THE CRYSTALLIZED SOUL: A MOTHER’S GRIEF AND HER SEARCH FOR RECOVERY FROM ADDICTION

by

DAVID PETER WESTWOOD

A clinical case study
submitted in partial fulfillment
of the requirements for the degree of

DOCTOR OF PSYCHOLOGY IN CLINICAL PSYCHOLOGY

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What do you think is the essence of Hell? Hell is where the depths come to you with all that you no longer are nor [are] yet capable of.

— C.G. Jung,
*The Red Book, Liber Primus*
ABSTRACT

The topic of this Clinical Case Study is the co-occurring disorders of complicated grief and addiction. Co-occurring disorders are common among those in treatment for addiction or other psychological difficulties. Complicated grief is a prolonged and affectively intense form of grief. The subject of this study is a 50-year-old Caucasian female who began using methamphetamine and cannabis at age 15.

The Literature Review addresses the etiology, symptoms, and treatment of the co-occurring disorders of complicated grief and addiction. Complicated grief disorder and two similar models are examined. Complicated grief and addiction share some biological bases and developmental origins. Cognitive deficits and negative affects are associated with methamphetamine use. Key concepts and major principles that informed my work include the concepts of ambiguous loss and imaginal structures, the principle that children growing up with addicted parents face difficulties maturing into adulthood, and relying on motherhood as an adult identity leaves women economically vulnerable. Additionally, the concepts of transference and countertransference informed my
understanding of therapy. I found that the literature did not adequately address factors that heal complicated grief.

The treatment progressed from working with the client’s grief to addressing her legal difficulties. Her children had been in the custody of her former husband for six years, and she missed them constantly. Imaginal approaches to therapy supported the client’s goals through objective caring. Therapy took several forms to help the client overcome her limitations through creativity and imagination.

I learned that her early life gave her few skills to cope with adversity. Additionally, I learned that understanding my own affective reactions, especially as they mirrored those of the client, gave me a clearer understanding about how to respond effectively. The *Hymn to Demeter*, an ancient myth that closely mirrored my client’s affective reactions, provided insight into how the client found resolution to her grief through corrective action and restoration of personal authority.

This Clinical Case Study shows how my client’s individual difficulties became confounded as a co-occurring disorder. The client did not quit using drugs during treatment. Future studies could discover other approaches to loosening the Gordian knot of co-occurring disorders that include grief.
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CHAPTER 1

INTRODUCTION

Clinical Topic

The topic of this Clinical Case Study is co-occurring complicated grief and addiction. The term *co-occurring disorder* is used when more than one disorder is present, and this is often the case. Kenneth Minkoff and Robert E. Drake find that among those in treatment for either drug and alcohol addiction or other psychological problems, having more than one disorder is “so common that it must be considered to be an expectation, rather than an exception.”¹ Bessel van der Kolk finds that drugs and alcohol are frequently used to self-medicate a variety of psychiatric symptoms associated with childhood abuse or neglect, and later experiences of trauma.² A parallel concept is dual diagnosis, but the term co-occurring disorders is used in this study because it is widely used in the literature and was invariably used at the fieldwork site where I worked with the client who is the focus of this Clinical Case Study.

Complicated grief is a concept described by Mardi J. Horowitz et al. as “the current experience (more than a year after loss) of intense intrusive thoughts, pangs of severe emotions, distressing yearning, feeling excessively alone and empty, excessively avoiding tasks reminiscent of the deceased, unusual sleep disturbances, and levels of loss of interest in personal activities.”³ These authors propose a definitive list of features for complicated grief disorder. Horowitz et al. assume grief is due to the death of a loved one, but Pauline Boss has developed a parallel concept, *ambiguous loss*, according to
which unresolved grief can occur when a family member is still alive but either psychologically or physically absent.\textsuperscript{4}

Addiction is a concept similar to \textit{substance dependence}, the term used in the \textit{Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)}, and features repetitive drug use and withdrawal symptoms, and can result in greater tolerance for the drug.\textsuperscript{5} The DSM notes that the use of drugs and other substances is often found in combination with many mental disorders, which complicates treatment.\textsuperscript{6}

Alternative views have been expressed about what causes and maintains addiction and complicated grief. The Literature Review explores the published research on these disorders from several perspectives, to provide a comprehensive view of the topic. No previously published research was found that focused specifically on the co-occurring disorders of complicated grief and addiction. However, this Clinical Case Study identifies features associated with addiction that appear to contribute to complicated grief, which makes these co-occurring disorders challenging for both clients and clinicians.

The biological perspective on complicated grief and addiction presents findings on brain functioning, particularly in the prefrontal cortex and limbic system, and the actions of dopamine and other monoamine neurotransmitters. In particular, research indicates that addiction is due to biological factors. Andrew Chambers, Jane Taylor, and Marc Potenza find that the predominance of dopamine during adolescence could be the reason teenagers are more likely to experiment with drugs and go on to establish addictions.\textsuperscript{7} Additionally, R. D. Rogers et al. find that taking methamphetamine changes monoamine neurotransmitters in the frontal cortex and limbic system, adversely affecting the ability to make decisions and solve problems effectively.\textsuperscript{8} Mary-Francis O'Connor
identifies a region of the brain that is active in both chronic longing of complicated grief and craving associated with addiction, suggesting a biological link between addiction and complicated grief.

