affects every interaction we have with others. I became aware of how my own experience affected my ability to understand and empathize with Raul’s experience, as well as the larger cultural influences that influenced his, my and our shared experience.

I also learned a great deal, although the experience was not always pleasant, about how to interact effectively with the myriad entities that encompass the mental health field, from individual practitioners such as internists, psychiatrists and psychotherapists, to the health insurance industry, and finally to agencies such as Ohlhoff itself. I learned about clinical diagnosis as it relates to insurance agencies, patient confidentiality and HIPAA compliance, and medical
record keeping. I also facilitated numerous group process and group therapy sessions and in the process became proficient in group facilitation and leading workshops.

**Personal and Professional Challenges**

I chose Raul as the subject of this case study for two main reasons. The first is that it was very obvious from talking to clients at Ohlhoff, and the data corroborates, that addiction and trauma go hand in hand, and Raul’s case, with addiction and both childhood and adult trauma, was illustrative. The second is that Raul and I were very similar in our existential wounds, and I experienced deep countertransference in working with him, as I will describe in more detail. Gelso and Hayes state, “Countertransference may be usefully defined as the therapist’s internal and external reactions that are shaped by the therapist’s past or present emotional conflicts and vulnerabilities.” 23 I believe these feelings were helpful in our work together as I was able to recognize how I was being affected and use these sensations to increase my empathy, which Gelso and Hayes describe as an essential element of using countertransference effectively, “…to temporarily put parts of the self aside and climb into the other’s shoes,” 24 but they also probably hindered us at times when I joined with him in avoiding difficult subjects. I speak about several examples of this in this case study.

The main crisis in the treatment occurred when I conducted a concurrent insurance review for Raul and he was denied more coverage. He had completed only two-thirds of the program. The program director offered to let him continue
if he paid cash for his treatment, an offer the client rejected, and this caused the client to leave abruptly. This created an ethical dilemma for me when I could not continue to treat my client. I felt that we were leaving Raul “in the lurch,” abandoning him before his treatment was complete, a feeling that was reinforced when he relapsed and returned to the program four months later.

In the course of writing this case study I learned a great deal about co-occurring disorders and how other factors, particularly the sociocultural location of a client, affect this condition. One of the personal challenges that I have experienced during the writing is my feeling of retrospective inadequacy with regard to my treatment of this client. “If only I had known then what I know now!” is my lament, because not only did I acquire academic knowledge, I also spent many hours applying it to this particular case. This is a luxury that does not happen very often in clinical work with clients. The saving grace of this experience is in understanding that my work has broadened my understanding and also opened up the ways in which I question knowledge itself. This understanding will help me in my work with subsequent clients. It is also heartening to imagine that students and researchers will read this case study and use it to build their own knowledge bases and broaden their frames of reference in regard to co-occurring substance use disorder and post-traumatic stress disorder.
CHAPTER 2

LITERATURE REVIEW

Introduction and Overview

The Literature Review addresses the topic of addiction from different theoretical perspectives, as well as the specific topic of co-occurring PTSD and substance use disorder (SUD). The Literature Review examines five different perspectives: Biological, Cognitive-Behavioral, Psychodynamic, Sociocultural, and Imaginal approaches to understanding addiction and trauma.

The Biological Perspectives section examines the evidence for viewing SUD as a disease of the brain, but also looks at the backlash against this approach. This section also looks at the neurobiological link between substance use disorders and PTSD. Cognitive-behavioral approaches to substance abuse treatment take the perspective that problematic behavior such as substance abuse can be extinguished by changing a client’s distorted thoughts or perceptions. In contrast, a psychodynamic perspective takes the view that addiction begins in early life. Freudian theory sees addiction as related to pleasure drives, while later psychodynamic theorists have seen addiction variously as: a disruption of a subject’s infantile attachment behaviors, self-medication for other mental disorders; a variant of narcissistic personality disorder; or an effort to reverse feelings of intolerable helplessness.
The section on Sociocultural Perspectives examines research in the following areas: 1) epidemiological and sociocultural aspects of methamphetamine use in the gay male population and its associations with HIV transmission and risky sexual behavior, 2) body dysmorphia in gay males, 3) research on the effectiveness of different psychological approaches in the mental health treatment of Latinos, and the limitations of such research; 4) the concept of the syndemic, which González-Guarda, McCabe, Leblanc, De Santis, and Provencio-Vasquez define as “…co-occurring epidemics or conditions that interact with one another to disproportionately impact the morbidity and mortality of marginalized communities."1

The Imaginal approach looks at addiction and trauma from the point of view of soul, because, according to Aftab Omer, “Imaginal Psychology reclaims soul as psychology’s primary concern.”2 The soul expresses itself in images that are found in dreams, symbols, mythology and the creative imagination as it expresses itself in art. The roots of soul care reach back to the ancient practices of shamanism and thus, according to Jaenke, transcend Western psychology’s entrenchment in Euro-centric points of view. Jaenke defines mental illness as a form of soul loss, a malaise she describes in this way: “…indifference to the soul’s passions in oneself and others, or attending certain passions while neglecting others, are manifestations of soul loss.”3

Imaginal approaches to understanding addiction, as discussed by Tyminski, Schoen, and Addenbrooke, discuss the human need for ecstatic states, the quest for initiation that often goes awry in the Western approach to seeking ecstatic states, and the need to integrate the shadow to embrace recovery.4 Perrera discusses the healing that can
occur when reaching back to mythological stories to help us understand and incorporate the soul’s need for ecstatic states as an expression of connection with the divine.⁵

**Biological Perspectives on SUD and Traumatic Stress**

In the 1950’s scientists identified an area of the brain that seemed to control the search for pleasurable experiences. Animals with electrodes in the medial forebrain bundle would repeatedly push levers that stimulated this area of the brain, which came to be known as the brain-reward system.⁶ The intense stimulation of the brain-reward system by drugs and alcohol was what caused addiction, according to these researchers.

Koob goes a step further in the neurobiological explanation for addiction, describing three major circuits in the brain that together create a reward and anti-reward system. This circuit consists of the extended amygdala, the nucleus of the stria terminalus, and the transition zone in the shell of the nucleus accumbens.⁷ The addiction process is identified as a three-part cycle that includes: a *reward period* when the substance is administered, dopamine floods the brain and the user experiences the high normally associated with addictive drugs; a *withdrawal period*, consisting of painful physical symptoms and obsession with obtaining the drug; and a *preoccupation/anticipation period*, during which the addict may not be in acute withdrawal but is instead affected by stress, craving and relapse triggers, and by a hypo-dopaminergic state in the brain.⁸

Some of the scientists who define addiction as a brain disease have come to the same conclusion with PTSD, identifying changes in the brain wrought by trauma that they define as PTSD. Pizzimenti and Latal state, “At it simplest, PTSD can be conceptualized as a disturbance of the hypothalamic-pituitary-adrenal (HPA) axis, which
governs stress response.” 9 Recent brain research in animals has found that both traumatic stress and substance abuse affect two areas of the brain—the brain-reward system, also known as the dopaminergic motivation system, for pleasure, and the HPA axis for stress (“stress” is the term scientists use when subjecting animals to physical stress to simulate human trauma). 10 Gerra et al. and Lijffijt et al. describe a web of connections, with addiction and PTSD each having the possibility of causing or exacerbating the other. 11 Lijffijt et al. describe the connections here:

Prevalence of childhood trauma (neglect, sexual physical or emotional abuse) and post-childhood stressful events is elevated in people with a substance use disorder across classes of substances of abuse, and childhood trauma or post-childhood stress increases risk of developing substance use or use disorders. Trauma or stress could precede onset of substance use, abuse or dependence, suggesting a causal relationship between stress and substance use, although substance use can also predispose to (additional) traumatic events. 12

People who suffer from traumatic stress are at a much higher risk of developing a substance use disorder and are at greater risk of relapsing after entering treatment. 13

Goldstein et al. found that this correlation is related to changes in fear conditioning as a result of intensified sensitization of the brain’s motivational systems. 14 Therefore we see that a biological perspective on addiction and PTSD views the disorders as disruptions in the stress and reward systems—literally, brain diseases—which act as catalysts to each other. Treatments based on biological perspectives are focused on pharmaceuticals that arrest the progress of the diseases. Pizzimenti and Latal state, “There is an emerging consensus that the best treatment strategies engage the circuits involved in behavior inhibition, coupled with pharmacological manipulations designed to target those circuits, with the goal of creating lasting behavioral inhibition.” 15
The drug of choice of the subject of this case study was methamphetamine (MA). The specific action of MA in the brain is to stimulate release of catecholamines in the central nervous system and block dopamine reuptake in the neurotransmitters.\(^\text{16}\) Dopamine is the brain’s natural reward system. A rat that has been food deprived will experience a dopamine spike of 100 units when it eats. When it has an orgasm it will experience an increase of 200 units. Alcohol creates a dopamine rush that is equivalent to an orgasm, up to 200 units, and cocaine almost doubles that pleasure, with a spike of 100 to 350 units. But Rawson calls methamphetamine the “mother of all” addictive drugs because of its effect on dopamine in the brain, causing a spike of up to 1250 units.\(^\text{17}\) Nothing produced by nature can come close to equaling it.

The experience of the MA high includes increased attentiveness, energy, euphoria, curiosity, interest in environmental stimuli, hypersexuality and decreased anxiety. Withdrawal from the drug creates severe psychological symptoms, but less physical symptoms than with other addictive drugs.\(^\text{18}\)

The process of becoming addicted proceeds more rapidly for methamphetamine than for cocaine.\(^\text{19}\) Although treatment for addiction in the brain disease model focuses on pharmaceutical interventions, particularly those that block the binding of addictive substances to the dopamine transporter site,\(^\text{20}\) there are currently no medications that are FDA approved for treatment of methamphetamine dependence.\(^\text{21}\) Haney, Cooper and Bedi point out that the pharmaceutical industry has yet to produce useful pharmacotherapies for stimulant dependence.\(^\text{22}\)

In contrast to the large body of research that postulates addiction as a brain disease, there is a smaller body of research that refutes this notion. A major triumph in
the addiction as brain disease revolution came in 1997, when the then director of the National Institute on Drug Addiction (NIDA), Alan Lesher, published an article in *Science* that used brain scans to reveal visible changes that occur in the structure and function of addict’s brains, thereby “proving” that addiction was a brain disease. But Satel argues that such changes are not a sufficient reason to label addiction a disease. The brain is constantly changing based on its experiences. Learning a new language causes changes in the brain, but we don’t call the ability to speak French a disease. The world of psychiatry and psychology recognize mental ailments as disorders, not diseases, with a very few exceptions that have clear organic origins. This is because the etiology of these problems is still unclear, according to Satel and Dodes.

Dodes refers to studies done of Vietnam veterans who became physically addicted to heroin while enduring the ravages of war in a far-away country. When the veterans returned to the United States and underwent detoxification, 90 percent went on to live their lives without addiction to another narcotic. Dodes argues that these results refute the neurological argument that brain changes indicate addiction. The brain changes occur in all people who are repeatedly exposed to the drug, whether they are addicted or not. He says, “…physiological changes caused by drugs cannot create addiction in people without the psychology for it.”

Satel argues that the reason that national drug czar Lesher put the disease moniker on addiction was because previously addiction was thought to be simply a lack of will power on the part of addicts, and therefore the problem did not need to have research money spent on it. Once given the disease label the stigma would lift and the fountain of research funding would turn on. The current head of NIDA, Nora Volkow, continued
the charge and took one step further. In 2007 she predicted, “We will be treating addiction as a disease by 2018, and that means with medicine.” The federal government is hoping that new medications will be found that will treat addiction, and half of NIDA’s funding goes to neuroimaging, neurobiological research and medication development.28 Yet despite years of research there are still very few drugs that directly target addiction.29

The opponents of the addiction as brain disease theory do not refute that brain changes occur with addiction and that medications might aid those fighting addiction, but they worry that a reliance on medications will drop the focus on self-control that is an essential aspect of recovery. They also are concerned that researchers only examine the negative changes in the brain that occur from using substances, rather than focusing on the effects on the brain of positive changes that recovering addicts experience, such as increased spirituality or sense of serenity, because these changes cannot be monetized.

Ohlhoff Recovery Programs sought to practice an integrated approach to addiction treatment without judgment as to the etiology of addiction. There was a psychiatrist on staff who prescribed medications to counteract cravings and to ameliorate the psychological effects of a lifestyle of addiction, including co-occurring mental disorders such as depression, anxiety and PTSD. In addition, intensive counseling, psychoeducation and involvement in Alcoholics Anonymous was required of every client and constituted the bulk of the program. In my opinion most of the people who argue that addiction is solely a brain disease—or on the other side argue that it is not a brain disease—usually have a reason, whether financial or academic, to be so dogmatic. The people on the front lines battling the epidemic of drug addiction, such as Gabor Maté, who says that addiction has “…biological, chemical, neurological, psychological,
medical, emotional, social, political, economic, and spiritual underpinnings…” are, like Maté, much more expansive in their definition.30

**Cognitive-Behavioral Perspectives on SUD and Traumatic Stress**

The history of addiction treatment parallels the history of mental health treatments in general. From the late nineteenth into the mid-twentieth century, addiction problems, when they were defined as a psychological issue rather than a legal problem or a social ill, were treated by the dominant mode of psychological treatment, psychodynamic or psychoanalytic therapy. However, traditional psychoanalysis or psychodynamic therapy did not develop a very good track record at curing addiction.31 When B.F. Skinner entered the mainstream with his theories of operant conditioning in the 1940’s and 50’s, a new model of treatment arose based on the notion of changing behaviors and cognitions rather than treating underlying unconscious psychological conflicts.

A cognitive-behavioral perspective views mental health problems, including substance use disorders and trauma symptoms, as a product of what Messer describes as “…distorted processing of environmental information…” which “…confirms the initial faulty schemas and general worldview of the client.”32 Interventions are aimed at correcting the faulty thinking that results in the undesirable behavior.33 In the 1990’s the National Institute on Drug Abuse (NIDA) focused a large part of its funding toward developing behavior therapies for addiction that could be disseminated via a community health model. They enforced a rigorous research model to prove efficacy. The treatment models that arose based on the behavior-based approaches included cognitive behavior
approaches, motivational interviewing, and contingency management, often used in conjunction with medication.  

One of the most famous and widely used models of cognitive behavior treatment of SUD is the relapse prevention model known as MATRIX, developed by Marlatt and Gordon in 1985. This model proposes to: 1) teach immediate skills needed to stop drug and alcohol use; 2) provide an understanding of factors crucial to sustaining abstinence/avoiding relapse; 3) educate family members affected by addiction and recovery; 4) explicitly reinforce and support positive behavior change; 5) familiarize patients with self-help programs; and 6) monitor drug/alcohol use by urine toxicology and breath alcohol testing. Although I never heard the term MATRIX used at Ohlhoff, every one of these techniques was employed there. Ohlhoff, however, went one step further by adding individual and if requested, family therapy for each client, thereby providing an integrated model that combined psychodynamic approaches with cognitive-behavioral ones. In this way they achieved what Merrill proposed in an article recommending the combination of cognitive behavioral techniques with psychodynamic ones, “…an important goal of psychotherapy is to develop mastery over dysphoric affects within a protected therapeutic setting, thereby enhancing the patient’s ability to identify, tolerate and respond appropriately to those internal experiences.”

Some cognitive-behavioral interventions used by substance abuse treatment centers directly address the connections between trauma and substance use, while other schools of thought argue that in treatment facilities the primary complaint of addiction should be addressed first, as dealing with trauma could cause a relapse in a newly
recovered client. A popular curriculum called *Seeking Safety*, which addresses both trauma and addiction, was used at my agency.\(^{37}\)

Other common cognitive-behavioral methods were used at Ohlhoff in both and individual therapy, including Motivational Interviewing, Acceptance and Commitment Therapy,\(^{38}\) and cognitive-based mindfulness techniques to reduce rumination and excessive focus on the self.\(^{39}\) A study by Kok et al. attests to the effectiveness of the DASS-21 (Depression, Anxiety and Stress Scale) as a tool to measure outcomes in therapy with substance users.\(^{40}\) The DASS scale was used by my agency at entry and exit from the program to assess the client’s progress during treatment, and was administered to Raul when he entered and exited the program.

**Psychodynamic Perspectives on SUD and Traumatic Stress**

In 1991 a monograph on addiction was published in *Current Issues in Psychoanalytic Practice*. The editor, Herbert Strean, a psychoanalyst himself, identified the contributors to the book as “pioneers.” He called them that because historically most practitioners of psychoanalysis avoided treating addicts, as their cases were not thought to be amenable to psychoanalysis. Strean then betrayed his own feelings by calling therapy with an addict “…a trying, tedious, and tumultuous ordeal for both the therapist and patient…” which invokes strong countertransference reactions of “…rage, helplessness, depression and withdrawal…” that mirror the internal state of the addict.\(^{41}\)

This question of whether addiction is treatable with psychodynamic methods is a throughline that appears in much of the literature on the psychodynamic perspective on addiction.
The early psychodynamic theorists saw addiction as a function of the id, as a drive-based search for pleasure, which from a Freudian point of view arises from infantile sexuality. Since the 1960’s a number of alternative theories expanded the psychodynamic point of view regarding the etiology of addiction. Khantzian developed the idea of the drug of choice as a means of self-medication, in which specific drugs were chosen by their users for their ability to control intolerable affects, such as cocaine for depression. Kohut saw addiction as “a defect in the self,” which arises from the failure of a maternal self-object to meet the infant’s needs. If the needs had been met the infant would develop the ability to meet his or her own needs as if the self-object were a part of his or her self. In the absence of this ability the drug becomes a mirroring self-object which soothes and accepts him, and thereby, “…provides him with the self esteem which he does not possess.”