If biology is at the beginning of the causal chain, then cognition and behavior can be viewed as being at the other end. The cognitive-behavioral perspective focuses on rational choice informed by new learning to promote behavioral change. However, models of treatment for co-occurring disorders used at the clinic where the subject for this Case Study was enrolled combined cognitive-behavioral methods with concepts and principles derived from other psychological orientations. Lisa M. Najavits’s *Seeking Safety*, a cognitive-behavioral model for treating co-occurring addiction and post traumatic stress disorder (PTSD), combines cognitive-behavioral psychoeducation with humanistic empathy and reflective listening. Ruth Malkinson’s cognitive-behavioral treatment for complicated grief challenges current maladaptive thinking, while adopting the psychodynamic concept of attachment to explain how this came about.

The psychodynamic perspective on addiction and complicated grief examines symptoms and underlying features associated with these disorders. Heinz Kohut considers addiction an attempt to self-medicate negative affects, and Joan E. Zweben et al. present a detailed account of negative affects associated with methamphetamine use. Regarding the loss of loved ones, Sigmund Freud considers normal mourning to be a process of disengaging affection for the deceased, whereas John E. Baker sees mourning as a process of changing feelings for the deceased. Chronic mourning is considered by John Bowlby to be due to traumatic experiences of abandonment and abuse during childhood, and Henry Krystal finds that similar traumas cause personality adaptations
that lead to addiction.\textsuperscript{13} The psychodynamic perspective also provides insight into interpersonal effects during the course of therapy. Affective reactions of both client and therapist are understood with the help of psychodynamic concepts, such as transference.\textsuperscript{14}

Rather than focusing on personal factors affecting co-occurring disorders, the sociocultural perspective focuses outward on the social conditions and cultural beliefs that contribute to and sustain addiction and complicated grief. Treatment for addiction and complicated grief has been separate, but coordinated services are emerging.\textsuperscript{15} Sheigla Murphy and Marsha Rosenbaum find that both addiction and loss of child custody are associated with disadvantageous social and cultural circumstances, and intergenerational abuse and neglect.\textsuperscript{16} George De Leon advocates modified \textit{therapeutic community} treatment for co-occurring disorders that emphasizes self-help and social support.\textsuperscript{17} Regarding grief in cases of loss without death, as experienced by the subject for this Case Study, Boss finds that ambiguity about the presence or absence of family members confounds the process of grieving.\textsuperscript{18}

Humanistic psychology includes several allied approaches to therapy that share a common belief in the human potential for psychological development and growth.\textsuperscript{19} Irvin Yalom’s existential therapy is a humanistic model that confronts fear of death, loneliness, and alienation with compassion, to encourage clients to enjoy life more fully.\textsuperscript{20} Carl R. Rogers’s person-centered therapy is a humanistic approach that emphasizes the therapeutic qualities of genuineness, empathy, and acceptance as the basis for helping people live up to their potential.\textsuperscript{21} A person-centered style of therapy has been incorporated in Najavits’ therapy for co-occurring PTSD and addiction, and also in William R. Miller and Stephen Rollnick’s \textit{motivational interviewing}, a treatment for
addiction that develops empathy with clients and challenges them to reach for their aspirations. Person-centered therapy was at the heart of the therapeutic approach practiced at the clinic where the subject for this study received treatment.

A central concern of imaginal psychology is how *imaginal structures*, or defensive character adaptations, insulate the soul (or psyche) from present experience in order to defend against past traumas. Developmental trauma can devastate development. Anthropological research by Collin M. Turnbull makes the observation that in times of severe social crisis, humans may abandon children to peer groups. Ethological research by Steven J. Suomi indicates that socialization of infant monkeys by peers is a natural but inadequate substitute for good parenting and increases the incidence of aggression, anxiety, and the use of alcohol. Imaginal approaches to treatment emphasize reawakening the transformative faculties of creativity and imagination.

The extant literature addresses the etiology and features associated with these disorders from a variety of psychological perspectives, including biological, cognitive-behavioral, psychodynamic, sociocultural, and humanistic orientations. Additionally, imaginal psychology is a distinct psychological orientation that reasserts the unfolding potentials of soul as the central concern of psychology. Imaginal psychology takes an interdisciplinary approach to addiction and complicated grief, has some features in common with other psychological orientations, and seeks a comprehensive basis for understanding co-existing disorders.

The subject for this Clinical Case Study is “Flora” (a pseudonym), a 50-year-old Caucasian female. Flora was admitted for treatment for methamphetamine addiction, but during intake, she said she was distressed at being separated from her three children. The
intertwined strands of addiction and grief became clearer as therapy progressed. Flora had used methamphetamine and cannabis for 35 years, and although she was keen on quitting, seeing her children was her first priority. Flora’s distress about her absent children preoccupied her attention during early counseling sessions, and she was willing to talk only briefly about addiction and recovery. A broad selection of literature provides insight into how addictions and complicated grief are influenced by childhood experiences. The literature also suggests that Flora’s distress was magnified by the negative affects associated with methamphetamine use, and that cognitive deficits resulting from methamphetamine use prevented her from resolving her problems.

**Personal Exploration of the Topic**

I selected Flora as the subject of my study because of her chronic state of grief, because of her struggle for recovery from drug use, and for the complex dialectic between these difficulties. I felt empathy for Flora because of my own experiences of obsessive grief, chronic underachievement in life, and past unstable relationships. Having gone through my own personal transformations in 12-step recovery and academic work, I hoped to see Flora begin to recover, too.

Flora’s distress awakened my empathy. Her voice had a plaintive quality that, like a child’s cry, was difficult to ignore. I felt she was in need, and recognized in myself a similar abiding sense of loss. I have very early memories of being left to cry myself to sleep, and of struggling with the precocious realization that I had to cope with overwhelming distress on my own. My mother ignored my cries because she was following a method of child rearing popularized in the 1950s. She later admitted to me
that she occasionally came to comfort me because she could not stand the distress she felt listening to me cry. Her occasional visits made me very dependent on my mother for emotional support, and in early adulthood, I felt bereft if did not have a girlfriend to assuage the chronic sense of loss I felt.

As well as recognizing my own distress when listening to Flora, I also was familiar with addiction. I had intermittently self-medicated longstanding dysphoria, and eventually sought help in a series of 12-step programs after a particularly painful relationship ended. I hoped to find a better way to cope with my discomfort, and learned my addiction was a symptom of underlying problems. Since then, I have worked on cultivating an inner ally, a resource I can access when I am aware enough to pay attention. My history of addiction is quite different from Flora’s, but one similarity is that we both self-medicated to change how we felt. Flora had used drugs since she was a teenager to overcome lack of energy and interest. A turning point for me occurred shortly after I realized my addiction had become a problem as well as a palliative. I have frequently heard addicts say they had a similar momentous realization, but continued to practice their addictions for years before the benefits ceased and only the problems remained; only then did their recovery become a necessity.

Framework of the Treatment

My practicum fieldwork site was East Bay Community Recovery Project (EBCRP), Hayward Outpatient Clinic, which specialized in the treatment of co-occurring disorders. Group therapy was provided to address various aspects of co-occurring disorders, and individual therapy was offered to clients who had issues not adequately
addressed in groups. There were approximately six full-time clinical staff, three part-time interns, and three non-clinical staff members. The number of clients enrolled in treatment for co-occurring disorders at the clinic varied between 15 and 30 while I worked there.

Flora sought services at EBCRP in 2006, following conviction for possession of a methamphetamine pipe, after a vehicle search by police a year earlier. She was court ordered to six months of drug treatment under Proposition 36. This is a California State law that gives judges the option of diverting people convicted of minor drug offenses into drug treatment at an approved facility, instead of probation or jail. Flora’s initial assessment was that methamphetamine abuse was her principal problem. Other difficulties noted were cannabis abuse and an unspecified mood disorder. Flora’s last problem was listed as a parent-child relational problem, which was explained as being out of contact with her children and lacking enough money to visit them.

I met with Flora for a total of 20 counseling sessions, over the course of 10 months. These were scheduled for one hour each week, but Flora often missed every other session, and sometimes was absent for longer. During this time, Flora also attended a total of 33 group therapy sessions on a variety of topics. The groups she attended most often included morning community meetings, early recovery group, women’s group, health and wellness, and seeking safety (a group for co-occurring PTSD and addiction). I brought drawing materials, and Flora and I completed one art therapy session. Occasionally, artwork also was included in group therapy.

I contacted Flora between counseling appointments when necessary. I sometimes left telephone messages for her after she missed counseling sessions, to remind her of her next appointment; I wrote two letters warning her she was about to be discharged from
treatment after prolonged absences; and I wrote five letters to the court reporting on her progress in treatment. Scheduled counseling appointments ended seven months into treatment, after Flora was absent for a month. Later, I made two telephone calls to a local residential detox facility that Flora had applied to attend, and I wrote to Flora updating her of the revised admission process.

Confidentiality and Ethical Concerns

The clinical director at EBCRP was initially unwilling to consider my request to write my Clinical Case Study about a client. Her concern was that my Clinical Case Study might violate the strict confidentiality requirements of the Health Insurance Portability and Accountability Act (HIPAA), which specifically restricts the disclosure of information about clients in drug and alcohol treatment programs. Over the course of several months, we spoke briefly at clinical meetings. She alluded to unfounded rumors about the graduate school I attended. I was able to allay her fears without becoming defensive, which favorably impressed her. She later referred me to someone who had expertise in the wording of informed consent forms, and she subsequently gave me permission to proceed with Flora as my subject.

Flora was pleased to hear I wanted to write about her experiences in treatment. When we met some months later to sign the informed consent forms, she showed the same careful interest she had displayed during the intake procedure more than a year earlier. She nodded in approval when she heard that my topic was complicated grief and addiction as co-occurring disorders, and showed pleasure in knowing her story was of interest to me, and perhaps to others.
My clinical supervisor at EBCRP was Anna Talamo, MFT. Anna had a special interest in expressive arts therapy, and encouraged me to try art therapy with clients. I met with her for individual supervision for an hour each week, and she also facilitated the weekly clinical meeting I attended with other interns and clinical staff. Anna helped me become aware of how attached Flora had become to me during counseling, and how this could help Flora face her difficulties. Anna also made me aware that clients at EBCRP often lacked experiences of appreciation and praise, and that tokens of appreciation could benefit their self-esteem. In addition, Janet Kirk, LCSW supervised my work when Anna was unavailable. Janet was trained in family therapy and provided guidance when family issues were discussed at clinical meetings. She helped me appreciate the healing power of therapeutic relationships, and encouraged me to let go of doubts about disclosing my personal experience of recovery.

An ethical concern emerged in supervision after my supervisor said I should stop making counseling appointments with Flora, after she had been absent from treatment for a month. I wanted to ensure that Flora was not abandoned by EBCRP, so I secured permission from my supervisor to continue to meet with Flora when she requested further letters for court hearings. I referred Flora for residential treatment because she was still using methamphetamine and cannabis. She later applied to be admitted to a local residential detox facility, but ultimately did not gain admittance. I continued to write letters for Flora to take to court, and she finally completed her court order, based on the work she had done at EBCRP.