Ulman and Paul build on Kohut’s self psychology model, presenting a theory that views addiction as a variant of narcissistic personality disorder. By using the word disorder they deliberately distinguish their conception as at odds with the disease model of addiction. For them the brain is one part of a chain reaction, in which the substance causes a neuroanatomical burst that induces an unconscious reaction involving the mobilization of latent fantasies and moods. Ulman and Paul describe addiction as a type of megalomania in which substances, which the authors label addictive trigger mechanisms (ATMs), allow the user to wield magical control and exert power over their experience, creating a fantasyland in which the user resides.

A current psychodynamic theorist, Lance Dodes, defines addiction as “…an effort to reverse feelings of intolerable helplessness.” The purpose of substance use is to
reverse feelings of helplessness, of being out of control. Substance use provides a false sense of empowerment, seducing the addict into believing that he is in control of his emotional experience, as well as his life. Dodes contends that his theory differentiates itself from the early psychodynamic conception of addiction as a pleasure drive, because the early view was that addiction is the direct expression of a desire. Dodes contends that the addict’s actions are substitutes, because direct action to combat the internal affect of powerlessness is not possible. This conception, he states, allows addiction to be viewed as “psychologically indistinguishable” from compulsions, and therefore they are as treatable as any other compulsion by a psychodynamic practitioner.  

Flores views addiction as an attachment disorder, asserting that “individuals who have difficulty establishing emotionally regulating attachments are more inclined to substitute drugs and alcohol for their deficiency in intimacy.” Flores offers Attachment Oriented Therapy (AOT) as a treatment for addiction, and contrasts his approach with traditional psychoanalysis, with its bias toward independence as the marker of development or mental health. In addiction, Flores charges, independence, or more accurately counterdependence, is the base for the addict’s narcissistic position. Instead of independence, Flores views healthy development as the movement from immature dependence to mature dependence or mutuality.  

In addressing the issue of whether addiction is amenable to psychodynamic treatment, Flores states that, “As long as the alcoholic remains attached to alcohol, he will not be able to establish a therapeutic alliance.” However, if the analyst does treat the addict, an opportunity for a breakthrough will arise when the addict hits what
Alcoholics Anonymous refers to as “rock bottom,” or what Flores calls crisis. Flores posits that the client’s attachment system opens up during trauma or crisis.

Many of the questions about the suitability of the psychodynamic model seem to reside with when a patient might become amenable to psychoanalysis in the course of their addiction. Most of the psychodynamic theorists I studied address the issue of whether it is ethical or therapeutic to treat a client while they are still actively using a substance, and there is no consensus on this point. Although psychodynamic theory posits that the problem of addiction is as old as the client, originating, as Liebeskind says, in the intimacy that did not occur between the infant and the mother figure, the response to it (the drug use) is daily and habitual and can interfere with any therapeutic work. Liebeskind says that if the patient is unable, because of their drug use, to form a relationship with the therapist, then “detoxification is the first order of business,” but can be deferred if a relationship can be established despite intoxication.52

Sociocultural Perspectives on SUD and Traumatic Stress

This section examines Raul’s case from various sociocultural perspectives, including what De Santis, Gonzalez-Guarda, and Deleon identify as “the tangled branches” of a sociocultural identity that includes both risk factors and protective factors that might affect mental health outcomes for Raul.53 Raul was male, homosexual, and HIV negative, born in the United States of Mexican heritage, whose drug of choice was methamphetamine. His drug use began while meeting male partners for sex, and then escalated to private and excessive use. He was sexually assaulted while using drugs and subsequently feared exposure to the HIV virus from those assaults.
One context for Raul’s case concerns the use of methamphetamine among men who have sex with men (MSM) and the risk of sexual violence, HIV infection and sexually transmitted diseases that this behavior can engender, as well as the inverse situation, in which the trauma of sexual victimization can lead to substance use and abuse. Solomon, Halkitis, Moeller and Papas found that among MSM who use methamphetamine there was a 78 percent clinical dependence rate, indicating that many men who begin using the drug recreationally become addicted. Mimiaga et al. undertook a qualitative study of MSM who had acquired HIV while using methamphetamine, in which the participants discussed the destructive effect meth use had on their lives and psychological health, with 95 percent reporting anxiety and chronic depression following cycles of meth use, and 90 percent reporting that they had lost social relationships, friends, and lovers, because of their addiction. Kalichman et al.’s research found that MSM who reported coerced sexual activity as adults experienced higher incidences of multiple behavioral risks, including substance abuse, trading sex for drugs, and relationship violence.

In reaction to the type of research cited in the previous paragraph, which some theorists saw as punitive or shaming in their search for a connection between methamphetamine use and increased risky sexual behavior in MSM, some researchers widened the lens they used to examine connections between drug use and risky sexual behaviors in MSM. Grov, Parsons and Bimbi undertook a somewhat larger research study, enrolling 738 men. Their results showed that although there was a bivariate relationship between meth use and sexual risk, they found that in their sample, among men reporting unprotected anal intercourse, only 18.9 percent reported having used
methamphetamine in the recent past. Therefore they argued that the push for using anti-drug campaigning as the public health focus for HIV prevention was shortsighted. This approach, they claimed, “…may also overlook the broader, political, social and psychological forces continuing to drive new HIV transmissions among sexual minorities.” Gideonse also used this wider social perspective, describing a public health care system and law enforcement system that systematically shamed, scapegoated and villainized gay users of methamphetamine and compounded their suffering rather than relieving it.

Up to this point in this section I have been looking only at the aspect of Raul’s situation as a gay man who used methamphetamine, sometimes in the context of “hooking up” and having experienced sexual violence as a consequence. Another important factor of Raul’s identity was being Latino, and understanding how his ethnic identity intersects with his homosexuality to form his particular experience. An important concept to consider in this case is the syndemic, which González-Guarda, McCabe, Leblanc, De Santis, and Provencio-Vasquez define as “…co-occurring epidemics or conditions that interact with one another to disproportionately impact the morbidity and mortality of marginalized communities.” Gonzalez-Guarda et al. identified a syndemic resulting from the combined effects of substance abuse, violence, HIV risk and depressive symptoms among Hispanic men. Bruce, Ramirez-Valles, and Campbell, although they do not use the word syndemic, identify a complex, intertwining relationship between stigmatization, substance use, and sexual risk behavior among Latino gay and bisexual men and transgender persons. One of their findings stated, “As acculturation
increases so does the negative views toward the Latino self, which is then linked to increased multiple drug use.”

Raul may have suffered from an eating disorder, which I discuss in the Course of Treatment section of this case study. DeSantis et al. used the *syndemic* model to test the relationship between depressive symptoms, self-esteem, substance abuse, eating attitudes and behaviors, body image, and sexual behaviors among a sample of Hispanic men who have sex with men (MSM). They found that eating attitudes and behaviors were predictive of depressive symptoms, low self-esteem, substance abuse, lower body image, and high-risk sexual behaviors in members of that community. A study by Jampel, Safren and Blashill described a positive correlation between muscularity disturbance (a type of dissatisfaction with body image affecting mainly males) in MSM and methamphetamine use. Studies such as these shed light on the complexity of Raul’s case, whose mental health was influenced by many of the factors that these researchers identify.

It is important to note that Gonzalez-Guarda et al. identify factors within the Hispanic community that contribute to stress for members of sexual minorities, but also identify aspects of culture which they label protective factors. One such factor is *familism*, which Gonzalez-Guarda et al. define as a sense of belonging, a notion of the centrality of family and the importance of family support that is a cultural value among Hispanics. Gonzalez-Guarda et al. identify *familism* as both a significant risk and protective factor for the *syndemic* of substance use, violence, HIV and depression that they identified in their sample of Hispanic men.
Research on mental health treatment for Latinos, especially in the area of addiction, has gaps, particularly as it pertains to Latinos who are acculturated into the dominant white culture, as Raul appeared to be. Researchers often make assumptions about Latino subjects having outsider status, rather than addressing the particular issues facing acculturated Latinos as they struggle with mental health issues. Reif, Horgan and Ritter found that substance use disorders were nearly four times as likely in US-born Mexican-Americans compared to those born in Mexico, and that the diagnosis of the disorder increases along with acculturation.\textsuperscript{64} Falicov describes and examines the efficacy of “culturally-attuned treatments” for Latino clients, including universalistic, culture-specific therapies and cultural adaptions, and argues that “…the collaborative encounters of Latino immigrants with experienced clinicians and researchers creates a bicultural encounter that goes beyond the notion of cultural ‘adaptation’ and presents a unique opportunity for a mutually enriching cultural integration of theory, research, and practice.” \textsuperscript{65}

Sociocultural perspectives on Raul’s case illuminates the complex interaction of factors—racial, sexual, psychological, medical, emotional, social, political, and economic—that affect how a client such a Raul perceives himself, and how he is perceived and treated by the mental health system (including the insurance industry), by clinicians such as myself and the agency for which I worked, and by the other institutions with which he came in contact, such as law enforcement. To do any justice to Raul’s case a clinician must attempt to understand the “tangled branches” that together weave the tapestry that constitutes Raul’s experience.
Imaginal Approaches to SUD and Traumatic Stress

I initially placed the Jungian perspective on addiction within the psychodynamic section of this paper, but moved it to the imaginal section when I encountered Carl Jung’s exchange of letters with the founder of Alcoholics Anonymous, Bill Wilson. These letters place the Jungian perspective on addiction squarely in the imaginal because in them we see that Jung is concerned with spirit, or soul, rather than on the instinctual drives of the mind, which is where we would see the psychodynamic perspective. In these letters Jung and Wilson conversed about Roland H., a former patient of Jung’s, who relapsed after a year’s sobriety during treatment with Jung, but who found long-term sobriety within AA.

Jung described Roland’s problem not as medical or psychological, but spiritual. “His craving for alcohol was the equivalent, on a low level, of the spiritual thirst of our being for wholeness, expressed in medieval language: the union with God.” 66 Jung recognized from his own experience that substances could create a false sense of wholeness, as he revealed when he described one of his first experiences of being drunk. “There was no longer any inside or outside, no longer an ‘I’ and ‘others’… caution and timidity were gone and the earth and sky, the universe and everything in it that creeps or flies, revolves, rises or falls, had all become one.” 67

While Jung sees addiction as a search for wholeness, other post-Jungian theorists have looked at the shadow aspect of addiction. David Schoen views addiction as an “archetypal shadow” that takes over all aspects of a person—physical, emotional, mental and spiritual. 68 Donald Kalsched uses the same terms to describe the defense reaction to trauma, calling it a “…Faustian bargain with a persecutory Devil who kept the soul disembodied and unrealized.” 69
According to Naifeh, because addictive possession is spiritual in nature, it can only be overcome by an equally powerful counterpoint—a spiritual path, such as the one offered by Alcoholics Anonymous, whereby one achieves wholeness such as Jung was describing by turning one’s will and power over to a higher power, as the Big Book of Alcoholics Anonymous describes, and working the 12 Steps. AA was an integral part of the treatment at the agency where I worked, and discussion of what constitutes a higher power happened at least weekly, if not daily. Schoen says the 12 Steps revolve around “…the establishment of a conscious ego connection with the true Self (or Higher Power),” although he does not define the Higher Power except to state that it must involve ego surrender. Kalsched describes this interplay between inner and outer worlds by interpreting the Jungian definition of wholeness as, “…a universal human urge to fulfill all of oneself—all of one’s potentials…” and “our life-long pursuit of it, and possibly its lifelong pursuit of us.” (italics original)

Other aspects of the imaginal approach to addiction refer to ritual and initiation, and how those rites have been lost in Western culture but the need for them still remains and often leads to substance misuse, which leads to addiction. Omer describes the universal human need for ecstatic states and how the human need for ritual is coopted by the addictive process. Zoja speaks of addiction as a misguided attempt to replicate the ancient rituals of initiation and initiatory structures, and describes how the longing for substances speaks to a longing for the sacred. Perera echoes this claim from a mythological perspective in invoking the ancient Celtic goddess Maeve, whose name means, “the inebriating one.” Perera states that “Maeve represents the profound and archetypal need for experiences of ecstasy and the transformative fullness of emotion and
vision such experiences may produce.” 75 Jaenke speaks of the soul’s need for ritual: “Without ritual, we drown, because ritual, in the sense of imaginative participation in mystery, creates a context for enacting the intensities of the imagination within a container, within a community, with discipline and accountability.” 76

Jaenke does not specifically mention addiction in her definition of soullessness, but she does refer to trauma and how it can cause the condition of soullessness. The following conditions define soullessness, according to Jaenke: an indifference to the soul’s passions, dissociation, psychic numbing, lying to protect injured and vulnerable sectors of psyche from exposure, and finally, perpetrating evil, defined as imposing one’s will upon others.77 All of these definitions could also be applied to addiction, so the loss of soul can equally be seen as a consequence of addiction.

It is interesting to contrast the imaginal perspective with the brain disease theory of addiction. In an article provocatively entitled The Myth of Addiction, Hammersley argues that in the modern Western approach to addiction, drugs are seen as modern day demons. “Like a demon, a drug is supposed to be able to possess a person and make them do things that the person themselves would not do.” 78 Hammersley says that Western people like this paradigm because of their obsession with the importance of self-control and their fear of loss of control, a view that is not shared by indigenous or Eastern perspectives. In non-Western cultures, not being in control is not considered deviant or undesirable, and possession by spirits does not have the negative connotation it does in Western religious and psychological thought. Western cultures have pushed out the initiatory rites, Hammersley states, because they involve loss of control, or giving over control to something greater than oneself. Hammersley’s theory may explain why the
scientific approaches embodied in the biological and cognitive-behavioral perspectives do not favor AA, because it involves a symbolic loss of control as shown in the words of the First Step: “We admitted we were powerless over alcohol—that our lives had become unmanageable.” The brain disease paradigm sees addiction as a loss of control, because a person with a disease is not in control of their symptoms, but the drugs that they are given as a cure will give control back to them.

**Conclusion**

The Literature Review examines the topic of addiction, as well as the co-occurring disorders of post-traumatic stress disorder and substance use disorder, from five different theoretical perspectives and describes how the disagreement in the field on the etiology of addiction has led to different theories about how best to treat the disorder.

The section on Biological Perspectives presents the argument for SUD as a disease of the brain, but also looks at the backlash against this approach. The claim of a neurobiological link between substance use disorders and PTSD is described.

Cognitive-behavioral perspectives on SUD treatment take the point of view that problematic behavior such as substance abuse can be extinguished by changing a client’s distorted thoughts or perceptions. Cognitive-behavioral approaches to treating trauma are examined, as well as the argument that SUD and PTSD cannot be treated simultaneously.

The literature on Psychodynamic Perspectives on SUD and PTSD examine a variety of theories on the etiology of addiction, including: a disruption of a subject’s infantile attachment behaviors; self-medication for other mental disorders; a variant of
narcissistic personality disorder; or an effort to reverse feelings of intolerable helplessness.

The section on Sociocultural Perspectives examines co-occurring disorders as they pertain to the sociocultural location of the subject as a gay, Latino male, and how some cultural institutions may serve to compound the negative impact of the co-occurring disorders, while others may provide protective factors.

Imaginal approaches to understanding addiction discuss the human need for ecstatic states, the quest for initiation that often goes awry in the Western approach to seeking ecstatic states, and the need to integrate the shadow to embrace recovery. The imaginal perspective looks at the wounding of addiction and trauma as a form of soul loss that can be mitigated by reaching back to ancient practices of ritual, active imagination, and shamanic practices.
CHAPTER 3

PROGRESSION OF THE TREATMENT

The Beginning

I sat in the staff work area on a Wednesday afternoon, reading a computer screen filled with information about my new client, Raul. Next to me another staff member stared at his own screen. Adjacent to him a counselor talked to an insurance company on the phone, requesting more sessions for one of our clients. A staff member’s spaniel puppy chewed a piece of rawhide near my feet. In the adjacent kitchen the microwave beeped and somebody laughed loudly. Above my head on the wall was a sheet of Global Assessment of Functioning (GAF) score definitions, the cell phone numbers of all the staff and interns, and a tiny printed sign that said, in cursive, “You are doing a *fucking* great job.”

I had been an intern at Ohlhoff Recovery Programs for three months. This was my first clinical placement. I was no longer so new that every assignment made my stomach churn with fear, but still I felt like I was learning something new every minute of the day. Raul was one of two new clients who had been assigned to me at the staff meeting the previous Thursday. One of the permanent staff members, Mark, had done Raul’s assessment, a comprehensive interview that takes at least an hour to complete. Mark had given us a thumbnail sketch of Raul in the meeting, so we learned that he was in his mid-30s, employed, Latino, gay, and that his drug of choice was crystal methamphetamine.
The staff and interns were all white, so there was no chance of assigning Raul a counselor who matched his ethnicity, but there was at least one gay counselor. However, generally the program director did not try to match clients and counselors this way, unless there was a particular need. For example, clients in the women-only outpatient program who had experienced sexual violence would be assigned to a woman counselor. But usually the assignment was random, based on who was available, so Raul was assigned to me—a white, cisgender, heterosexual, middle-aged woman.

**Treatment Planning**

Raul’s assessment gave a wealth of other information that I tried to absorb without forming any a priori judgments about how successful he might be in the program. One of the staff counselors, an old AA hand, joked that clients never came to Ohlhoff on the best day of their lives. In fact, it was usually the worst. Clients had hit “rock bottom” as they say in AA, and were looking to change their lives. Whether they would or not was a complete crapshoot. Many people succeeded, and left the thirteen week program sober and stable, and many others never finished, dropping back into the quicksand that they had managed to climb out of for a few short weeks. Some even died, as did one client from the inpatient facility during my tenure, someone I thankfully did not know. So many clients arrived at outpatient treatment after near death experiences that it was almost routine. Life and death were the stakes we were dealing with, a fact of which we were all acutely aware.