A legal issue surfaced when the judge at one of Flora’s hearings questioned whether EBCRP was qualified to treat Flora under the California Proposition 36 drug
treatment program. I discussed the question with my supervisor, who said the clinic was qualified to treat Proposition 36 clients. She telephoned the person at the court who worked on Proposition 36 cases, confirmed EBCRP’s qualifications, and found out how Flora could receive better representation in court from her public defender.

A confidentiality issue emerged when I reported to the court that Flora had tested positive in drug tests during treatment. My supervisor advised me about how to express this in the least damaging way. Flora became angry when she read her copy of my letter to the court reporting on her progress in treatment. The limits of confidentiality had been explained to Flora during intake. I told her at the beginning of treatment she would not be penalized for testing positive during treatment. Apparently Flora assumed this meant I would not tell the court about her test results.

**Client History and Life Circumstances During Therapy**

I learned that Flora had grown up in a family of alcoholics and addicts, and that she had lost custody of children after each of her two marriages failed. All adults in Flora’s extended family were alcoholics, and her aunt also used methamphetamine. Flora and her cousin began using cannabis and methamphetamine together when they were teenagers. By the time Flora was in treatment, her cousin had been in recovery for 15 years. Flora’s brother also had a history of alcohol and drug use.

Flora grew up in an extended matriarchal family, which consisted primarily of her mother and her mother’s sister, their respective husbands, and their three children. Flora, her brother, and her female cousin often lived at each other’s homes. Flora’s mother left her father when Flora was three years old because he was abusive, and she remarried
within a year. Flora adored her stepfather, who was generous and fun loving with the children, and she said she was “best friends” with her mother.

Flora had two children in her first marriage, both grown to adulthood by the time she entered treatment. Her first husband was an alcoholic, but did not engage in domestic violence. That marriage ended in divorce, and her husband obtained custody of their children. Flora remarried and had three children with her second husband. Her second marriage also ended in divorce, and following an intervention by Child Protective Services six years before Flora began treatment, her husband gained custody of the children. Her second husband did not drink while married to Flora, but later began drinking heavily. As she began treatment, Flora’s two oldest children were aged 29 and 27, and her youngest children, two daughters and a son, were 18, 14 and 12, respectively. At that time, she had not seen her youngest in two years, although they spoke occasionally by telephone and exchanged messages over the Internet.

At the time she entered treatment at EBCRP, Flora was 50 years old. She had never worked for a wage, having worked as a full-time homemaker and mother. Flora relied on a small cash income from General Assistance for living expenses, and received food stamps. Flora lost these benefits for several months during treatment, so she had almost no money. She did occasional yard work and helped friends in exchange for favors and a little extra cash. She lived in a relatively poor neighborhood in a predominantly working-class city in the San Francisco Bay Area, and had lived in the same county all her life. During her 10 months of treatment, Flora had a room in the home of a former boyfriend, who did not drink alcohol or use drugs. This was apparently a secure arrangement; without this room, she could easily have become homeless.
At the beginning of treatment Flora had a boyfriend, with whom she used drugs. She spent most evenings and nights with him, but returned to her own place each day to shower and change clothes. She complained that her current partner was disrespectful, and she separated from him after finding him in bed with another woman and moved back to her former boyfriend’s house.

**Progression of Treatment**

I worked with Flora for 10 months in individual therapy, and she also attended group therapy for the first six months, then intermittent counseling without group therapy for the remaining four months. Flora initially talked about her distress at being apart from her children, later revealing her unfulfilled aspirations, family background, and fear of death. Flora visited her children twice while in treatment, once after five months, and again two months later. Six months into treatment, scheduled counseling appointments ceased after she was absent from treatment for a month. Upon her return, we occasionally met for impromptu therapy sessions, while her outstanding legal problems continued.

Flora thought of completing her court order as a separate problem from quitting drugs. She worked assiduously to convince the court that her work at the clinic fulfilled her court order, but only occasionally discussed her interest in quitting drugs. Late in treatment, she conceded that recovery from addiction was more difficult than she had anticipated, and we worked on getting her admitted to a 45-day residential rehabilitation program. Additional stressors included financial insecurity, the death of her aunt, disappointment with her current partner, and difficulty completing her court order.
At the beginning of counseling, it was clear Flora was very concerned about the absence of her children. Her subjective level of stress was high, and she obsessed constantly about reuniting with them. This had apparently started six years earlier, after Child Protective Services (CPS) removed her children, and the court granted custody to her former husband. Flora thought of her children as if they were still the ages they had been before she was separated from them, and was concerned they had become emotionally estranged from her. While visiting her children, Flora was distressed at how oppositional and defiant they were toward her, and later became concerned her youngest daughter was too young to have a boyfriend and was growing up too quickly.

Flora’s family history of alcoholism and addiction became clear as therapy progressed, and she became preoccupied with her own health and aging. Her mother separated from her alcoholic father when Flora was three, and Flora went to live with her aunt for a year. Following her aunt’s hospitalization and death, Flora became concerned about her own health, and feared she might die without family support, as her mother had done. She also became concerned about how little she had accomplished in life.

Before her current relationship, Flora said she had been single for two years. She was initially optimistic that she and her boyfriend would quit drugs together, but this did not happen. When she moved back into her own room, she saw this as an opportunity to focus on her own recovery. She did not quit while in treatment and eventually resumed the relationship.

Flora’s distress was alleviated after visiting her children, but despite a growing awareness of how dissatisfied she was with her life, she felt helpless to change. I encouraged her to seek recovery from addiction as a way to progress, disclosing that I
had started my own recovery in midlife. Flora’s first visit to see her children was a breakthrough, but her sense of accomplishment was dampened when she learned that her positive drug tests would be disclosed to the court at the end of treatment. Her subsequent absence from counseling led to the end or our scheduled appointments, though she continued to meet with me occasionally until a judge accepted that her court order was complete. Flora did not quit using drugs during treatment, but her grief subsided after visiting her children. I later learned that Flora continued to visit them, and she felt increasingly limited by her friendships with other methamphetamine users.

**Learnings**

The key concepts and major principles from the literature that informed my work with Flora include Rogers et al.’s principle that methamphetamine adversely affects the ability to make decisions and solve problems effectively; Zweben et al.’s principle that methamphetamine users experience pronounced negative affects; Boss’s concept of ambiguous loss, which describes chronic grief resulting from the absence of family members under inconclusive circumstances; Brown’s principle that the development of children in an alcoholic family is constrained by their parents’ immaturity; Murphy and Rosenbaum’s principle that motherhood, as a way to establish a socially valued adult identity, leaves women economically vulnerable; and Freud’s concept of transference.27

As I worked with Flora, I became aware of the effects of methamphetamine on her thoughts and feelings. Flora’s affects often were negative and her narrowed ability to respond left her feeling helpless to quit using drugs and hopeless about renewing contact with her children. Distress had become her predominant affective state, and she had
apparently been stuck in this condition since her children had been removed six years earlier. Flora’s childhood in an alcoholic family had not prepared her well for adult life. Flora was left destitute after her husband took custody of their children. She had no skills to earn a living, and as an adult, had focused on being a mother as a validating identity.

During therapy, Flora confused me with other men in her life, particularly her stepfather, who while an alcoholic, had been a benign and trustworthy figure. Freud’s theory of transference indicates that Flora thought of me as an important person from her past. Indeed, Flora was exploring family relationships from her childhood, as well managing relationships with the men on whom she currently relied.

Whereas transference occurs when the client projects images of their own onto the therapist, the reverse phenomenon, countertransference, occurs when therapists project unconscious images onto their clients. Carl Jung’s concept of countertransference helped me understand my motivation for disclosing my experience of recovery to Flora.

Bion’s concept of projective identification postulates that clients can project unwanted feelings into their therapist without knowing it, and the therapist may feel them instead. This occurred during an art therapy session with Flora, when I felt powerful and unexpected sadness that had nothing to do with my thoughts or the circumstances.

The imaginal psychology concept of imaginal structures helped me understand how Flora and I each reacted in set ways that did not leave room for alternatives. Such limitations are illustrated by the adage that to a hammer everything looks like a nail. Aftab Omer provides the following definition of this concept:

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. During the individuation process, imaginal structures are transmuted into emergent and enhanced capacities as well as a transformed identity. Any enduring and substantive change in individual or group behavior requires a transmuting of imaginal structures. This transmutation depends upon an affirmative turn toward the passionate nature of the soul. 31

Flora resorted to four distinct imaginal structures during therapy: the Bereaved One, the Helpless One, the Manipulative One, and an emergent structure of the Resourceful One. The structure of the Bereaved One is a personification of Flora’s reactions to the loss of her children and the deaths of her aunt and mother. Flora’s Helpless One contrasts with her Resourceful One, which emerged with her first visit to see her children, when she found she was not as helpless as she had believed. The Manipulative One was evident after I disclosed her positive drug test results to the court.

During my work with Flora, I identified several imaginal structures of my own. These were the Abandoned Child, the Vulnerable One, the Recovering One, and the Reliable Ally. The Abandoned One was activated when Flora expressed her grief and helplessness, and I found it difficult to distinguish her distress from my own. The Vulnerable One was activated when Flora accused me of lying to her when I disclosed her drug test results to the court. The Recovering One developed from my 12-step recovery experiences. This structure believed that the answer to Flora’s problem was to work a 12-step recovery program. My Reliable Ally was an emerging capacity present when I appreciated that Flora was doing her best with limited resources.

The events in Flora’s life had a mythic equivalent in the Hymn to Demeter, which illuminated important factors in how her grief was resolved. The Hymn dramatizes a child custody dispute from the mother’s point of view. Though ancient in origin, the Hymn echoes the themes of grief, betrayal, and anger with which Flora struggled. The other
major parallel is that both Flora and Demeter persisted in their grief until their rights to have contact with their children were recognized. In each case, limited contact was all that was necessary to assuage their anger and grief. From the mythic perspective, Flora’s distress can be seen as a positive human response to the threat of separation, thereby restoring dignity to her struggle for self-assertion and justice.

My personal and professional development progressed as a result of working with Flora. My personal development included a better understanding about my affective reactions, as I learned to differentiate between reactions reminiscent of my own early life and those signaled by current events. My professional abilities grew as I discerned the boundaries between Flora and myself more clearly. I found my counseling skills were limited, so I needed to change plans on occasion. I learned to be more realistic in my expectations of Flora, and I saw the value of acknowledging progress. This was my first clinical fieldwork placement, and I gained valuable experience in developing assessments and treatment plans in collaboration with my supervisor and other staff at EBCRP.

In my work with Flora, I incorporated several imaginal approaches to therapy that brought her greater awareness of the limitations imposed by her imaginal structures. I encouraged her to express her emotional experience, which helped her uncover a greater variety of feelings. Flora incidentally engaged in imaginal approaches to therapy by working with peers in group therapy, exposing her to other people in recovery and seriously challenging her beliefs. She told me a joke that revealed a playful self-awareness of her addiction. We did some art therapy to engage her creativity. I challenged her to overcome her belief that she was helpless and to arrange visits to see her children. Flora’s visits with her children restored her physical connection to them,
bringing her interior images of longing and loss into contact with reality. These visits reduced her preoccupation with the past, and increased her awareness of present circumstances and her ability to respond effectively.