I read through Raul’s assessment and made note of anything that seemed like it might be clinically relevant, as well as trying to get a general feel for my new client. Raul
had a stable job in the health care industry with an income in the mid-five figures. He had stated that he had “a large family and was close to all members on both sides.” In the assessment there is a place where the client lists everyone they consider close family members. The majority of the clients at Ohlhoff are white, and most of the assessments I’d seen had three or four family members listed, and the electronic form only had space for five. Raul’s form listed five family members and then an added note in which he’d included his four-year-old niece. I wondered whether this was a cultural difference, indicating that his view of family was more expansive than our typical client.

In the “history of abuse” section Raul had been quoted as saying there was, “…lots of violence between parents. Had to call the police often. Parents were ‘old-school’ immigrants who tried to ‘beat the gay’ out of him. Lots of neglect as well.” The assessment stated tersely, “Emotional abuse from mother. Nothing he did was good enough.” In the “sexual abuse as an adult” section Raul stated that he been “taken advantage of in sexual situations against his will.” I noted the delicate wording of what was most likely rape. I paused and took in how these short sentences contained a world of hurt and pain, the kind of trauma that some people spend the rest of their lives working on in therapy.

Raul had been hospitalized twice for side effects from his methamphetamine use, including malnutrition and kidney failure. He had been in residential substance use treatment twice before, and had attended a partial hospitalization treatment for patients with dual diagnosis, but there was no mention of a second diagnosis beyond substance use disorder. He had a psychotherapist and a psychiatrist, as well as nurse practitioner for his medical needs.
I scrolled down to his DSM IV diagnosis and his scores on the DASS, an inventory of stress, anxiety and depression. Raul’s diagnosis and DASS scores from his assessment at intake were as follows:

**Diagnosis (based on DSM IV)**

<table>
<thead>
<tr>
<th>Axis I</th>
<th>304.40 Amphetamine-type substance use disorder, Severe</th>
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<tbody>
<tr>
<td>Axis II:</td>
<td>Deferred</td>
</tr>
<tr>
<td>Axis III:</td>
<td>Kidney failure, 2011</td>
</tr>
<tr>
<td>Axis IV:</td>
<td>Health, family, social relationships, employment</td>
</tr>
<tr>
<td>Axis V:</td>
<td>51</td>
</tr>
</tbody>
</table>

**DASS Scores**

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<tbody>
<tr>
<td>Anxiety</td>
<td>28 (&gt;20 = extremely severe)</td>
</tr>
<tr>
<td>Depression</td>
<td>36 (&gt;28 = extremely severe)</td>
</tr>
<tr>
<td>Stress</td>
<td>32 (26-33 = severe)</td>
</tr>
</tbody>
</table>

Axis V noted the GAF score, which was an indication of the level of impairment the client was suffering in the emotional, physical, and social realms, as well as day to day living. The GAF score of 51, assigned by Mark, stated that Raul was suffering moderate impairment to his life from his addiction. His self reported DASS scores revealed extremely severe anxiety and depression and severe stress.

I clicked over to the group therapy notes, which Raul had attended the night before. Group therapy consists of a process group and then a psychoeducation group. In the process group each client checks in with a feeling word that describes their current mood, and then speaks on a topic of their choice and receives feedback from his or her peers and the counselors. Topics are supposed to be sobriety related; they might be about personal issues a client is having or questions that have come up for them as they begin working the program of Alcoholics Anonymous. The counselors note what the topics were and how each client engaged with the rest of their peers. The treatment notes
described Raul’s first session in this way: “Client checked in as anxious and chose the topic of being present. He admitted that he is having trouble staying focused and present now that he is in recovery. He is trying to meditate but he has trouble with the breathing. Client was engaged with other peer's topics and received feedback from his peers.”

As I closed his file and turned to other duties I thought that Raul was going to be an interesting client, and also that I felt worried, both about his ability to be successful in the program and about my ability to be helpful to him.

**The Therapy Journey**

I met with Raul later that night before group therapy. As I walked into the waiting area I identified him immediately, as he was the only Hispanic person. He stood up with a smile and shook my hand. Raul was slender and not very tall, perhaps 5’8”. He had an attractive, fine-featured face with dark eyes and long eyelashes, and light freckles. He spoke with just a hint of a Spanish accent. He had neatly combed short dark hair and was clean-shaven. He wore a button down shirt, a sweater and a zip up jacket. After we sat down across from each other I immediately noticed how anxious Raul appeared. He sat forward in his chair with his back straight, as if he was ready to jump up at any moment. He had a tic of combing the fingers of both hands from above his ears down to his neck, and had a nervous laugh.

At this meeting we mostly spoke of logistical issues, such as his treatment plan, the schedule and penalties for missed sessions, but at one point he alluded to “embarrassing things” that had happened to him during his drug use. I knew that those things probably related to what he had referred to in his assessment as “being taken
advantage of” in sexual situations, but I did not follow up. I told myself I was being sensitive, and perhaps I was, but already I felt a resistance to hearing this story, a resistance I noticed as it came up.

Raul was very cooperative and signed the releases for audio recording of our sessions as well as consents for me to speak to his nurse practitioner and psychiatrist. I also reminded him of Ohlhoff’s rules against benzodiazepines, even when prescribed by a doctor, and how he had agreed in his contract to taper off the lorazepam that he took at night for sleeping. He agreed that he would do that, but told me that it would be difficult because he had tried lots of other drugs and they didn’t work, as most of them upset his stomach.

I facilitated Raul’s group therapy that night, with about five other clients. He shared about his anxiety in groups and how he had difficulty coming up with topics to discuss. He was wearing a jacket with a zipper and during the session he zipped and unzipped the jacket many times. He would unzip it as if he was going to take it off and then zip it back up to his neck. I felt a visceral sense of discomfort and deep empathy as I watched Raul. His physical motions seemed to echo the emotional state he was in, as he attempted to disclose to the group, to open up, and then felt the need to retreat and close himself back up again, over and over.

As if to show that the previous group session had been too much for him and required a retreat back into his shell, Raul called in sick for the following day’s group therapy. At our next individual session he said that he wasn’t ill; he just couldn’t face the group. In making this confession Raul posed a dilemma for me. It was the first of many times I had to decide between my therapeutic alliance with Raul and enforcing the rules
of the agency, which I also knew were for the benefit of the clients, who needed the “self-binding” that the rules provided. I decided to let the comment slide and allow Raul to be “sick.” When I asked how he was feeling now he replied, “To be honest, I’m not doing well at all.” Raul’s physical demeanor corroborated his statement. His hands shook slightly as he ran his fingers though the hair above his ears. It looked like he was petting himself, as you might pet a cat, a self-soothing gesture.

Speaking quickly and almost without stopping for breath, Raul described how many of the feelings that he had bottled up while he was using drugs were coming up and it was overwhelming. He told me that he may have to quit treatment, because sitting with the other clients was causing him too much anxiety, as was going to AA meetings, which also required him to sit with other people and share his feelings. Raul alluded to his addiction being a symptom of something deeper when he said, “The addiction, you could call it the devil in disguise, whatever it is that, (makes an erupting sound) that eruption, it’s you know, those feelings…”

I was worried that Raul’s anxiety would take him out of treatment before he had a chance to experience any benefit. I suggested that he talk to his psychiatrist about an Ohlhoff approved medication for his anxiety. He spoke about how many other psychiatric medications he’d tried that hadn’t worked, but said that he’d also been using crystal methamphetamine at the time and that might have contributed to them not working. He already had an appointment set up with the psychiatrist and said he would discuss these issues with him.

During this session we also developed Raul’s treatment plan. The agency has a standard set of treatment goals that they suggest each client start with. Those goals are: 1)
Abstinence from all mind and mood altering substances; 2) Learn and practice relapse prevention tools; and 3) Build sober social support. After these three they can add anything that they might want to work on. Raul wanted to have only the standard three goals in his treatment plan; he said that was plenty.

At our third individual session I once again had to open with discipline issues related to the Ohlhoff rules. Raul had missed group therapy on Monday in order to attend a Madonna concert, and his meeting log was short again, meaning he hadn’t attended enough AA meetings. We had an awkward discussion in which Raul stated that he thought that he had been to enough meetings. I ploughed through his paperwork looking for where the disconnect had happened. It turned out that he misunderstood when each week began with regard to attending meetings. I struggled between my empathy and my role as the treatment center’s disciplinarian. The protocol was to give the client a “green slip,” which meant that the client needed to process their infraction with the larger group and seek support as needed. The green slip was meant to be a motivator to the client to be honest with himself and to strengthen his social bonds with the group; it was also seen by both the clients and the counselors as a punishment.

I pondered how much of Raul’s noncompliance was due to the “fog brain” of early recovery, how much might be resistance to being in the program, and how much was anxiety about sitting and talking with strangers. I decided that our therapeutic alliance was more important than discipline at this point in the treatment, and ended up not giving Raul a green slip, which was technically an infraction on my part.

I noted that Raul appeared much more at ease in this third session. His hands rested calmly for the most part and his laughter came more naturally. I mentioned this to
him. He said that he was doing much better, although he said that most of the past two weeks he’d been on “cloud nine.” After some questioning I ascertained that he thought that the term “cloud nine” meant spaced out, not happy. He hadn’t yet met with his psychiatrist but stated that he was “willing to do anything” to secure his sobriety including trying different medications for his anxiety and tapering off the lorazepam. He had also found a sponsor in the AA community.

At this session I introduced a DBT exercise called “Thought Defusion” from the *Dialectical Behavior Therapy Skills Workbook.* As I look back I realize that I betrayed my discomfort with this type of intervention by introducing it at the end of the session and telling Raul that we could look at it now or he could take it home and practice it on his own. He took it home and we never mentioned it again.

My feelings at this point were a sense of inadequacy and fear that Raul was going to drop out of treatment because of his anxiety and that I didn’t have any way to help him or keep him in treatment. I also began to think about him having PTSD and the dilemma that we were in at the substance treatment facility because while many of our clients had co-occurring substance use disorder and traumatic stress diagnoses, we had been advised that we were not to encourage a client to “open up” their trauma because it is advisable that the client first become stabilized with regard to their addiction.

At my individual supervision meeting that week my supervisor and I discussed Raul’s anxiety, his trauma history, and his difficulty sitting in groups. We discussed whether he might have PTSD. My supervisor noted that he might not have “textbook” PTSD but that he was certainly suffering from trauma-induced stress from the sexual assaults that was probably compounded by his childhood trauma. We also discussed my
reticence to give Raul green slips and other tokens of my role as disciplinarian, and the conflict I felt about the agency making Raul taper off the lorazepam when it had been prescribed by a psychiatrist and Raul appeared to be taking it responsibly.

In our fourth individual session Raul and I talked about his “drug and alcohol history,” an important step that each client undertakes in which they write out the answers to a set of questions about their addiction and then present it to their peers in group therapy. Clients are encouraged to be 100 percent honest, but Raul and I discussed whether he would be able to be that honest, and whether it was even desirable. During this conversation we did not specifically discuss his trauma, the “embarrassing things” that had happened to him, but it was the elephant in the room that day. I encouraged him to be completely honest while writing out the history, not to censor himself while he was writing because that would not be helpful to his healing. When he was done he could decide what parts to share in group and I could help him with that.

We discussed his upcoming trip to Mexico, and he said he had looked up the AA meetings in the area where he would be vacationing. That led me to ask him if he had ever gone to any AA meetings in Spanish. He said he had been to one, and that it had lasted two hours, and so he never went to another one. When I asked why it was two hours long he said, “they like to talk” and we both laughed. I then asked him about whether he felt bicultural and he said yes, and that maybe going to a Spanish AA meeting might be beneficial, “Cuz you know maybe I might express myself in Spanish a little better sometimes. Or maybe I express myself in Spanish in different ways than I express myself in English.” At this point there was a fairly long pause in our conversation, which was unusual because normally Raul talked in long run-on sentences with hardly a breath
for a break. I had brought up the subject, and although he followed me on it, he did not seem as comfortable with it as he did with other topics.

After a few long moments I asked him how his week had been, and he moved on to a subject that had probably been on his mind when he came into the session. Raul spoke about his outside therapist, a gay man whom he had been seeing for two years. Raul said, “…for the first time I wasn’t really happy about what my therapist had to say about me,” because he had suggested that Raul might have an eating disorder. We talked about why the therapist might have said that. Raul said that he had always been thin, that he had spent a month in the hospital for malnutrition and kidney failure, but that this was due to lack of hunger and thirst caused by methamphetamine use. He had also at one point taken Weight Gainer (a nutritional supplement) because people told him that he was too thin. In a later session Raul told me that he had also taken steroids during this time, but at this moment he said he never thought he was too thin, he just listened to people too much, but that he didn’t have a problem now; he was eating enough.

Raul added that he was feeling much more anxious than the week before. He was having a great deal of trouble staying present in the group therapy meetings, especially the friends and family sessions, when clients bring loved ones, because then there are new people to meet and this was very anxiety provoking for him. At this point Raul brought up that he “had some very bad experiences with people when I was using.” At that moment I began to get very sweaty and my face reddened to such an extent that I was sure he would notice it and make a comment. I could not concentrate and I felt an extreme desire to run out of the room.
As a trauma survivor myself this was the therapy moment that I had long feared. For many years I had dealt with my own issues around feeling trapped, sometimes having to exit crowded rooms and always choosing an aisle seat in theaters and airplanes. I had successfully worked through most of these issues, but one of my imaginal structures about being a therapist was that I would not be able to sit in a room for 50 minutes with a client. What if I started feeling trapped? Well, here it was. I sat through the session, and we began to talk about what this feeling felt like in Raul’s body, and as he began to calm down I realized I was calm too.

This experience could be conceptualized as projective identification, a concept first developed by Melanie Klein, and described by Waska as “…an intrapsychic and interpersonal phenomenon that draws the analyst into various forms of acting out. The therapist struggles to use understanding and interpretation as the method of working through the mutual desire to act out the patient's core fantasies and feelings.”² It could also have been an enactment of what Peter Levine describes as the desire for a “discharge of energy” to complete the physiological response to threat.³ In essence I wanted to run away for Raul. But I also accomplished a major milestone for myself as a new therapist; I sat through a moment of extreme discomfort and stayed present, both literally and psychically, to hold the container for Raul’s efforts to work through his trauma.

We went on to talk about other topics. Raul stated that he had tried to taper off the lorazepam by himself by cutting the pill and taking only half. He had been awake until 4am and then had taken the second half. I said that he should talk to his psychiatrist before he tried to taper off again.
It is protocol at Ohlhoff, when a client is on medications, to contact doctors or psychiatrists to confirm diagnoses, prescriptions and dosages. During this week I exchanged voicemail messages with Raul’s psychiatrist, although I never spoke to him in person, and he gave me information on Raul. Dr. X (pseudonym) had seen Raul three times in 2012, three times in 2013, and two times in 2015, and given him three “possible” diagnoses—anxiety, bipolar disorder and Attention Deficit Disorder (ADD). For the ADD diagnosis he had prescribed Strattera and Adderal XR. He gave these medications, he said, because Raul “…had tried (a relative’s) Adderal and it helped him.” Lamotrigine and Seraquel, which are medications for anxiety and bipolar disorder, had also been prescribed, but Raul had stopped taking them because they upset his stomach. He had prescribed Trazadone for sleep, which Raul discontinued due to side effects, and six months ago Dr. X had given Raul a prescription for lorazepam, with several refills. This was the prescription that Ohlhoff was asking him to discontinue.

This information raised a number of concerns for me. I did not know how to reconcile the various diagnoses that Dr. X had suggested. Was I supposed to consider that Raul had bipolar disorder, or that he had ADD, two diagnoses that Raul’s symptoms had not suggested to me? How could Raul have all of these disorders, I wondered.

The psychiatrist appeared to be operating on the assumption that the medications would tell him whether Raul had a particular diagnosis; if the medication helped then the patient had the disease. This, along with Raul’s confession that his psychotherapist thought he had an eating disorder, was the beginning of an issue that continued throughout my work with Raul. In the literature this issue is referred to as “split treatment,” defined as the concerns that arise when a psychiatrist and a therapist co-treat
a patient, although in this case it was even more complicated because instead of triangulation, it was quadrangulation, as Raul had a psychotherapist, a psychiatrist, and me, his substance use counselor.4 Goin describes one of the issues as “…the replication of the parent-child relationship, with all of its pleasures, pain, rivalries and potential transferences.”5 I felt that Raul might be playing one of us against the other, and I felt a sense of wanting to join with my client rather than siding with the other therapist, whom I didn’t even know. Riba speaks to the power of being prescribed a psychotropic medication, and all the meaning that might be ascribed to that prescription. She says, “This external agent, now incorporated into the patient, carries the power of transforming one’s inner sense of identity.” 6 This transformation, I learned, can also be extended to the other members of the therapeutic alliance.

In his fifth week of treatment Raul presented his “contemplation” in group therapy. A contemplation might be a poem, song, aphorism, prayer, or photograph—anything that helps a client with his or her sobriety. Raul played a song by Madonna called Devil Pray, a song with interesting lyrics that refer to Catholic religiosity. On the same night a young Latina woman joined the group. Raul instantly gravitated to her. I saw them sitting together and whispering, and Raul appeared animated and cheerful in her presence, more so than he was with many of the other clients. Ohlhoff clients are primarily male and white, although it usually has a large number of gay men. Raul later told me that he felt more comfortable with women than with men.

In our individual session Raul informed me that he had been to his psychiatrist and had been prescribed a medication whose name he didn’t remember. Raul had spoken to Dr. X for the first time about being sexually assaulted, and I found out later from Dr. X
that he had given Raul a new diagnosis, post-traumatic stress disorder (PTSD), and had prescribed Tenex for that diagnosis. Raul said that he was having severe stomach problems from the medication, although he said it had helped his anxiety. The psychiatrist had advised him to wait before tapering off the lorazepam, but Raul said that he had done it anyway the night before, by cutting his pill into quarters and taking $\frac{3}{4}$ of it.