Concern for the soul is the primary focus of imaginal psychology. This central purpose has parallels in other psychologies: *individuation* in depth psychology, and *self-actualization* in person-centered therapy. Additional parallel concepts provide a bridge between imaginal psychology and other psychological orientations. *Imaginal process* is the imaginal approach to transformative learning, which cultivates self-awareness by closely examining experience. A similar concept in Gestalt therapy is the *continuum of awareness*, which is to become aware of what requires attention in the present moment and to be able to respond appropriately. Imaginal process takes place within the context of a *collaborative community*, among peers. A learning community of this kind is the *therapeutic community*, a sociocultural concept exemplified by 12-step groups and treatment models in which peers provide a collective learning experience that benefits each participant. The concept of imaginal structure has a parallel in *cognitive schema*, the cognitive-behavioral concept that describes a belief or assumption that is acquired early in life by observing and imitating others. The concept of imagination is important in imaginal psychology because it is the mental faculty that enables coherent meaning to emerge from experience. A parallel psychodynamic concept is the *intermediate area*, between self and other, where inner and outer perceptions are compared to distinguish between subjective and objective reality. These and other parallel ideas help bridge imaginal psychology and other psychological orientations.
Personal and Professional Challenges

Working with Flora presented both personal and professional challenges for me. Personal challenges included listening to her distress without feeling anxious and distressed, too. When she became angry with me for disclosing her test results, and later for withholding further counseling appointments, I felt fearful of her rage and ashamed of letting her down. Flora’s in-the-moment reactions were difficult for me to face because I had spent months trying to be agreeable and build her trust in me.

Professional challenges included working with Flora’s two distinct but overlapping difficulties. Flora’s cognitive limitations made it difficult to communicate effectively with her, and I often expected more of her than she was able to achieve. Staff at the clinic were very supportive of clients, knowing that encouragement was necessary to retain them in treatment, but this was a demanding model to follow. My inexperience led me to accept Flora’s absence from appointments and groups, and I was both surprised and relieved when my supervisor instructed me to curtail counseling appointments. I was unprepared for Flora’s angry reaction to my letter to the court, and I did not have the foresight to prepare her for this eventuality. I was disappointed Flora continued to use drugs, and that her treatment had no clear conclusion; these outcomes left me doubting the value of the work we had done. My supervisor supported my work and helped me realize I could not determine clients’ outcomes.
CHAPTER 2

LITERATURE REVIEW

Introduction and Overview

This Literature Review examines the research, theory, and treatment pertinent to
the co-occurring disorders of addiction and complicated grief. Literature on these topics
is explored from several psychological orientations in six sections, including the
biological, cognitive-behavioral, psychodynamic, sociocultural, and humanistic
perspectives; lastly, imaginal approaches to addiction and complicated grief are explored.

Research on the etiology of the co-occurring disorders of addiction and
complicated grief indicates both heritable traits and environmental factors are involved.
There is a consensus of opinion among researchers from the various psychological
orientations surveyed that adverse developmental experiences during childhood are
correlated with the emergence of complicated grief and addiction.¹

Psychotherapies for co-occurring disorders differ with respect to how much
authority is ceded to clients to trust their own judgment and make their own choices.
Alternate approaches include person-centered therapy, in which the client’s perceptions
are accepted as facts that may be subject to change, and cognitive-behavioral treatments
that challenge the client’s opinions and choices if they appear irrational.² Some treatment
models combine approaches from cognitive-behavioral and humanistic psychological
orientations.³
The Biological Perspective on Co-occurring Disorders explores biological processes that affect symptoms associated with the co-occurring disorders of complicated grief and addiction. Neuroimaging has shown that particular brain areas are affected by drug use, and one area is also involved in complicated grief. Studies also have shown that monoamine neurotransmitters, particularly dopamine, mediate the effects of addiction.

The Cognitive-Behavioral Perspective on Co-occurring Disorders focuses on the thoughts and behaviors associated with addiction and complicated grief. Cognitive-behavioral treatment for addiction includes providing information about addiction, examining the consequences of addiction, and promoting alternative thinking and behavior. Cognitive-behavioral treatment for complicated grief promotes alternate patterns of thinking to integrate feelings for the deceased, and increase social engagement.

The Psychodynamic Perspective on Co-occurring Disorders examines the symptoms and etiology of addiction and complicated grief. Negative affects are noted in both disorders, and addiction is considered an attempt to self-medicate them. Underlying features associated with addiction are thought to be personality distortions resulting from unmet needs during childhood. Similarly, the course of mourning is thought to be shaped by the quality of attachment during infancy. Two proposals of diagnostic criteria for complicated grief are included.

The Sociocultural Perspective on Co-occurring Disorders focuses on the social conditions and cultural milieu in which addiction and complicated grief occur. Similarly, treatment from this perspective finds solutions in increased social support and cultural
understanding. The therapeutic community model for addiction treatment has also been applied to co-occurring disorders. Opportunities for mothers with addiction are forestalled by intergenerational abuse and drug use, and inadequacies in services available to support recovery, which are sustained by the high cultural and low economic values attached to mothering. The grief of impoverished mothers who have had children removed from their custody and the institutional barriers to family reunification are presented from the perspective of front-line social service workers.