In the context of sharing his Drug and Alcohol History with me, Raul then finally addressed the elephant in the room; he described the two sexual assaults that had occurred a few years prior. During the most recent one Raul was unknowingly drugged with GHB and assaulted while he was unconscious. When he woke up the next morning he kissed the perpetrator goodbye and thanked him for a “fun time.” Then he went to the emergency room and had colorectal surgery to repair damage caused by the attack. Later, his attacker sent him a taunting text message. The man said he had not used a condom and that Raul should be tested for the AIDS virus. I asked Raul if he had any relationships since then. He replied that he hadn’t had any “relationships” since his husband, that the rest were just “encounters.” I realize now that my imprecise language led me to misunderstand what Raul was telling me. Because I didn’t use the word “sex” I never learned exactly what Raul’s sex life had entailed since the sexual assaults.

When I first started writing this section I called Raul’s descriptions of sexual assault his “confession.” It was an illuminating word choice. Raul had talked about being Catholic and his conflicted feelings about the church. The word “confession” implies that he had something to be ashamed of or to atone for. In Imaginal Psychology these judgmental, restrictive states of mind are referred to as gatekeepers. According to Omer, gatekeepers are “…individual and collective dynamics that resist and restrict
experience…” In this case my gatekeeper formed a belief about Raul’s experience, his “confession,” before I had a chance to consciously examine whether this point of view was true or useful. By choosing the word “confession” my own gatekeeping was colluding with Raul’s, reflecting and reinforcing Raul’s internalized shame and silence.

I found Raul’s trauma story painful to listen to, but I realized that Raul and I had been dancing around these truths since he began treatment, and that my resistance to hearing what he had to say had perhaps kept him from speaking out until this moment, but that I had managed to make myself open to holding his pain. We then talked about how keeping this secret was familiar behavior for Raul, as he had been forced to keep the secret of his parents’ domestic violence during his childhood. It came out, I’m not sure exactly when, that Raul had been called to testify in court against his father. His mother had told Raul he had to lie, and he had done so to appease her, but it had rankled him ever since that he had been forced to lie in court.

The next week Raul delivered his Drug and Alcohol History to the group. I did not usually work that night, and I had apologized earlier because I wasn’t going to be there, but I changed my mind and came in to support Raul. Raul was very honest with the group, although he omitted some of the details of the sexual assaults, which I thought was valid self-protection. After the presentation Raul thanked me for coming and handed me the typed sheets from which he had read.

This seemed to me a significant milestone in our alliance. I felt that my willingness to hear and hold his story had allowed him to open up and receive the catharsis that comes with sharing the tale with his “tribe.” Peter Levine speaks of how indigenous tribes “catalyze powerful healing forces” by conducting rituals “in an
atmosphere of community support enhanced by drumming, chanting, dancing and trancing…” that acknowledge the trauma and welcome the member back. The Drug and Alcohol history, which is conducted in a ritualized fashion, with low light, is an approximation of this type of ritual. It is meant as a precursor to the “sharing your story” which is a staple of AA meetings, and has also taken the form of ritual.

Raul’s delivery of his Drug and Alcohol history to the group, and his frank discussion of his trauma with me and with his psychiatrist, represents to me a positive working of the balance that Ohlhoff seeks to draw in treating clients who have co-occurring trauma and substance abuse disorder.

In our sixth individual session Raul expressed satisfaction with the Drug and Alcohol history, and said that he was glad that he had been honest, and that he had felt supported by the men and women in the group. The medication he had been prescribed, Tenex, was still bothering his stomach, but he didn’t have an appointment with his psychiatrist until a week later and didn’t want to unilaterally take himself off it. He said that his anxiety symptoms were somewhat lowered, but that he still felt extreme anxiety at times. He said he had been trying mindfulness meditation but that he had trouble concentrating. I noticed that Raul seemed to feel a lot of shame about his inability to meditate.

We then had another episode where I had to “play the heavy” for the Ohlhoff program, because Raul had not attended enough AA meetings during three different weeks, which required me to give him a notice. Notices are a higher level of infraction than the green slip, and three of them can cause a client to be discharged. The counselor and the client fill out the notice, and then the client has to process it at the group level,
explaining what the problem was and ask for the group’s support in helping him to do better. Raul argued with me, saying that he attended sufficient meetings the previous week, and took out his own original meeting log to prove it. We counted up the meetings and he was correct, he had only had two short weeks, so it didn’t warrant a notice. I apologized, and felt relieved.

Also during the sixth week Raul’s urinalysis (UA) showed no discernible benzodiazepines, which meant that cutting his lorazepam pill in half had dropped the level in his blood below what the test could discern. This created an ethical dilemma for me, because theoretically he was supposed to be entirely off this medication in order to graduate from the program, but if it wasn’t being detected by the UA then he could stay on that dose and no one would be the wiser. I elected at this point not to tell him about the UA result while I tried to figure out what would be the best way to present this information to him.

Raul brought a female cousin to the next Friends and Family group. I was not there but the attending counselor wrote in his notes that Raul and his cousin spoke about the positive changes in their relationship as a result of Raul’s sobriety. During the course of treatment Raul brought two cousins to Friends and Family group, but none of his nuclear family, although he lived with his mother and stepfather and had two sisters in the Bay Area.

In the seventh individual session Raul once again had a short meeting log. He told me that he had not attended any AA meetings on the weekend because of the stomach upset caused by the Tenex, even though he had stopped taking the medication. He had met with his psychiatrist that week and been given a prescription for a different
medication but hadn’t filled it yet. He said that he was considering just trying to manage with no medication at all, because so many medicines produced side effects. He said that his stomach was still upset. Because he didn’t have a doctor’s note for his absence I still had to give him a green slip, which is a precursor to a notice, but also requires processing with the group.

As I reflect on our sessions, I realize that there were several avenues of inquiry that Raúl opened that I did not pursue. Raúl told me that his therapist thought that he had an eating disorder, and then in several sessions he described gastrointestinal symptoms, always attributing them to medications. In the one session we had after he relapsed and came back to Ohlhoff, Raúl admitted that he sometimes took laxatives and that the therapist “might” have been right about an eating disorder. Raúl’s weight always appeared normal to me, although he was slender, and it did not appear to fluctuate. I took him at his word when he said that he did not have an eating disorder. I also was aware of the need to keep the focus on his substance use issues. Looking back on it I regret that I did not follow up on these indications. I held a bias that eating disorders and body dysmorphia were seen mainly in women, and so I did not follow up on the signals that Raúl was sending me.

Raúl was down to .5 mg of lorazepam a night and had a second negative urinalysis, which I did not disclose to him. I ended up informing him of the negative urinalyses on the last session of his first treatment, after the insurance had refused to authorize further sessions and we were processing his termination.

Raúl brought up his therapist and again expressed dissatisfaction with him. Raúl had been seeing Eric (pseudonym) every two weeks while he attended outpatient
treatment at Ohlhoff, instead of his usual weekly visit. He said that he had asked Eric to
talk to Dr. X because sometimes Raul could not remember everything that he wanted to
say to Dr. X during his appointments. Eric had agreed, but when Raul asked Dr. X if Eric
had been in touch he said I was the only provider who had contacted him.

Raul said he’d been seeing his therapist for two years, and maybe he’d make more
progress with someone different. He also told me that Eric had been telling Raul that he
needed to “get out there” and date, and that he didn’t feel ready to do this, although he
agreed with Eric that it was something that he should do. I suggested he talk this out with
Eric before he made any final decisions, because the exercise of sharing his feelings with
Eric would be good practice for getting his needs met in the real world. It is interesting to
wonder how Raul held me at this time, as opposed to how he held Eric. He never referred
to me as his “therapist,” as did some of my other clients at Ohlhoff, yet obviously we
were talking about subjects that went far beyond sobriety, and he was asking me for help
with his relationship with his therapist. I felt the mother archetype being evoked, both in
the way Raul was treating me, and in the way I was feeling towards him.

I never contacted Eric during the course of treatment, and I don’t remember
thinking that I should do so. Looking back, it seems a logical step, and while I was
writing this case study I contacted my supervisor to ask him whether he remembered us
talking about this aspect of the case. He said that it was standard to communicate with the
therapists of shared clients, and he did not remember why I had not done it in this case. I
remember feeling at the time that the information that the psychiatrist gave me, with his
multiple possible diagnoses and multiple prescriptions, was not helpful, that it “muddied
the waters” of my ability to see Raul clearly and without bias. It may be that I
unconsciously did not reach out to the therapist for this reason. It may also have been that I was unconsciously siding with Raul as he expressed his annoyance with the therapist. Goin, in an article about split treatment, describes this dilemma: “…a countertransference wish to be the favorite parent may encourage a therapeutically destructive power struggle with the collaborating psychotherapist.” 

In the context of talking to me about what Eric thought he should be doing about dating, Raul brought up sex and intimacy, and spoke of how he would like to have these in his life again but that he didn’t feel ready. I relayed my understanding that his sex life before the trauma had been entwined with his meth use, which he agreed was true. I asked him whether he would need to work on how to have sober sex. I provided two referrals that my supervisor had given to me, for a sober sex support group at a local non-profit center and also a gay crystal meth users support group. Raul said that he would look into it, but he didn’t sound convinced, displaying again the ambivalence that he had shown before in wanting to begin his life again but feeling uncomfortable being in groups of gay men.

Raul brought a male cousin to the next Friends and Family group. The cousin had lived with Raul after Raul’s husband left him, during a time when Raul was heavily using methamphetamine. The cousin said how happy he was that Raul was seeking treatment. I attended this session, and I did not come away with a strong impression of the relationship between the two men, either positive or negative. The cousin spoke of how isolated Raul had been during that time, even though the cousin was living with him.

As I look back on it, I suspect that Raul had chosen family members with whom he had a friendly but more superficial relationship to come to these meetings, rather than
ask his nuclear family members, but unfortunately I did not think at the time to ask him about it. I suspected that his relationship with his mother and father was strained because of the childhood history of violence, even though he professed that he was getting along well with his mother currently. This is one theory, but it also quite possible that I did not understand the breadth of Raul’s family connections, and was displaying a cultural bias based on my own notions about what constitutes “close” family.

For our eighth session we met on a Monday instead of our usual Wednesday because Raul was leaving for a vacation in Mexico. Raul brought up gay men’s AA meetings, and told me that he had trouble sitting in meetings with gay men because of being assaulted, but that in fact he had been forcing himself to go to them to try to learn to be more comfortable around gay men again. He said it was helpful to be around sober gay men. Reflecting back, I realize that when I suggested attending groups specific to gay men and methamphetamine the previous week I had not thought about the fact that sitting with men talking about sex and crystal meth might be triggering for him.

In this session we also talked about Raul’s mother and father; about how Raul’s father was an active alcoholic. He talked more about the domestic violence perpetrated by his father against his mother, and also about violence his mother perpetrated against him. He said that he now had a relationship with his father and had forgiven him.

Raul spoke at various times about how much his stepfather, a white man, had been helpful and supportive of him. At another time he spoke of an argument he had with his mother and how his stepfather had stepped in to support his mother, a small sign that Raul’s relationship with the man was not as perfect as he indicated. He also spoke of his
stepfather’s Christian religiosity and his conservative politics, but again reiterated that
they had a good relationship despite these differences.

Although he did not often refer to it explicitly, Raul’s lived experience was what
Anzaldúa calls living on the borderlands. Referring to the three cultures of Mexican,
American and indigenous, Anzaldúa describes being “…cradled in one culture,
sandwiched between two cultures, straddling all three cultures and their value systems,
the mestiza undergoes a struggle of flesh, a struggle of borders, an inner war.” Raul
never made explicit to me whether he experienced this straddling of cultures as a war or
as something more benign, but it was clear that the aspects of his identity were more
islands than contiguous landmasses, and travel was required to move between them.

When Raul returned from his vacation in Mexico. I was surprised to hear that he
been at a resort in Cancun. I had imagined him, not in a tourist context, but rather in some
sort of family home more in the interior of Mexico. Once again this points to assumptions
that I made about Raul’s cultural location, which leaned toward expecting him to be more
traditionally Mexican, rather than occupying the cultural borderland that appears to have
been more his home at this time.

He described having a great time scuba diving, saying it reminded him of his
favorite movie, The Little Mermaid. There were some very interesting archetypal and
mythological connections to draw from this, as I thought later about Raul and what
formed his identity, and The Little Mermaid story became the basis for the Primary Myth
section of this case study.

Raul mentioned that he had put an app called Scruff on his phone while he was in
Mexico, “just to see who was around,” but that he had not used it to meet anyone. He
then said that he had used Scruff to meet up with men to use meth and have sex, that he had removed it from his phone when he got sober, but that now the app was still on his phone. He had also received a message once he was back in the States from a former using and sex partner, who invited him to meet up. He had not replied.

I told Raul that I was very concerned about the fact that the app was still on his phone, and I urged him to talk to his sponsor about this. I was thinking, but did not say, that his sponsor was a gay man and would perhaps be able to relate better than me. I urged Raul to be “rigorously honest.” Raul laughed and told me that he wasn’t “100 percent honest with anyone at this point in my life.” I felt disappointed and hurt. I felt that Raul was in some way telling me that he couldn’t be honest with me, and it made the breakthroughs we had had seem diminished because I wondered whether they were real, or if Raul was just telling me what I wanted to hear. I also felt inadequate, and worried that my resistance to his disclosures about trauma and sex had closed Raul off from me.

When he did not turn in his meeting log at group later that night I emailed Raul and asked for it. He had not attended any AA meetings in Mexico, despite our conversation and his writing of a safety plan. I also noted that Raul’s anxious tics were back in full force during this session.

There is no mention of Raul’s upcoming insurance review in my notes about the session, and I do not remember whether I mentioned it to him. At the time I was not aware that people often get cut off in mid-treatment, and so I may not have warned him, as I learned to do with other clients later in the year.
Legal and Ethical Issues

The legal and ethical issues that arose concerning my work with Raul included the following: considering whether I was adequately serving Raul, given our sociocultural differences; the conflicts between the multiple roles that I fulfilled as an intern at Ohlhoff Outpatient Services, including being Raul’s individual therapist as well as a group facilitator; being the enforcer of the agency’s rules as they pertained to Raul; and the ramifications of my interactions with Raul’s medical insurance company. There were also ethical concerns about *split treatment*—the fact that Raul was being treated by multiple providers, including a psychiatrist, psychotherapist, and an internist. Every interaction I had, or did not have, with these providers influenced the dynamics between Raul and myself and the experience he had at Ohlhoff.

With regard to the topic of our sociocultural differences: there was no therapist at Ohlhoff who exactly matched Raul’s sociocultural profile, but it remains an open question as to how much better he would have been served by someone who was more demographically similar to him. He himself did not seem concerned about our differences, and he even noted in our last session that I was “the right person” for him, but in the course of writing this case study I encountered instances when I “dropped the ball” because of my lack of awareness of clinical factors that can affect clients like Raul. The most obvious example was when he dropped hints about having an eating disorder. He spoke of taking laxatives, and mentioned having a “system” when it came to eating. He told me that his psychotherapist thought he had an eating disorder, but said he was angry at the psychotherapist and denied the diagnosis. During my research I encountered information about a type of body dysmorphia particular to gay men that could have shed
light on the question of whether Raul had an eating disorder, but the fact that Raul had been confronted by his psychotherapist and denied it only deepens the complexity of this issue. And this is only one aspect of the many layers that constituted Raul’s identity.

I was Raul’s individual therapist, as well as a facilitator of group therapy that Raul attended. The ethical and legal issues that arose from that had to do with confidentiality issues, as well as the fact that the roles sometimes conflicted. Raul was very anxious in group therapy. He sometimes called in sick because he couldn’t face being around so many people and being expected to talk in front of them. As his individual therapist I felt a great deal of empathy towards Raul’s condition, but as his group facilitator, and the enforcer of the Ohlhoff rules, I had to question whether Raul was actually sick, and I was expected to take disciplinary action when I knew that he was not physically ill. In fact, on the one occasion when this happened I did not take disciplinary action because of my empathy for Raul, which then put me at odds with the agency.

It was protocol at Ohlhoff for a client’s individual counselor to also be the enforcer of the rules that clients were expected to follow. Counselors monitored the urinalyses that clients submitted, they followed up with sponsors to make sure that clients were attending AA meetings, and they gave clients “green slips” for rule infractions. The first green slip meant that the client needed to process their infraction with the peer group and seek support as needed. After three green slips the client was put on notice that they might be expelled from the program. Green slips were meant to be a motivator to the client to be honest with him or herself, and to strengthen his social bonds with the group; it was also seen by both the clients and the counselors as a punishment.
There were a number of incidents with green slips that occurred with Raul which I discuss in greater detail in Chapter Three, so it will suffice to say here that being both Raul’s therapist and the enforcer of these rules put me in an awkward ethical situation, where I often felt that my duty to him was at odds with my duty to the agency. At times I neglected to give Raul green slips that were warranted, which made me feel guilty towards the agency, and at other times I did give a green slip, which caused me to feel resentful of the agency. I understand why the agency had these rules, and I do agree that they were necessary, but having the individual counselors enforce them for their clients seemed to me to create a conflict of interest. It might have been less of a conflict if the management or the administrative staff managed the green slips.

Another ethical concern was my duty to interface with the insurance company on Raul’s behalf, which caused me to feel that his benefits cut-off was a personal failure on my part. Conferring with them also raised confidentiality concerns, because during his insurance review I was required to report details of Raul’s treatment, such as medications and dosages, and his meetings with his psychiatrist, his psychotherapist and his AA sponsor. I felt that the insurance care manager was using this plethora of information to bolster her case to discontinue coverage, and to move the onus of responsibility onto me, but I felt that if I did not answer her questions then they would deny coverage because of my lack of transparency. My interactions with the insurance companies were some of the most ethically questionable experiences of this internship.

During his treatment at Ohlhoff Raul continued to see a private psychiatrist and psychotherapist. I was expected to confer with the psychiatrist to check diagnoses and medications. I was not required to speak with the psychotherapist, and I did not, although
I now believe I should have done so. I discussed the issues of split treatment with my supervisor, and recounted how I was affected by the several diagnoses that the psychiatrist offered. I was pulled between my deference to the psychiatrist as an authority figure and my discomfort with the accuracy of his diagnoses. I also discussed with my supervisor the conflicted feelings generated by Raul’s reports of anger at his psychotherapist and his psychiatrist for diagnoses they had given him; diagnoses that I heard directly from the psychiatrist and indirectly from the psychotherapist through Raul. At various times I felt rebellious towards Raul’s psychiatrist and psychotherapist, when I sided with Raul against their diagnoses. Goin, in an article about split treatment, describes this dilemma as “…a countertransference wish to be the favorite parent…” 12 I also at times felt inadequate to bring their disparate opinions into consensus so that I could feel comfortable with Raul’s diagnosis.

The multiplicity of roles and responsibilities that I held created a complicated ethical landscape. Some of this would have existed had I just been Raul’s psychotherapist, but much of the complexity was created by the organizational structure of Ohlhoff Recovery Programs, which expected interns to act as both therapist and disciplinarian to their clients. In some ways it was not unlike a private psychotherapy practice, in which the therapist, by establishing rules and norms, creates a “container” in which the client can feel safe to explore deep feelings. But in the case of substance use treatment the “container” extends beyond traditional psychotherapy boundaries, into demanding clients stop using certain substances, for example, so someone who is trained in a traditional psychotherapeutic model rather than a substance use treatment model is going to find the role challenging, as I did.
Outcomes

Raul came in for his final session ten days after his last group therapy session and two weeks after our last individual therapy session. He looked calm, even happy, and his laughter was more synchronous with the content of what he was saying, but he still displayed the habit of stroking his hair above his ears with both hands. He reported that he was doing “really well.” He was attempting to replicate the structure of intensive outpatient treatment by attending five to seven AA or CMA meetings per week, meeting with his therapist biweekly, and with his sponsor weekly. He had cancelled an appointment with his psychiatrist that week because he feared the side effects of any medication Dr. X might give him. He felt he was doing well on his own, although he was still taking .5 mg of lorazepam at night for sleep. He said that what had changed for him during treatment was that he used to worry about what other people thought of him, and let that rule his behavior. Now he realized that the only person he needed to please was himself. This statement seemed so perfect that I wondered whether he was making it up for my benefit, but he seemed genuinely happy. When I spoke to my supervisor about it he brought up the concept of the “flight to health” and said I should wonder about it, since the client was so abruptly cut from treatment, but on the other hand Raul still had a lot of support in place, which was easy to discount because I was only seeing what he was doing at Ohlhoff.

Raul had found a new apartment with roommates and was planning to move from his mother and stepdad’s in January. His understanding was that his new roommates had interviewed many people but had chosen him, and he felt very appreciated, like he had won a contest. He revealed to me that he had been living at his mom and stepdad’s for
much longer than he had told me, and that he hadn’t been truthful about it because he’d been embarrassed.

Raul spoke excitedly of a great many plans during this session. He mentioned he wanted to join a soccer team, to do volunteer work, to go back to school and to change jobs. But he also said that he realized that he was a work in progress and that he was going to take things very slowly. When I asked him about dating he said that this was on hold for now, until he felt more stable.

When I asked him during this session if he would be willing to be my case study subject he readily said yes. He likened being chosen for the case study to being chosen for the apartment. He said that people were noticing something special about him, and that made him feel good.

As part of the exit packet I asked him to fill out, Raul took the DASS assessment again. His post-treatment DASS scores indicated that he went from extreme anxiety, depression and stress to normal levels within the ten-week course of treatment.

<table>
<thead>
<tr>
<th></th>
<th>Post-treatment Scores</th>
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<tbody>
<tr>
<td>Anxiety</td>
<td>8 (0-7 = Normal, 8-9 mild)</td>
</tr>
<tr>
<td>Depression</td>
<td>8 (0-9 = normal)</td>
</tr>
<tr>
<td>Stress</td>
<td>13 (0-14 = normal)</td>
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I was happy that Raul seemed to have achieved such improvement from his ten weeks of treatment, and I did not doubt that he actually felt better and more secure, but I worried that the effects would not last. One of my imaginal structures was that no one with post-traumatic stress disorder as a result of sexual assault improves with such short term treatment, but on the other hand Raul had been working with a therapist for two years before he came to treatment, and so I hoped that perhaps he may have been
subconsciously ready, and that was why he chose intensive outpatient treatment at this moment in time. I also held the awareness that Raul had been in treatment twice before and had achieved months of sobriety, only to relapse again.

Four months later Raul returned to treatment after a relapse. He underwent an updated assessment with the program director, and asked her if I could be his counselor again. One of the ironies of insurance coverage for substance use treatment is that the insurance company will authorize further sessions if a client relapses, so they authorized twelve sessions for Raul, which would have covered him for one month.

When I saw Raul for an individual session he looked thinner than I remembered. He displayed several nervous symptoms, including shaking hands, moving around in his chair, and laughing nervously. He said he was doing well, except for this “slip-up,” as he referred to the relapse. He said he had been going to AA and Narcotics Anonymous meetings, but had been having problems because when he opened up and shared people “took it wrong” and got too close. He said that men at meetings had kissed him and propositioned him. I asked him if he had sex since I saw him last and he said “not exactly.”

Raul mentioned that his new living situation was very good, but now that he was away from his mother “stuff” was coming up for him from his childhood. He then said, “My mom is a fucking bitch,” laughed and said, “I love her, but…” and then repeated the comment.

Raul recounted a harrowing encounter with law enforcement that had occurred during his recent relapse. Raul had answered a Craigslist ad from someone who said he was a straight man who just wanted someone to use and hang out with, and that sounded
appealing to Raul, so he went to meet the man, bringing drugs with him. The man was an undercover cop. The cop ascertained that Raul wasn’t a dealer and let him go with a warning. After being released he went to his dealer in the Tenderloin, who gave him a big rock of methamphetamine. He put it in his pocket and then went out in the street but “freaked out” that people were following him, so he went to a hotel room and flushed the drug and ran back home. Raul felt he needed to get control of the situation quickly because the police officer had taken his information, and now Raul was afraid of what might happen if he were caught again.

When I asked what had led up to the relapse he said that he felt it coming for two to three weeks before it happened. He had talked to his sponsor but the sponsor said it was just thoughts and not to worry about it. He had called his therapist, but Eric was on vacation. He said also that he had been having a lot of stomach pain, and then admitted that the pains were related to not eating, and said that Eric had brought up the notion of an eating disorder again and that he still was “pissed” about it, but said that he was thinking now that it may be true. He said he had been taking laxatives leading up to his relapse.

Raul said that he just needed a “tune up” and that the month that the insurance gave him might be all that was necessary. He said he had missed a week of work after the relapse and his nurse practitioner had given him a doctor’s note, but that he was in trouble at work because of all the missed time. As we said goodbye we exchanged some information about meeting times for the following week. I had no idea that this would be the last time I would see him.
Six days later Raul sent an email asking me to call him. When I called back he said he was thinking of dropping out of the program. He said he was overwhelmed, and that all the time spent in groups and in therapy was too much for him. He was behind at work because of missing a week and he didn’t want to miss out on the practices for the softball team he had joined. He said that he knew what the problem was; that there was just “one thing” that needed to be worked on. I asked if this thing had led to his relapse and he said yes. I asked if he had talked about it with his therapist and he said yes, but did not elaborate on what the thing might be.

I said I was worried about him relapsing, because being overwhelmed was a big cause for relapse. He said he realized this, but that he had run to Ohlhoff too quickly, and that he thought if he just made sure he was going to his meetings and working through this “one thing” with his therapist, everything would be all right. I asked, “Are you sure about this?” He said, “Pretty sure.” I asked him to take a couple of days to make the decision. Two days later he emailed and said he was withdrawing. I called him and he confirmed that he did not want to continue in the program. I said that I was happy to have seen him, even if the circumstances were not the best, and told him that we were here if he changed his mind.

Three months after his brief return, and a week before the end of my internship, Raul called the office and asked to speak to me. He also emailed me. I wasn’t in that day, and it was a Friday, so I called the following Monday. The program director also phoned him back on the day that he called. He never returned any of our communications during my last week of internship, and if he called back subsequently I will never know.
Raul was the only client I heard from after their treatment ended. When I told my supervisor that Raul had returned to treatment and asked for me, my supervisor’s response was, “Of course he did!” The tendrils of our relationship are still wrapped around me, especially as I write this case study, and although I feel there is unfinished business in the therapeutic space between us, I also feel our story had a beginning, middle and end. I hope Raul continues to work on himself—whether it is in Alcoholics Anonymous, therapy, sports, volunteering, or some other endeavor—to achieve the peace of mind that he so richly deserves. I hope our relationship, as brief as it was, was emotionally satisfying for him. I hope I provided him at least a small measure of what he gave me by trusting me with his story.
CHAPTER 4

LEARNINGS

Introduction

In this chapter I take a wider perspective on the experience of working with Raul while he struggled with his addiction and the consequences of his early childhood trauma and the traumas he suffered in his recent past. I examine how I was affected, what meaning I make of my own and my client’s imaginal structures, how we affected each other, and how theories from different psychological perspectives about the causes of addiction and the consequences of trauma can inform this meaning making. A mythic dimension was added when Raul brought the fairy tale *The Little Mermaid* into the room. I explore the archetypal and mythic dimensions of the mermaid, a creature both ancient and modern, whose very body represents a crossing over between two distinct environments, and how her story relates to Raul’s lived experience.

Key Concepts and Major Principles

The key concepts and major principles that give meaning to my work with Raul include the following: the conclusion of van der Kolk that a “circular relationship” between trauma and substance abuse exists, in that drugs or alcohol ease the symptoms of trauma while withdrawal from the substance intensifies those same symptoms, leading to a higher rate of relapse for those with dual diagnosis; Dodes’ concept of substance use as
a means of fighting intolerable helplessness; Flores’ view of addiction as an attachment disorder treated by developing a capacity for healthy interpersonal relationships; González-Guarda, McCabe, Leblanc, De Santis, and Provencio-Vasquez’s definition of a syndemic as “…co-occurring epidemics or conditions that interact with one another to disproportionately impact the morbidity and mortality of marginalized communities,” and their identification of a syndemic resulting from the combined effects of substance abuse, violence, HIV risk and depressive symptoms among Hispanic men; Gideonse’s description of the shaming and villainization of gay users of methamphetamine; Bruce, Ramirez-Valles, and Campbell’s depiction of the complex, intertwining relationship between stigmatization, substance use, and sexual risk behavior among Latino gay and bisexual men and transgender persons; and Anzaldúa’s literary interpretation of the borderland inhabited by gay Latinos and Latinas in the United States.¹ Also important is Jung’s concept of addiction as a search for wholeness that can only be fulfilled by a union with God; and Schoen’s expansion of Jung’s assertion to include a non-dual perspective on a higher power as the cure for addiction.²

What Happened

One of my earliest experiences of Raul was watching him in a group psychotherapy session, zipping his jacket to his chin and unzipping it, again and again. As I looked back on it when our work together was over, this simple movement typified Raul’s ambivalence, his desire to step into sobriety, to begin asserting himself and his right to exist in the world as his authentic self, and his fears that his exposed self would be hurt, exploited or deemed unlovable. Flores says, “…addicts feel at their core that
they are unworthy or defective in some way. Their chemical use is way to combat their feelings of worthlessness and contributes to their false-self formation.”

Raul’s anxiety and depression increased during the first few weeks of his treatment, consistent with van der Kolk’s description of how withdrawal from substances can intensify trauma symptoms. In our second session, Raul described how he felt when another client asked him a simple question about how he was feeling. “I was like, don’t say okay if you’re not okay. I mean, I’m not. I’m really not, to be honest. I think because I’m starting to feel things and recognize where I am and recognize what has happened.” Raul’s anxiety spiraled, reaching intolerable levels that caused him to call in sick and miss sessions, and then ebbed and allowed him to participate and have periods of connection with me and the other clients in treatment.

Raul described an early history of abusive treatment by his parents, in which he witnessed many scenes of domestic violence between his parents and called the police multiple times when he was very young. He recounted a time when he was seven or eight years old and was called to testify against his father and his mother coerced him into lying to the authorities so that his father would go free. Raul expressed regret that he was not able to tell the truth, because then “…maybe I would have gotten the help I needed.” By being forced to lie, Raul was forced to deny his own needs and the reality of what was an untenable situation, in the service of maintaining a relationship with his mother. As van der Kolk describes it, “Erasing awareness and cultivating denial are often essential to survival, but the price is that you lose track of who you are, of what you are feeling, and of what and whom you can trust.”
Another developmental trauma that Raul experienced was a cultural dislocation. Raul was raised until the age of six in a deeply interconnected Latino community, which he described in this way in his written Drug and Alcohol History: “Spanish was the primary language spoken until I was five years old. Holidays were celebrated with piñatas, fireworks, the dead were honored in festivals, and Christmas was celebrated in a parade-like fashion, walking in and out of neighbor’s homes like family members… There were lots of parties, there was always an excuse for a celebration. Baptisms were celebrated like weddings, and weddings would never end, with bottles of tequila on every table as if it was water.” When his parents achieved a level of financial success they moved the family to a white neighborhood and enrolled Raul in a predominantly white Catholic school, where he was bullied both for being Latino and for being gay.

But while Raul yearned for the home of his early life he also acknowledged that the culture of his birth created its own dislocations for him as a homosexual, stating that his parents were ashamed of him for being gay, and alluding to them trying to “beat the gay” out of him. Gloria Anzaldua describes the dilemma of being gay in Latino culture in the following way: “We’re afraid of being abandoned by the mother, the culture, la Raza, for being unacceptable, faulty, damaged. Most of us unconsciously believe that if we reveal this unacceptable aspect of the self our mother/culture/race will totally reject us.”

Raul’s pattern of engaging and then withdrawing from his mother, his husband, his therapist and psychiatrist, and the psychotherapy group at the agency, were all evidence of a disorganized attachment style. Bowlby and Ainsworth originated the studies of infants that culminated in the development of a theory of four different attachment styles that infants develop, based on the availability of their caregiver to
provide a base of security from which the child can explore their world, but the theory has been extrapolated by many others as the etiology of certain psychological disorders. In Raul’s case the relevant extrapolations are from Flores and van der Kolk. Flores attributes addiction to insecure attachment: “Experiences related to early developmental failures leave certain individuals with vulnerabilities that enhance addictive type behaviors and these behaviors are misguided attempts at self-repair.” 6 Van der Kolk describes how children who have been subjected to disorganized attachment, which is a developmental trauma in and of itself, often are then subjected to further trauma in adulthood. “If you have no internal sense of security, it is difficult to distinguish between safety and danger. If you feel chronically numbed out, potentially dangerous situations may make you feel alive.” 7 Therefore, individuals with disorganized attachment are at a higher risk to suffer trauma in adulthood, as Raul did with the sexual assaults he endured, and to develop psychological symptoms as a result of these traumas. Van der Kolk says, “In practice it is often difficult to distinguish between the problems that result from disorganized attachment and those that result from trauma: They are often intertwined.” 8

During the session when Raul recounted to me the specifics of the two sexual assaults he suffered while he was using methamphetamine, I found myself flooded with a desperate feeling of panic and overwhelm. As my face flushed red and I began to sweat, I imagined myself running out of the room. But I felt trapped by my role as Raul’s therapist and extremely aware of how inappropriate it would be for me to leave. I worried about whether he was noticing the red flush, and wondered what he was thinking about me. Looking back on it, I can see that this was an incidence of projective identification, a concept first developed by Melanie Klein, and described by Waska as “…an intrapsychic
and interpersonal phenomenon that draws the analyst into various forms of acting out. The therapist struggles to use understanding and interpretation as the method of working through the mutual desire to act out the patient's core fantasies and feelings.”

Raul had been assaulted while unconscious, and when he woke up later, knowing from the pain that something terrible had occurred, he still thanked the man who had assaulted him for his hospitality in hosting him for the night. I felt in my body Raul’s incomplete action of running out of the house, or fighting back, or somehow reclaiming the lost power of this interaction.

Had I known at the time what was going on, I might have used this feeling to help Raul process the somatic sensations in his own body. As it was I acknowledged that I was uncomfortable, asked him if he was feeling the same way, and told him how honored I was that he was willing to share this material with me, and how important it was for him to feel that he did not have to bear this burden alone and in shame.

Treatment providers and researchers are divided in their theories of what causes addiction and what is the best method for treating it, and Raul’s experience mirrored this dichotomy. From the agency where I worked he received the message that addiction was a spiritual disease that was best treated by reliance on Alcoholics Anonymous and on a higher power. This model told him that he should not use any potentially addictive medications, such as the lorazepam that he took for sleep, even if they were provided by a physician. The other end of the spectrum was represented by his psychiatrist, who provided a number of different medications in the search for the one that would be the “cure” for the various disorders from which Raul was potentially suffering. I felt myself pulled in both directions while I enforced the agency’s rules against potentially addictive
medications and simultaneously supported Raul’s choice to take them on the advice of his doctor. In my ambivalence I embodied the schism between the two points of view, because as an intern I was trying to please everybody while simultaneously working to form the opinions that would inform me when it was my turn to decide on the rules.