The Humanistic Perspective on Co-occurring Disorders examines two associated psychologies that seek to promote the development of individuality, freedom, and choice. The first is Carl R. Rogers’s person-centered therapy, which encourages self-acceptance as a prerequisite for personal development, catalyzed by the empathic and genuine interest by the therapist. The second is Rollo May’s existential psychology, which considers anxiety a natural response to the limitations of life. Motivational interviewing, an eclectic treatment for addiction, combines person-centered, empathic therapy and individual choice with cognitive-behavioral interventions.

Imaginal Approaches to Co-occurring Disorders includes concepts and principles relating to experiential influences that shape the individual, and also heritable possibilities collectively described as soul. As Omer states, “Imaginal Psychology is a distinct orientation to the discipline of psychology. This orientation reclaims soul as psychology’s primary concern.” Soul, like psyche, is intangible, but manifests through images. Omer continues: “The soul expresses itself in the images we inhabit. Care of the soul asks that we pay close attention to images we inhabit.” Images in this case are the
potentials of human nature that blossom as feelings, dreams, and thoughts. Omer states that “the soul’s transformative imperative is to grow and differentiate.”

Imaginal Approaches to Co-occurring Disorders integrates research from various disciplines and proposes that both nature and nurture, or soul and experience, are involved.

**Biological Perspective on Co-Occurring Disorders**

The Biological Perspective on Co-occurring Disorders explores biochemical processes in particular brain areas, and how these affect symptoms associated with addiction and complicated grief. The literature presents a complex picture of the neurological processes underlying addiction, focusing on altered functioning in particular areas, notably in the prefrontal cortex and the limbic system. Related neurochemical research focuses on the influence of neurotransmitters on the functioning of these brain areas, especially the main monoamine neurotransmitters (i.e., dopamine, epinephrine, norepinephrine, and serotonin) on arousal, motivation, learning, and behavior. First-time drug use, novelty seeking, and impulsivity are associated with adolescent cognitive development, and are mediated by changes in the balance of dopamine and serotonin.

Four central features of addiction (i.e., the desire to reuse, obsessive craving, loss of control leading to compulsive drug use, and withdrawal) are explored. Cognitive changes associated with exposure to addictive drugs include increased risk taking, slowed thinking, and inflexible thinking. There is evidence complicated grief involves a brain area associated with attachment, craving, and rewards, indicating a link between the
processes that maintain addiction and chronic mourning. Chronic distress is shown to be associated with addiction and several co-occurring disorders.

Roy A. Wise cites a variety of research, including his own animal studies with rats, indicating that although various addictive drugs act on different parts of the brain, the compulsion to continue using is a habit formed by positive reinforcement of the reward circuits (a system of associated brain areas that usually promotes behavior to satisfy natural desires, such as for food and sex). He asserts that the positive reinforcement value of euphoria associated with drug use, rather than an aversion to the unpleasant feelings of withdrawal, accounts for drug dependence. Wise theorizes that withdrawal is a rebound depression (dysphoria caused by depleted dopamine following drug use), and that craving and drug-seeking behavior represent an attempt to secure renewed stimulation of the reward system.

Wise asserts that addictive drugs affect the brain because they are similar to natural brain chemicals, and addictive drugs act by stimulating the release of neurotransmitters, prolonging their presence or sensitizing their receptors. Wise cites various studies indicating that addictive drugs (e.g., amphetamines, nicotine, cocaine, and opiates) activate the neurotransmitter dopamine in both the frontal cortex and limbic areas of the brain.

The tendency among drug addicts to continue using despite negative consequences was investigated by Edythe D. London et al. Drawing on findings from several functional magnetic imaging (fMRI) studies, London et al. hypothesize that addiction persists because of dysfunctional thinking and emotional dysregulation that occur with long-term use of various addictive drugs. London et al. propose that the
orbitofrontal cortex mediates between the executive functions of the prefrontal cortex and the emotional influences of the limbic system. They find that drug use causes functional deficits in the ventromedial prefrontal cortex, which bias evaluations in the orbitofrontal cortex in favor of impulsive action. London et al. suggest this finding explains why addicts are compelled to use drugs to gain immediate relief from craving, while ignoring negative long-term consequences to their health and well-being.

Chambers, Taylor, and Potenza regard impulsivity and novelty seeking as developmentally appropriate for adolescents. They assert that young people are more likely than adults to try drugs for the first time, that adults with addictions often started using as adolescents, and that earlier onset leads to more severe addiction. Chambers, Taylor, and Potenza present convergent findings from various sources indicating that adolescents are biologically predisposed toward seeking novelty and excitement because of a developmentally timed shift from the inhibitory neurotransmitter serotonin, to dopamine, which signals “go.” They also assert that impulsivity is correlated with immature brain development, particularly of the prefrontal cortex and connected underlying structures that regulate motivation and reward.

The effects of long-term amphetamine and opiate use on cognitive abilities were explored by R. D. Rogers et al. in a study involving the quantitative analysis of results from several neurological assessments. They report that the speed and quality of amphetamine users’ decision making declined with years of use, and that cognitive declines were associated with neurotransmitter deficiencies in the orbital prefrontal cortex and associated limbic structures. Rogers et al. studied 18 amphetamine addicts (16 also used cannabis) and 13 opiate addicts, who had used for an average of 13 to 14
years. Three comparison groups and a control group were included. Rogers et al. report declines in the speed of all drug-using subjects on decision-making tasks. Similar performances were noted among comparison subjects with orbital prefrontal cortex lesions and among normal subjects with induced tryptophan depletion to mimic reduced monoamine neurotransmitter levels. Uniquely, the authors report the amphetamine users persisted in using problem-solving strategies that did not lead to success. This result also was observed in non-using subjects with artificially reduced monoamine neurotransmitter levels.