At the end Raul and I were both buffeted by forces beyond our control, when Raul’s insurance coverage came up for review. I underwent an hour-long interrogation by an insurance representative, after which they denied any further service for Raul, because in their opinion he was doing so well that he did not need outpatient treatment but could rely on Alcoholics Anonymous instead. My powerful feelings of failure and guilt could be attributed to countertransference, that I had taken responsibility for Raul’s sobriety and had failed him during my interview with the insurance representative, or it could be looked at as an imaginal structure, perhaps the Perfect Mother, who had failed in her attempt to save her child. Both interpretations are equally apt, I believe.

**Imaginal Structures**

**How I was Affected**

Although I only saw Raul for a few months, I felt deeply connected to him and he expressed similar feelings about me. I had been initially concerned about whether I would be a good “fit” for him, because of our obvious differences (gender, sexuality, race, age, religion). We shared some deep commonalities in our life histories, but Raul had experiences that I did not share or have much understanding of, and this probably hampered our work together. For example, when Raul spoke of his psychotherapist
saying that he had an eating disorder, my preconceived notions probably kept me from asking helpful questions about what this diagnosis might mean for Raul. As I looked back over the transcripts I saw that he brought it up several times, and that at one point he told me that had taken steroids and Weight Gainer because “...everyone around was talking about how skinny I was,” but at another point he admitted to taking laxatives and to controlling when and what he ate. He said, “I just have a system when it comes to eating.”

Raul looked normal to me, albeit slender, which I ascribed to the malnutrition he had experienced while using methamphetamine. Therefore when Raul described his anger at his psychotherapist for conjecturing he might have an eating disorder, my countertransference and my assumption that eating disorders were a mainly female issue caused me to side with Raul in thinking that the psychotherapist was incorrect.

This experience also addresses another area of clinical significance—the relationship between Raul’s other care providers and me. I found myself being pushed and pulled in Raul’s interactions with his other care providers, his psychiatrist and his psychotherapist. When Raul told me about his psychotherapist’s diagnosis he was angry about it and seemed to be seeking for me to join with him against his psychotherapist, which I did, rather unknowingly.

I felt this sense of triangulation again when I conferred with the psychiatrist and he told me that he had given Raul three possible diagnoses—anxiety, bipolar disorder and Attention Deficit Disorder (ADD) and treated him with medications for all of these, before he later diagnosed him with PTSD after Raul told him about the sexual assaults he had suffered. I felt the psychiatrist was putting the cart before the horse, trying a medication and if it alleviated symptoms then assuming that the patient must have the
disorder that the medication treated. For patients this sense of triangulation manifests when one professional does something the patient doesn’t like, then they can turn to the others, and for the clinician it can manifest as both siding with the other clinicians against the patient or vice versa.¹⁰

Another version of triangulation occurred between me, Raul, and Ohlhoff Recovery Programs. I identified with Raul on many levels, and this may have helped our progress in some ways and hurt it in others. I sided with him in my mind, if not my actions, when I was required to insist that he taper off from the benzodiazepines that he took for sleeping. I was reluctant to give him the green slips that constituted infractions of the clinic’s rules, and didn’t give him some that were warranted.

I experienced a sense of projective identification in the fourth session. Raul raised the subject of the sexual assault, and I had a strong somatic reaction of panic and a desire to run out of the room. My ability to tolerate these feelings and stay present for my client both increased my empathy for him and probably his trust in me.

I blamed myself when Raul’s insurance company terminated his treatment, feeling that if I had been a more experienced clinician I would have known the “magic words” to say to the insurance company so that they would see the necessity of paying for more sessions.

My Imaginal Structures

I have named the imaginal structures that affected me during my work with Raul as The Hurt Child, the Perfect Mother, and The Wise Woman. The Hurt Child has been with me all my life, limiting my experiences in the interests of trying to keep me safe from traumas I experienced in my childhood. The Perfect Mother manifested in my early
adulthood, as I began my working life, and grew more powerful when I became an actual mother. The Perfect Mother believed the 1960’s psychologists who argued that everything from addiction to homosexuality was caused by bad mothers. I told myself that if I were perfect then my children would be perfect. As I began seeing clients the Perfect Mother believed that her actions alone would secure a client’s success or failure. The Wise Woman was a positive structure that allowed me to be comfortable with my power and expertise, and to be present with my clients while still maintaining healthy boundaries.

The Hurt Child showed herself in my interactions with Raul when we were processing both his early childhood trauma and his recent trauma. The Hurt Child wanted to protect Raul from further harm and was willing to break rules to do it, because these were rules neither of us had created. My Hurt Child huddled with Raul’s Hurt Child, defending against the rules of the agency, against the demands and diagnoses of his psychiatrist and his psychotherapist. My Hurt Child shared the shame of what had happened to him, because she believed that he had caused it, and even in her magical thinking believed that if he spoke the words of his truth he would bring more punishment down on both of us. The Hurt Child wanted to protect both of us—through our hiding, our silence, and swallowing our shame.

The Perfect Mother sounds like she would be the one to triumph in Raul’s successes and take responsibility for them. And she did, but her primary activation was when I perceived that I wasn’t doing a good job. She showed up whenever I experienced a success with Raul, and also whenever I perceived a setback. The perfect Mother is a narcissist. She imagines that everything is about her. The Perfect Mother felt inadequate
when Raul called in sick to group and then said that he had been too anxious to come. She felt responsible when Raul’s insurance cut him off, and she felt proud when it seemed Raul was choosing me as his “favorite” of his therapists, and finding fault with the others.

The Wise Woman is the imaginal structure that is able to admit that she is wrong, or uncomfortable, or unsure about what to do. The Wise Woman was the one who stepped in when Raul was trying to speak about his trauma and I experienced physical symptoms of panic that interfered with my ability to present in the moment. The Wise Woman was able to admit to Raul that this was uncomfortable for both of us, but that it was right for us to continue, which alleviated the anxiety. The Wise Woman was able to tell Raul that she felt conflicted about her dual role as both his counselor and the enforcer of the agency’s rules, which made it easier to straddle this divide.

The Client’s Imaginal Structures

The imaginal structures that Raul manifested during our work together included the Hurt Child, the Rebel, and the Adept Traveller. Raul’s Hurt Child met my Hurt Child as we discussed the issues of Raul’s childhood and adult trauma, and also in his anxiety and discomfort in the groups. The Rebel appeared when Raul broke the rules of the agency and then argued with me about them, when he became angry with his psychotherapist and disagreed with his diagnosis, when he called his mother “a fucking bitch.” The Rebel was both protective of Raul but also led him into behaviors that were counterproductive to his sobriety, because the Rebel had a “to hell with it all” attitude.
The Adept Traveller was the imaginal structure that allowed Raul to navigate the intersectionality of his identity, to cross back and forth between the multiple worlds that he inhabited. The Adept Traveller was at home in the traditional Hispanic world of his mother and father, to attend church and quinceañeras, to visit family in Mexico and to attend Spanish speaking AA meetings, as well as the white world of his workplace and the dominant culture at large. The Adept Traveller was also able to navigate in multiple gay worlds, including the underground one that combined drugs and sex.

The Adept Traveller was successful, but that success came at a cost, as the Traveller had to hide certain aspects of his identity to be accepted in the different worlds, so the Traveller had to be bifurcated, not integrated. I believe the Adept Traveller imaginal structure exists in some form in most adults who grew up in unpredictable environments. The Adept Traveller is required to “put on a good face” in order to protect his or her parents from the judgments for the outside world and sometimes even to keep the family intact, as was the case with Raul lying to the court about the domestic violence in his home. Being an Adept Traveller makes it much easier to navigate between different worlds, but the Adept Traveller wears so many costumes it is sometimes difficult to know internally what is real, and therefore to trust when other people are being authentic. At its worst this amounts to soul loss, or “depersonalization,” as James Hillman and Archetypal Psychology would define it. In this state, as Hillman says, “All particular functions of ego-consciousness operate as before; associating, remembering, perceiving, feeling, and thinking are unimpaired. But one’s conviction in oneself as a person and the sense of reality of the world have departed.” ¹¹
New Learnings About My Imaginal Structures

I discovered that the Hurt Child could allow me to use my projective identification to access areas where shame might be impeding my client’s ability to access their experience and to reflect on the affects that experience has evoked. In essence, the Hurt Child could recognize another Hurt Child, and go with them to places where an adult might not be able to go. But the Hurt Child could also limit access to affect because of shame, both my own and Raul’s, because the Hurt Child did not have the language and the mature ability to transmute shame. Instead she could only cower and hide, and invite Raul to cower with her. The Hurt Child colluded with Raul against the rules of the agency, and sometimes let him down by not holding him accountable.

The Perfect Mother made me a ferocious ally, and aided me in going above and beyond the requirements of my internship to try to ensure success for my clients. The Perfect Mother thought nothing of coming in on her days off and of spending hours on the phone trying to negotiate further insurance benefits for my clients; the Perfect Mother scoured textbooks and websites for the perfect group therapy exercise or mindfulness tool. The Perfect Mother worked on her birthday and over Christmas and New Year’s Day. But the Perfect Mother was also resentful when her work wasn’t appreciated and frightened when her work didn’t have the benefit she had hoped it would. The Perfect Mother blamed herself and blamed her clients for relapsing, rather than take it in stride and help her clients to do the same.

I learned that the Wise Woman was a more mature form of the Perfect Mother. In fact, I might have called this structure The Good Enough Mother, except that the mother archetype doesn’t encompass everything that the Wise Woman embodies. The Perfect
Mother hampered me, because if I thought of myself as my client’s mother, then I had to take on more responsibility for their healing because they, by extension, were not fully mature and able to take an “adult” role in their own healing. The Wise Woman could allow others to take responsibility for themselves, and in the case of the clinical team, even to take responsibility for the Wise Woman if she needed support. This happened when I cried in front of the team after Raul was denied insurance coverage. One of the other therapists wrapped me in a big hug and told me I’d done everything possible, and I was able to take in their love and support. The shadow side of the Wise Woman appeared when she denied that she needed help, or that she sometimes needed mothering too. Raul had been hurt, and struggled with letting others in. So did the Wise Woman and the Perfect Mother, as they pretended that they could be all things to all people without asking anything for themselves.

**Primary Myth**

In one of our sessions Raul described an ecstatic experience of scuba diving in Mexico. He likened it to the Disney movie *The Little Mermaid*, which he stated was his favorite movie. As I looked for a myth through which to explore Raul’s experience, the Little Mermaid fairy tale on which the Disney movie is based revealed itself to have many connections to Raul’s experience. These include: a sense of otherness resulting in a devaluation of the self evidenced by the need to become something or someone else; a loss of “voice” that causes one to have to rely on physical attractiveness rather than one’s authentic self to win love, and a soul loss that can only be cured by the love of *an other*, whether that other be a handsome prince or God.
Myths about mermaids go back thousands of years, but the Disney movie is based on a much newer fairy tale, written by the Danish author Hans Christian Andersen in 1836. The difference between a myth and fairy tale is instructive. According to scholars of fairy tales such as Bruno Bettelheim and Marie Louise Von Franz, both myths and fairy tales contain archetypal contents, but while myths are “…grandiose, awe-inspiring, and could not possibly happen to an ordinary mortal like you or me…” the fairy tale is “…something that could happen to you or me or the person next door when out on a walk in the woods.” It is this very subjectivity, Von Franz says, that makes fairy tales an ideal vehicle for studying collective unconscious psychic processes. According to her, fairy tales and myths both mine the collective unconscious, but fairy tales contain “…much less specific cultural material and therefore they mirror the basic patterns of the psyche more clearly.” Fairy tales are stories that bridge the real and the imaginary, and Jung himself saw fantasy as the bridge between the conscious and unconscious minds. “It is in creative fantasies that we find the unifying function that we seek. All the functions that are active in the psyche converge in fantasy.” Hillman defined “the imaginal perspective” as bringing the lens of fantasy to view the content of our psyches: “Thus everything is transformed into images of significance, and with that change in view we view ourselves differently, we see that we too are ultimately a composition of images, our person the personification of their life in the soul.”

I use the original story by Hans Christian Anderson as the source for my analysis, so I will synopsize that story here, but will also give a brief synopsis of the Disney movie of the same name, which was the source of Raul’s familiarity with the narrative.
The story begins in the kingdom of the Sea King, who is a widower of long standing. He has six daughters who are being raised by his mother, a wise woman of high birth. The Little Mermaid is the youngest daughter and the prettiest, while also being quiet and thoughtful. She is obsessed with the world above the sea, and looks forward to the day of her fifteenth birthday when she will be allowed to leave the sea and view the terrestrial world. One by one, her older sisters attain their fifteenth year and visit the surface, then return to tell their stories. Each experiences a little bit of the human world—the pealing of church bells, the frolicking of naked children in a river, the barking of an angry dog—and informs her fascinated sister. Soon the sisters grow bored of the human world and prefer to stay below, but when storms occur they go to the surface together and sing to sailors on ships. They sing of the beauty of the sea world, which the men would encounter if their ships wrecked. But the sailors misunderstand the mermaids’ songs and take them for the howling of the storm, and even while the mermaids extoll the beauty of their land, they know that if the sailors visited their world it would be as dead men.

Finally the Little Mermaid has her fifteenth birthday. Her grandmother outfits her to go to the surface with beautiful but painful jewelry made of oysters clamped onto her tail. She rises up and encounters a sailing ship, on which a handsome prince is celebrating his sixteenth birthday. As she watches him in fascination a storm arises, and the prince is thrown into the roiling water. The mermaid rescues and delivers him back to land, where he is found by several young human girls.

Back in the ocean the mermaid pines for the prince. She asks her grandmother about the differences between merfolk and humans. The grandmother tells her that the
main difference is that humans have an immortal soul, whereas merfolk merely turn into seafoam when they die.

“Is there anything I can do to win an immortal soul?” the Little Mermaid asks. Her grandmother replies that the only way is if a human were to fall in love with her. Then he “…would give a soul to you and retain his own as well; but this can never happen. Your fish’s tail, which amongst us is considered so beautiful, is thought on earth to be quite ugly; they do not know any better, and they think it necessary to have two stout props, which they call legs, in order to be handsome.”

The mermaid decides she must have both the prince and an immortal soul, so she goes to a sea witch, who offers human legs in exchange for her beautiful voice. “But if you take away my voice,” asks the little mermaid, “what is left for me?” “Your beautiful form, your graceful walk, and your expressive eyes; surely with these you can enchain a man's heart,” the witch replies. The catch in the deal is that if the Little Mermaid cannot make the prince fall in love with her and he marries someone else, then she will die and become foam on the ocean.

The Little Mermaid undergoes an exceedingly painful transformation. She emerges from the sea and is found by the prince, and cannot speak to him, but he is charmed by her beauty and child-like ways. He treats her like a beloved little sister while he searches for the girl with the beautiful voice, whom he believes rescued him. His father arranges a marriage to a princess from a nearby town and the prince believes that she is the one. He marries the princess while the mermaid watches in misery.

The mermaid is about to die, as the witch prophesied, when her sisters appear and tell her they have brokered a deal with the witch. If the mermaid kills the prince with a
magic knife she can return to the sea. But the mermaid will not do this and she jumps into the sea, expecting to die. But instead she is lifted from the sea by the “daughters of air,” who tell her she has been rewarded for her goodness by joining them. In becoming one of these creatures, the mermaid will be able to earn eternal life in the kingdom of heaven by doing good deeds for humans for three hundred years. So the Little Mermaid, although she never becomes human, uses her love and charity to earn the prize that only humans can attain, an immortal soul.

The Disney movie from 1989, while following the basic Andersen plot, has some crucial differences. The Little Mermaid Ariel has a fascination with the human world that is expressed in a collection of artifacts that she has collected from shipwrecks. In the movie the Sea Witch is named Ursula. Ursula harbors a desire to be in charge of the kingdom of Ariel’s father, Triton. Like the Andersen story, Ariel makes a deal with the witch. The deal is this: if Ariel, without the use of her voice, fails to make the prince fall in love with her within three days, then she will return to the sea as a mermaid and become Ursula’s slave. Even without a voice, Ariel is almost successful in causing the prince to love her, so to thwart them Ursula takes on a beautiful human form and uses Ariel’s voice to make the Prince fall in love with her instead. Ariel manages to stop their wedding, but a huge battle ensues and Ursula for a time usurps Triton’s power to almost destroy the whole underground kingdom. In the end the Prince kills Ursula and Triton is restored to power, wherein he turns Ariel back into a human and allows her to marry the prince, thus creating a more conventional happy ending, rather than the Christian one that Andersen provided.
I could have picked this story as a lens to view Raul’s experience even if he had not picked it himself, as his story and the fairy tale share a number of poignant parallels: a sense of otherness resulting in a devaluation of the self evidenced by the need to become something or someone else; a loss of voice that causes the hero to have to rely on physical attractiveness rather than their authentic self to win love; and a soul loss (or essential soullessness) that can only be cured by the love of another, whether that other be prince or God.

Several writers have used the story as a vehicle to examine women’s psyches, and it is interesting to look at these interpretations with regard to Raul as a gay man and his connection to his own anima. Branham theorizes that the Little Mermaid story represents for women an undervaluing of the anima, or the sacred feminine, symbolized by the watery depths that the mermaid shuns, in favor of the masculine “rational consciousness” symbolized by the land. To Branham, the mermaid’s tale warns of the loss that incurs when women undervalue their authentic selves, and when they are undervalued by society.¹⁸

Branham and Gale have connected the little mermaid story to anorexia nervosa, a food addiction wherein the sufferer painfully transforms their body to achieve a “perfect” self.¹⁹ When the Little Mermaid reaches her fifteenth birthday, her grandmother attaches eight oysters to her tail. When she complains of the pain her grandmother answers, “Pride must suffer pain.” The little mermaid undergoes a transformation that is extremely painful, and the pain is ongoing and unrelenting, but she bears it because it brings her closer to her ideal state.
Mirabito describes a very personal connection between some anorexic patients and Ariel in the Disney movie. Ariel’s “…pact with the deceitful witch Ursula leaves her without a voice, identity, visibility and means for authentic self-expression, much like the implicit contract between individuals and their eating disorder. Like Ariel, these individuals believe that if they live according to their eating disorder’s demands (or in line with Ursula’s contract) they will in turn receive an ideal body type that is noticed and loved but what it actually does is get them into life threatening trouble and eliminates everything authentic and unique about them.”

One of the things that came to light in Raul’s therapy was that his psychotherapist believed that Raul might have an eating disorder, an issue Raul presented to me in the context of being annoyed with his therapist for having suggested it. Yet although he rejected this diagnosis, Raul did tell me at other times that he had adjusted his diet, taken a supplement called Weight Gainer, and had taken steroids at one point because “people,” as he put it, had told him he was too thin. Although the issue of body dysmorphia and eating disorders in men is much less studied than women, there is a body of research on body dysmorphia in gay men, and it has been shown that body dissatisfaction and disordered eating occur to a greater degree in the gay male population than in the straight male population, leading to a particular form of disordered eating that scientists have termed “muscularity oriented disordered eating.”

But whether or not Raul had a literal eating disorder, there is a more archetypal connection here in the disconnection from the sense of the essential self, and perhaps the disconnection from anima. Like the little mermaid, Raul had been subjected to pain by his parents in the interest of achieving what they considered a more perfect form. As he
said, they tried to “beat the gay out of me.” And Raul did suffer from drug addiction, which is also seen by many theorists as a disconnection from self, or on an imaginal level, a soul loss. The Little Mermaid experienced a deep sense of not being enough in and of herself. If only she were human, she thought, and then if only she could earn the love of the Prince, she could be complete. She was willing to give up her family, her home, her own voice, and endure great physical pain in order to make this transition. In this sense the story mirrors the psychodynamic and imaginal theories of the causes of addiction, as well as describing the actual experience of being in the thrall of an addiction, when the addict gradually loses everything that is important to him in the pursuit of a “pipe-dream.” This is why authors such as Gale and Branham have seen connections in this story to eating disorders, but the story could also be used to illuminate Raul’s substance addiction.

Kohut saw addiction as a failure of the maternal self-object to meet the needs of the infant, which later in life causes him or her to choose a drug to act as a mirroring self-object which soothes and accepts him.\textsuperscript{23} The psychospiritual or imaginal perspective looks at the positive side of the same picture, we might say, and understands addiction as Gale describes it, as “…a call from the higher or spiritual self towards growth and wholeness.”\textsuperscript{24} She goes on to say, “For the woman suffering from a food addiction, no amount of food will fill her, so she eats more to soothe her pain, to punish herself, to reach for the love she so desperately longs for.” This search for love and acceptance was Raul’s search—to be accepted by his religion, by his parents, by the gay world with its emphasis on physical appearance, and by the white world with its prejudices and assumptions.
While many theorists have analyzed the Little Mermaid through the content of the story, biographers and at least one psychoanalyst have used the story to theorize about the author himself. The Little Mermaid story, unlike folk tales that have been passed down through generations and have no single author, was written in the mid-nineteenth century by a Danish man, Hans Christian Andersen. Psychoanalyst Robert Meyers uses the fairy tale and Andersen’s autobiographical data to theorize that Andersen “…had a strong unconscious feminine identification which had to be repressed because his masculine identity would not tolerate it.” 25 Meyers describes the story of the Little Mermaid in the context of Freud’s notion of the negative Oedipal complex, in which a boy harbors love for his father, which is forbidden because to indulge it the boy would have to undergo castration. He also uses biographical information to speculate that Andersen identified with his mermaid creation on another level, as an “…outsider who came from the depths and felt that he was never really accepted in the new world into which he moved.” 26

I have already stated that I am relatively sure Raul did not read the original The Little Mermaid, nor is he likely to have known much about Hans Christian Andersen. But the parallels between Andersen and his creation are also parallels between Raul and the Little Mermaid in the Disney movie, and these unconscious associations are likely to have caused Raul’s fascination with the story as he encountered it. Raul’s homosexuality caused him to be both more connected to his anima, but also to have to disavow it in order to be accepted by his parents and by his schoolmates while he was growing up. As he described his high school years, “…getting called a girl or getting called faggot, you hear that word, I just, hiding is just normal… I mean, that’s the way it’s been and that’s the way it is ‘til now…”
Von Franz dismisses the canon of Andersen’s fairy tales as being less useful for archetypal analysis because they are too tinged by what she calls Andersen’s personal neurosis—“…an imposed Christian prudishness with a very wild pagan temperament underneath,” but then attributes this same neurosis to the entire Scandinavian culture, “…a tension to be found in the whole of the North.” Whatever Von Franz’s prejudices about Scandinavia might be, she makes a point about Christianity that cannot be denied with regard to Raul’s underlying sense of himself; that his sexuality was at odds with his religion. Raul was raised Catholic, and the idea of being accepted by God was real for him, and that he had struggled with the idea that he could not be accepted by God (have a soul) in his current form (being gay) but would have to transform if he were to be accepted by the god of his childhood.

When speaking about his interpretation of the Madonna song *Devil Pray*, a song that had deep resonance for him, Raul said, “Well, it’s me and being Catholic…and living with God, I was taught to fear God, and that’s not what, that’s why I didn’t want to believe in that God, cuz it seemed like God was the devil himself…” The singer Madonna is famous for her sexuality being at odds with her Catholic upbringing, and this song, especially the video that was made for it, shows this struggle, with images of a young nun looking at a pornographic magazine. According to Meyers, Hans Christian Andersen struggled to reconcile his sexuality and his desire to be “good”, which manifested as an inability to have any sexual relationships. These same struggles can be seen in the Little Mermaid story. The mermaid longs to be both good, as exemplified by having a soul, and to be human, something other than what she is. Only by transforming herself can she achieve both immortality and love.
Raul made great headway in being out and accepted as a gay man by his family and by his religion, but even in the gay world of San Francisco he still struggled with whether or not his outward appearance met the standards of attractiveness set by that world. Raul crossed between worlds, as the Little Mermaid did, from the insular Latino world of his youth to the world of the dominant white culture, and the process was painful and required a transformation and a leaving behind of a beloved home.

**Personal and Professional Development**

My personal and professional development expanded as a result of addressing the issues of diversity that arose as a result of me, a white, cisgender, heterosexual woman, counseling Raul, a Latino, cisgender, homosexual man. I found Pamela Hays’s ADDRESSING framework useful in considering the many strands of identity that impact and construct an individual’s life experience, and how what each of us was bringing to the intersubjective field influenced the therapy. Hays states that, “…knowing that a client is Black (or for that matter, White) does not adequately inform the therapist about the client’s views of psychotherapy, personality, psychological conflict, aspirations, or goals in therapy, ‘let alone about educational level, social background, or environmental context’.” 29 I felt this intuitively when working with Raul; that I should not make assumptions about what being Latino meant to him, or for that matter what being gay, or any other aspect of his identity meant to him, because it would most likely be wrong. Instead I needed to stay curious and non-defensive and follow where Raul led me.

The model Hays developed identifies nine different attributes that come together to compose an individual’s cultural identity. Those categories are: Age, Developmental
and acquired Disabilities, Religion, Ethnicity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin, and Gender. Considering these categories together, according to Hays, aids a therapist in bringing awareness to and challenging their own biases and areas of inexperience, and as a lens to view the “…salience of multiple cultural influences on clients of minority cultures.” This constitutes the first way in which the ADDRESSING framework can be helpful to therapists. The second way is to “…broaden and deepen counselors’ understanding of racism, ethnocentrism and other forms of oppression that affect people of color,” while also acknowledging that having an awareness of or membership in one minority culture does not lead automatically to understanding of a different minority culture. A third way of using the model is as a way of looking at “…within-group differences corresponding to each of the ADDRESSING factors…” which decreases the tendency of a therapist to make inaccurate generalizations based on a single factor, for example, by assuming that one can know a person’s experience because they are Black or because they are gay. The central task for a therapist, according to Hays, is to seek to learn “…what cultural factors are important in each client’s life,” (emphasis mine) by probing a client’s self-identification, both through what they name and what they omit in their self-descriptions. Raul’s experience was shaped by being gay in a Latino family and neighborhood, by being Latino and gay in a primarily white heterosexual work environment, by being Latino in a primarily white gay community, and a myriad of other intersections of identity and culture.

I was not introduced specifically to the ADDRESSING framework until after the therapy with Raul was concluded, but the concept of intersectionality, a similar concept to the ADDRESSING framework, was introduced at Meridian University in courses on
both cross-cultural perspectives and transformative learning praxis. *The Handbook of Transformative Learning*, a core text for Meridian, states, “Although gender and race are both social constructs, they intersect with other positions, such as class, age, and sexual orientation, to affect and order our everyday lives…” 32

Over the course of therapy, Raul and I spoke of race, sexual orientation, religion, national origin and socioeconomic status, and through these discussions wove a tapestry that began to reflect the unique experiences, as well as the social forces of prejudice and inequity, that constellated Raul’s life. In this learning I became aware of how my own experience affected my ability to understand and empathize with Raul’s experience, as well as the larger cultural influences that exerted force on his, my and our shared experience.

**Applying an Imaginal Approach to Psychotherapy**

The school I attended, Meridian University, defines Imaginal Psychology as a “…distinct orientation that reclaims soul as psychology’s primary orientation,” and stated that the way to access the soul is through images found in dreams, symbols, mythology and the creative imagination.33 Aftab Omer, a cofounder of Meridian University, referred to Imaginal Psychology’s roots in “…transformative practices that are at the core of many spiritual traditions and the creative arts.” 34

In *Care of the Soul*, Moore states, “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.” 35 By bringing imagination to bear on “…the myths, rituals, and poetry of a life…” we bring the soul to light. 36 Imaginal Psychology can be defined as a psychological orientation that focuses on the use of images and the imagination as a means of accessing the soul, with roots in ancient traditions that appear in all cultures, including mythology and shamanism.

Practitioners of Imaginal Psychology do not shy away from using religious terminology (although they are non-ecumenical) or from viewing the work of psychological healing on the grand scale of myth or archetype; indeed to be imaginal, one must work on such a large canvas, in the realm of what Houston calls the ultimate reality, the “…realm of God as the Unity of Being.” 37

Houston talks about the three realms of human experience—the historical and factual (THIS IS ME), the mythic and symbolic (WE ARE) and the universal or source level (I AM). The third level, I AM, is the realm of “…Being itself, pure potency, a realm of love and organicity, the very stuff of reality. It is the realm many of us know as God.” 38 She finds that many doctors and psychologists operate only in the first realm, thereby rendering “…the transformation aspects of psychology impotent.” 39 What Houston calls sacred psychology, which can also be defined as Imaginal Psychology, operates in this third realm of I AM, while maintaining awareness of the influence of the other dimensions.

How can a therapist view the dual diagnosis of SUD and PTSD through an imaginal lens, bringing the matter of soul into consideration, and how can he or she apply imaginal approaches to the treatment of these disorders? Due to the prevalence of Alcoholics Anonymous in the treatment of addiction, this is one area of psychology
where a frank discussion of soul or spirit is not out of place, although this is changing, as
the pharmaceutical industry develops new drugs for addiction and exerts an influence on
the industry to view addiction as a brain disease that can be cured with medication.

In the Literature Review I described how Carl Jung and Bill Wilson, the founder
of AA, exchanged letters discussing the spiritual aspect of addiction and AA’s treatment
of alcoholics. In the letters Jung asserted that, “An ordinary man, not protected by an
action from above, and isolated in society, cannot resist the power of evil, which is called
very aptly the Devil.” 40 In this sentence the Devil he refers to is addiction.

Many theorists and psychological practitioners who take a spiritual approach to
the treatment of addiction have taken Jung and Bill W’s short exchange and expounded
upon it. Schoen describes addiction as archetypal evil that possesses the soul of the addict,
unapologetically using religious language to make his point about the spirituality of
addiction. Tacey speaks of the spiritual dimension of healing from addiction as finding
life outside the ego, another way of describing Houston’s move from the THIS IS ME
realm to the I AM realm. Tacey states, “If we do not cultivate a symbolic reality or find
life outside the ego, inferior ecstasy will invade the body and psyche, destroying both in a
disorderly spectacle.” 41 The ego could also be thought of as the adaptive identity, a term
used at Meridian and defined in this way: “In the course of coping with environmental
impingement, as well as overwhelming events, the developing soul constellates self
images associated with adaptive patterns of reactivity. These self images persist as an
adaptive identity into contexts where they are maladaptive and barriers to the unfolding
of Being.” 42
The imaginal approach would not use religiously laden words such as the Devil to define its concepts, but when one expands one’s consciousness to the realm of I AM, it cannot help but encompass archetypal good and evil. The imaginal perspective states that our addictions, illnesses, or “woundings”, as Reis identifies them, give us access to soul if we go deep enough into the psyche. Patricia Reis says, “…everything begins and ends deep in the embodied psyche. That is where I find the woundings—and openings—through which soul passes.”  

Jaenke describes how the imaginal process can integrate such painful material: “Soul carries an inherent largesse, a capacity for ingesting and metabolizing the full range of life’s experiences, even difficult and horrific ones, and for creating something of beauty even from the messiness, disappointments, and tragedies of life.”

Even psychological practitioners who are not explicitly Imaginal or Jungian oriented see the need for an imaginal perspective in healing from trauma and addiction. In her famous book, *Trauma and Recovery*, Judith Herman describes three stages of recovery from trauma. (Herman uses the female pronoun so I will do the same.) The first stage is establishing safety; the second stage is for the survivor to tell the story of the trauma, including affect and bodily sensations, which transforms traumatic memory into metabolized material. In the third stage the survivor comes into possession of herself and works on becoming the person whose development trauma interrupted, by using all her creative and transformative capacities. “The recreation of an ideal self involves the active exercise of imagination and fantasy, capacities that have now been liberated.”

Although Herman is not speaking in a spiritual sense, she is referring to the ability of, and the necessity for, the survivor to move beyond her adaptive identity as a victim
and embrace a new understanding of herself as bigger than her wounding, even as paradoxically she may “…become aware of her ordinariness, her weakness, and her limitations, as well as her connectedness and indebtedness to others.” 46 This paradox occurs when the survivor lets go of an understanding of herself as combining a “grandiose feeling of specialness” with “self loathing and feelings of worthlessness”; a state of mind a friend of mine from AA once referred to as being “the piece of shit that the world revolves around.” In Imaginal Psychology these states of mind could be referred to as gatekeepers. According to Omer, gatekeepers are “individual and collective dynamics that resist and restrict experience,” even though they developed to keep the person safe or protected.47

Even if one does not speak specifically about soul to a client recovering from substance abuse and trauma, there are areas of Imaginal Psychology that apply directly to these clients and to the therapist as they interact in the intersubjective space. Helping a client to identify the aspects of his or her adaptive identity that acted as defenses, and bringing reflexivity (awareness of how one is being affected) to that understanding can allow a client to transmute those ingrained ways of interacting with the world into creative participation in his own healing process.

Imaginal Psychology speaks of moving from the historical and factual realm of experience, Houston’s THIS IS ME, to the universal or source level, what Houston terms, I AM.48 Omer, using the term “the I” to describe this same state, speaks of how when the I develops, self consciousness and victimization recede and are replaced by participatory consciousness, defined as “…states of consciousness which are unobstructed by a delusionary sense of a separate self.” 49 The more the grip of the ‘I’ lessens, the more
victimization lessens, as does the grip of engrained patterns of adaptive identity, multiple patterns under which we live unaware but deeply affected by, from mandated gender-specific behavior to living in Chronos time. Omer states that the paradox of this development is that “…the soul’s individuality unfolds optimally to the degree that it is fed ‘participatory nutrition’, which is collective engagement.” 

Participatory consciousness is similar conceptually to the state being cultivated by AA and by any outpatient substance use treatment that involves group therapy, such as Ohlhoff’s model. As Schoen describes it, the purpose of AA and the 12 Steps is to “…place the Archetypal Shadow/Archetypal Evil of addiction where it can be seen and neutralized in the eternal sacred fires of the Self and the Higher Powers of healing, light, and grace.” In one of the group therapy sessions on the subject of spirituality, Raul produced a piece of artwork that represented a self-portrait of his sober self (included in the Appendices). In the head-shaped template that had been provided, Raul filled the space with blue sky and puffy clouds. To me this artwork represents beautifully Houston’s notion of “…states of consciousness which are unobstructed by a delusionary sense of a separate self.” In this aspirational image Raul was relieved of the bondage of self; he was able to envision himself at peace and in union with a higher consciousness.
CHAPTER 5

REFLECTIONS

The process of writing this case study allowed me a rare opportunity for a psychotherapist—time and resources to reflect at leisure upon all the many facets of the crystal that constituted my work with Raul. Aspects that might have seemed trivial in the normal course of psychotherapy, such as Raul’s mentioning that *The Little Mermaid* was his favorite movie, when allowed the time and space to reveal themselves fully, became deeply consequential and revealing. The study of information relating to Raul’s sociocultural location revealed implications that neither of us could have known at the time but that have great impact on the understanding of his case.

**Personal Development and Transformation**

In *Approaches to Case Study: A Handbook for Those Entering the Therapeutic Field*, Higgins declares a truism that at first glance seems obvious to the point of being trite. “The sufferings of patients arise from a combination of events occurring inside and outside of them.”¹ Yet during Raul’s treatment, and later as I worked on this case study, my understanding of the spheres of influence upon his illness came to seem like the expanding ripples on the surface of a lake when a stone is thrown into it. From my schooling at Meridian, where I took courses in both substance abuse and trauma treatment, I had an understanding that addiction and traumatic stress were complicated
disorders with roots in “...biology, psychology, cultural considerations and human yearning,” but it was only during the course of researching this case study that I began to understand how many, varied, and far reaching are the influences that affect how these disorders are viewed, who is diagnosed with them, how different people who experience events that might trigger substance abuse or PTSD either come down with the disorders or remain resilient to them.

In writing this case study and applying the lenses of the biological, cognitive/behavioral, psychodynamic, imaginal, and sociocultural perspectives to the issues of addiction and traumatic stress, I was able to clarify my personal point of view, and thereby develop a broader, more complex and more objective perspective on these disorders and how they interact with each other. Laurel Richardson describes this way of seeing as crystallization. She uses the metaphor of the crystal because a crystal is solid rather than amorphous, it is fact, and yet what we see in it depends on the angle of the viewer. She says, “...crystallization provides us with a deepened, complex, thoroughly partial understanding of the topic. Paradoxically, we know more and doubt what we know.” My understanding of Raul’s case has deepened and become more complex as a result of writing this case study, and allowed me to see that the differing on views on the topic (the etiology of addiction as a brain disorder or an outgrowth of trauma, for example) represent facets of the crystal, casting light in different colors and patterns.

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

I was first introduced to the adage, “The personal is political” when I was an undergraduate women’s studies major at UC Santa Cruz in the 1980’s. It meant that the
issues of our personal lives, such as a choice to have an abortion or the inability to secure an abortion, were not simply about us individually, but they told a story about our society and its cultural values. While working on this case study I began a search for research studies that looked at the broader implications of my client’s very personal story. And I was surprised over and over by how much the literature illuminated his story, where I saw Raul’s very personal story fitting into a larger pattern. It is interesting here to ponder the nature of knowing—how do I know what I know and what do I do with it once I know it?

Paradigms in research methodology include the positivist paradigm, the constructivist, and the participatory paradigm. Each comes with a point of view about the nature of reality (ontology); the nature of knowledge and how it is obtained (epistemology); and methodology, referring to assumptions about how knowledge is obtained. The positivist paradigm asserts that “…there is an external objective reality that exists, is knowable and follows particular laws.” This paradigm assumes the researcher is a disinterested, neutral observer, who does not affect the results of the inquiry, and is not affected by the subjects of the research or the action of the research itself.

The constructivist paradigm disagrees with the positivist premise that it is possible to be objective. It argues that all knowledge is subjective and based on the personal history of the subject, and acknowledges that researcher and subject will inevitably affect each other.

Meridian University favors the third type, the participatory paradigm. The assumption about epistemology (how we know what we know) is critical subjectivity,
otherwise known as reflexivity. It is asserted at Meridian University that, “It is possible to be an objective observer of our subjective experience. Objectivity is achieved through accounting for our own subjectivity and the subjectivity of the field.” 5 Thus we see that the participatory paradigm takes the constructivist approach one step further, in stating that although we stipulate that knowledge is subjective, i.e. viewed through a particular lens, when we are aware of our own lenses and any other lenses affecting the field, then we can be objective about our results.

Each of these paradigms has a goal for its inquiries. The positivist paradigm believes it is possible to uncover an objective truth, and this revelation of truth is its ultimate goal. The other paradigms argue that it is not enough to simply uncover a truth—one must then take action on it. But there is disagreement between the constructivist and the participatory as to what action is warranted. Lincoln and Guba identify this difference between the positivist, constructivist and participatory models’ beliefs about the uses of research: “…positivist and post-positivist adherents…view action as a form of contamination of research results and processes…” while those they term interpretivists, meaning both constructivist and participatory researchers, “…see action on research results as a meaningful and important outcome of inquiry processes.” 6

This move toward the necessity for social action is a fundamental aspect of the participatory paradigm, whose goal for its research endeavors as stated in a Meridian University course handout is, “Action that would transform the world in the service of flourishing.” 7

In an ideal participatory paradigm there would have been a feedback loop in which Raul could have been both a participant in and a beneficiary of the new knowledge
generated by this case study. But there were logistical and ethical constraints involved that did not allow the feedback loop to return directly to Raul. Instead it will hopefully flow back to him indirectly in the form of new understandings about the complex interactions of biological, societal, cultural, and archetypal influences in what was simultaneously an individual experience and an example of larger forces in action.

The task for me is to make plain the reflexive processes that I undertook, and to explain how I was transformed by the new material that the case study revealed. It is also essential to show how using the participatory paradigm to view this case study allows the reader to be aware of the various lenses that are in operation, including those that I have employed by articulating the different perspectives (biological, psychodynamic, sociocultural, etc.); those that I have employed from my own sociocultural location; and those the reader may be employing based on his or her own operant lenses. In this way, rather than behaving like a fish that does not know it is in water, we can instead act “…as an objective observer of our subjective experience.” 8

Mythic Implications of the Learnings

Raul’s choice of the tale of The Little Mermaid yielded mythic implications to the story of Raul’s epic struggle with addiction and traumatic stress, and the efforts of his authentic self to emerge despite the forces of society and culture that conspired to tell him that he wasn’t good enough as he was. But viewing Raul’s story through the prism of The Little Mermaid also yields rich implications about the role of feminine identified archetypes in illuminating the identity formations of men, both gay and straight, and how cultural prejudice influences the ability of men to integrate these aspects of themselves.
A search of academic journals reveals that several authors have used the little mermaid fairy tale as a jumping off point to discuss psychological issues from the point of view of women. One scholar used the text of *The Little Mermaid* to examine possible latent homosexuality and feminine identification in the author, Hans Christian Andersen. But as far as I can tell no one has looked at how this fairy tale might pertain to the larger archetypal longings of men, and what the tale might reveal about the relationship of men, either gay or straight, to their animas.

Anima is a concept developed by Jung to describe the feminine aspects of the male psyche, as opposed to the animus, which is the masculine aspect of the female psyche. Jung said of the anima, “Every man carries within him the eternal image of the woman, not the image of this or that particular woman, but a definite feminine image. This image is fundamentally unconscious, an hereditary factor of primordial origin engraved in the living organic system of the man, an imprint or archetype of all the ancestral experiences of the female…”

It is most likely due to the inherent hostility of Western patriarchy to the acceptance of “feminine” traits in men, and attributing those traits to homosexuality when they do appear in men, that contributes to the dearth of examination of how this archetype can illuminate male psychology. In *A Primer of Jungian Psychology*, published in 1973, Hall and Nordby revealed this bias when they wrote, “One consequence of this imbalance between the persona and the anima or animus is that it may trigger off a rebellion…in which case the person overreacts. A young man may accentuate his anima to the extent that he is more feminine than masculine. Some male transvestites and some effeminate homosexuals fall into this category.” As long as the fear of and bias toward male
homosexuality persists, it may only be male homosexuals such as Raul, and perhaps Hans Christian Andersen himself, who can serve as examples of how this archetype illustrates the yearnings of men—toward aspects of their psyches that are traditionally considered feminine, toward a merger with the divine, and toward a desire to be their own “perfected” self; a self that may be authentic, or perhaps born of cultural directives that need to be examined and perhaps discarded.

A second mythic implication was revealed to me when I read *Celtic Queen Maeve and Addiction* while doing research for this case study. Sylvia Perera describes Maeve, a goddess of the ancient Celts whose roots go back very far, even to pre-Celtic times. Maeve is seen as a “…primordial tribal goddess, [who] represents the qualities of encompassing wholeness and grand diversity…from a time before attributes or functions were split among a pantheon of deities that were regrouped under some hierarchical order…” 11

Maeve’s name means the inebriating one, and the ancient alcoholic drink mead, or meadhbh in the Celtic language, is named after her. Perera describes how Maeve holds within her image the duality of the craving for ecstatic states and the annihilation that those states can bring; like a homeopathic medicine, she contains both the disease and the cure. “Maeve is the alpha and omega, the cravings and the mediating structures that transform craving into desire.” 12 Maeve teaches us that nothing that one is can be thrown away in the search for healing; instead light and shadow must be integrated, because shadow denied will find its way back home. Perera says of Maeve: “We have already seen that she is battle goddess, earth mother, inspiriting muse, sovereign process, loathsome hag, inebriating drink, passionate appetite, and sacred vessel. To all of these
aspects of the goddess in us, the addicted personality must consciously discover new relationships, accepting them as necessary for life and also seeking among them the balances that can support creativity.  

This search for wholeness, an integration of light and shadow, of what are seemingly opposites, is also what is done in the transformational process that occurs in Alcoholics Anonymous. One of the fundamental tenets of AA is that only by admitting their powerlessness over alcohol can persons master their addictions.

Like the Little Mermaid who gives up her authentic self in her quest to be loved, Raul was searching for acceptance by projecting his ideal self into the world. Drugs gave him an illusion of mastery, of perfection, but what he really wanted was acceptance of his authentic self. Ironically, one time when Raul experienced acceptance of his true and authentic voice was when he gave his Drug and Alcohol history speech to the group at Ohlhoff. In that moment he told the truth of his experience to his “tribe” and found himself accepted for the one identity that he sought to avoid, that of addict. Like Maeve, the goddess who embodies both the divine ecstasy of inebriation and the devastation that can be wrought by it, Raul’s healing was enacted by finding the cure at the center of the poison.

Significance of the Learnings

The participatory paradigm asks of researchers that we engage in a form of social action, from involving the participants in the creation of the research to developing strategies for social action as a result of the new knowledge. We also understand from considering the concept of the syndemic that psychological issues do not exist in a
vacuum, but are intrinsically linked to the cultural norms of the society. Yet consider the current paradigm of psychotherapy—all of its imagery is constellated around privacy, from the closed door of the therapy room to the HIPAA patient privacy regulations we all sign onto when we become licensed. There is an implicit bias in the way psychotherapy is currently constituted that discourages psychotherapists from becoming activists for their clients or for themselves. It perpetuates the notion that the things discussed in therapy rooms are inherently shameful, and for the protection of the patient should only be discussed behind closed doors. This is a lens that we would do well to examine with healthy skepticism, rather than take it on a blind faith that it is in the best interests of our clients.

**The Application of Imaginal Psychology to Psychotherapy**

Addenbrooke describes the Alcoholics Anonymous process of healing from addiction using Jungian language that could also be understood as imaginal: “Underlying the Steps is the archetype of initiation in the form of containment, confrontation with the shadow, and finally the relinquishing of ego control, that is, of heroic qualities, in favour [sic] of the Self as the organizing force within the psyche.” 14 Schoen provides a helpful interpretation of the word “Self” from a variety of perspectives as a “… a transcendent center—which many call God, some call the Universe, Jungians call the Self, and AA refers to as the higher power.” 15 In imaginal terms we might think of the Self as the soul, and Addenbrooke’s description of the journey that the Self takes towards wholeness is what Imaginal Psychology would think of as the soul’s imperative.
Omer speaks of participatory consciousness as necessary for transformation; ecstatic states are a form of participatory consciousness. Ecstatic states can be channeled into either negative or positive actions, depending on the conditions in which they are experienced. He describes the serial killer Jeffrey Dahmer as being in an ecstatic state when he committed a series of heinous murders involving cannibalism, and also a case that had been in the news media about a group of men in India committing a gang rape. Keeping the human need for ecstatic experiences in mind when one is engaging in psychotherapy, and how these impulses can be channeled for good or evil, is an essential aspect of how Imaginal Psychology can be important to the practice of psychotherapy.

**Bridging Imaginal Psychology to Other Orientations**

As I have described previously, Imaginal Psychology has much in common with the long-standing practices already set in place by AA. Because of this the area of addiction treatment is one that may be more amenable to imaginal approaches that involve participation, ritual, initiation, imagination, and transformation. These practices are already in place at substance abuse treatment centers that use an AA focused methodology, but more of the methods of Imaginal Psychology, such as active imagination, ritual, and expressive arts, could be mindfully applied. Many people are discouraged by what they perceive as the religious tone of AA. If treatment providers used the elements of Imaginal Psychology and incorporated the concept of soul in a nonsectarian way, then perhaps more or different people could be persuaded to participate.
The elements of transformative praxis could also be brought to bear on treatment for traumatic stress. Peter Levine has already identified the importance of ritual and being brought back into the tribe for healing after trauma, and these elements are already in use in substance abuse treatment centers. A wider use of ritual for healing from traumatic stress, and closing the feedback loop so that action could be taken to prevent such trauma from happening in the first place, would truly be as Meridian University describes, “Action that would transform the world in the service of flourishing.”

Areas for Future Research

Most research in the field of psychology is not done within the participatory paradigm, and therefore does not undertake social action as a consequence of its findings. To close the feedback loop researchers need to find out whether treatment for PTSD and complex trauma (that often begins in childhood) impacts the incidence of SUD. Another gap is in research regarding culture specific treatment for Latino men who have sex with men (MSM) who struggle with substance abuse and trauma, especially taking into account differing levels of acculturation.

An even larger perspective would take in the notion of the syndemic into the feedback loop. It might examine the effectiveness of attempts to ameliorate the effects of cultural biases on addiction, such as efforts to decriminalize drugs, as has happened in Portugal, or to develop drug treatment programs that, rather than treat addiction as a one size fits all program, targets specific populations and takes into account the unique stressors in their lives. This was already being done at Ohlhoff, with its women only outpatient treatment program that used the Seeking Safety curriculum to simultaneously
treat PTSD and addiction. But there was no equivalent for gay men, or for Latino men, although research indicates that these populations undergo unique stressors. Although it may be difficult on a practical level to parse these populations out in this way, it would still be possible to screen male clients for PTSD and to offer them culturally appropriate treatment for their trauma simultaneously with their substance use treatment, using a curriculum in the vein of *Seeking Safety*. 
APPENDICES
APPENDIX 1

INFORMED CONSENT FORM

To ____________________,

You are invited to be the subject of a clinical case study on the treatment of substance use and trauma symptoms. The study’s purpose is to better understand how these two difficulties affect the lives of people who experience them concurrently.

This study is of a research nature and may offer no direct benefit to you. The published findings, however, may be useful to people who have experienced trauma in their lives and are seeking recovery from addiction.

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. If at any time you develop concerns or questions, I will make every effort to discuss these with you.

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, and all information that could serve to identify you will be altered to ensure your anonymity.

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 up until the publication of the study. Please note as well that I may need to terminate your role as 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 Doctoral Project Director at Meridian University, 47 Sixth Street, Petaluma, CA, 94952, telephone: (707) 765-1836.

I, __________, understand and consent to be the subject of, and to be referred to in, the clinical case study written by Clare Willis, on the subject of co-occurring substance use and trauma symptoms. I understand private and confidential information may be discussed or disclosed in this clinical case study. I have had this clinical case study explained to me by Clare Willis. 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 the 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 Clare Willis will not disclose my name or the names of any persons involved with me, in this clinical case study.
I hereby unconditionally release Clare Willis and Meridian University (and all of its trustees, officers, employees, agents, faculty, successors, and assigns) from any and all 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. 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 ____________, 20___, at __________________, CA.

By: ________________________________
Client’s Signature

Print Name: ________________________________

Print name clearly and legibly on this line
APPENDIX 2

ARTWORK
NOTES

Chapter 1


8 Working the steps of AA involves meeting with a sponsor, who is another member of AA, and discussing and performing actions centered on the tenets of AA. The first three steps are as follows: 1. We admitted we were powerless over alcohol - that our lives had become unmanageable. 2. Came to believe that a Power greater than ourselves could restore us to sanity. 3. Made a decision to turn our will and our lives over to the care of God as we understood Him. The Steps and the method for working them can be found in *Twelve Steps and Twelve Traditions*. (New York, N.Y.: Alcoholics Anonymous World Services, Inc., 1999).


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24 Satel and Lilienfeld, “Addiction and the Brain-Disease Fallacy.”


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28 Ibid., 4.

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30 Mate and Levine, *In the Realm of Hungry Ghosts*, 137.


34 The National Center on Addiction and Substance Abuse at Columbia University, “Addiction Medicine: Closing the Gap Between Science and Practice” (Columbia University, June 2012).

36 Merrill, “Psychotherapy with Substance Abusers,” 577.


46 Ibid., 32.


48 Ibid., 125.

49 Flores, Addiction as an Attachment Disorder, 7.

50 Ibid., 242.

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52 Smaldino, Psychoanalytic Approaches to Addiction, 75.


60 Bruce, Ramirez-Valles, and Campbell, “Stigmatization, Substance Use, and Sexual Risk Behavior Among Latino Gay and Bisexual Men and Transgender Persons,” 252.

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10 Anzaldua, *Borderlands/La Frontera*, 100.

### Chapter 4


4 van der Kolk, The Body Keeps the Score, 134.

5 Anzaldua, Borderlands/La Frontera, 42.

6 Flores, Ed., Group Psychotherapy with Addicted Populations: An Integration of Twelve-Step and Psychodynamic Theory, 46.

7 van der Kolk, The Body Keeps the Score, 118.

8 Ibid.


12 Clements and Musker, The Little Mermaid.

13 “Short Stories: The Little Mermaid by Hans Christian Andersen.”


17 Hillman, Re-Visioning Psychology, 41.


26 Ibid., 156.


30 Ibid., 334.

31 Ibid., 335.


36 Ibid., 10.


38 Ibid.

39 Ibid., 24.


42 Unknown, “Institute of Imaginal Studies, Definition of Terms.”

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3 Richardson, *Fields of Play: Constructing an Academic Life*, 92.

4 Course handout given in PSY 751, Imaginal Inquiry I, “Five Research Paradigms” (Meridian University, Fall Quarter 2014), 1.

5 Ibid., 3.


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11 Perera, *Celtic Queen Maeve and Addiction*, 34.

12 Ibid., 170.
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