Kenneth M. Dursteler-MacFarland, Katrin Herot Cereghetti, and Gerhard A. Wiesbeck express concern that the research showing an association between cognitive deficits and substance use has not been integrated into treatment for co-occurring disorders. They suggest that cognitive testing and the use of appropriate treatment methods to accommodate varying cognitive abilities could improve treatment retention rates and reduce the incidence of relapse. They assert that substance users are difficult to retain in treatment and have poor outcomes because neurocognitive deficits acquired from drug use affect attention, comprehension, memory, and decision making. They recommend testing, especially of memory and executive functioning, for substance-using clients who do not respond well to treatment.

Another feature associated with addiction is chronic distress (constant stress response). Kathleen T. Brady and Rajita Sinha report the experience of chronic distress is integral to both the causes and effects of addiction and other co-occurring disorders. They compared extant research on the neurological and functional processes of addiction in combination with several co-occurring disorders (e.g., depression, PTSD, ADHD, and
and conclude distress can aggravate the primary disorder, and then precipitate subsequent co-occurring disorders. Despite the variety of brain areas and neurotransmitters excited by different drugs and involved in the co-occurring disorders discussed, Brady and Sinha claim the common feature of subjective distress is dysregulation of the reward system and stress response system.

A quantitative study by O'Connor et al. isolates an important distinction between normal grief that resolves in time and complicated grief that persists. This study indicates that the resolution of grief involves two processes: acceptance of loss and a diminished longing for the lost one. The authors report that all grief subjects in their study experienced momentary pangs of grief when viewing pictures and words associated with their lost ones, but subjects suffering from complicated grief experienced additional yearning, no matter how long ago their loss had occurred. The evidence cited for this finding comes from fMRI scans that show two distinct brain areas are activated by stimuli associated with the subjects’ loved ones. The dorsal anterior cingulate cortex (dACC), associated with both physical and social pain, was activated in all subjects, but subjects suffering from complicated grief showed additional activity in the nucleus accumbens (NA), an area associated with attachment, craving, and reward. O’Connor et al. assert that activation of the NA also is associated with addiction, suggesting similarities between distress induced by complicated grief and distress induced by drug dependence.

The Biological Perspective on Co-occurring Disorders indicates that biological processes associated with addiction adversely affect several cognitive faculties, including learning, memory, and impulse control. Additionally, physiological and biochemical
research has found that addictive drugs affect specific brain areas, particularly in the frontal cortex and limbic system, through changes in monoamine neurotransmitters.\textsuperscript{56}

Of particular relevance to this Case Study, because the client in this Case Study began using drugs as a teenager, is research indicating that changes in neurochemistry during adolescence can induce drug use and long-term addiction.\textsuperscript{57} The client’s difficulty attending treatment, her lack of comprehension, and her limited problem-solving abilities were found to occur with drug use.\textsuperscript{58} The high level of distress experienced by the client is associated with both addiction and several co-occurring disorders.\textsuperscript{59} Also relevant is the finding that a brain area that integrates emotional and physical pain is associated with both complicated grief and craving linked to addictions.\textsuperscript{60}

**Cognitive-Behavioral Perspective on Co-occurring Disorders**

The Cognitive-Behavioral Perspective on Co-occurring Disorders focuses on identifying and promoting effective ways to treat addiction and co-occurring mental disorders by promoting new thinking and alternative responses.\textsuperscript{61} From this perspective, drug abuse is viewed as a habit with maladaptive consequences, and change is seen to result from informed choice.\textsuperscript{62} Najavits’s cognitive-behavioral treatment for co-occurring addiction and PTSD combines cognitive-behavioral and humanistic therapeutic theories.\textsuperscript{63}

Cognitive-behavioral research focusing on types of grief reaction and on factors that contribute to complicated grief (e.g., relational deficiencies and trauma) is included.\textsuperscript{64} Malkinson’s cognitive-behavioral treatment regards grieving as a process of adjustment, with continued attachment to the memory of the deceased, and sees complicated grief as a maladaptive form of grieving due to trauma or attachment problems.\textsuperscript{65}
James O. Prochaska and Carlo C. DiClemente developed a cognitive-behavioral model for treating addictions and compulsive disorders. They view addiction "as an overlearned habit" and assert that recovery involves intentional change: choosing beneficial over harmful thinking and behavior. Their main principle is that change progresses through four stages of change: precontemplation, contemplation, action, and maintenance. Prochaska and DiClemente claim their model is based on quantitative research and uses principles derived from various psychological orientations. For example, in their model, consciousness raising (raising unconscious motivations to conscious awareness through feedback and education) is intended to promote the belief that change is both possible and beneficial. Prochaska and DiClemente report particular processes to promote change are effective at specific stages (e.g., consciousness raising is effective during the contemplation stage of early recovery).

A comprehensive approach to treatment for co-occurring PTSD and drug abuse is represented by Najavits’s Seeking Safety, a primarily cognitive-behavioral therapy manual that includes a humanistic interpersonal approach. Najavits’s model is intended to provide integrated treatment for both PTSD and substance abuse, simultaneously addressing treatment concerns common to both. Najavits addresses the first stage of Lisa Herman’s three-stage process of recovery from trauma: safety, mourning, and reconnection. Najavits’s treatment for PTSD is present centered, focusing on solving current problems, rather than on exploring past trauma, exposure, or flooding. Najavits makes abstinence a goal that is supported by harm reduction, drug testing, and suggested participation in 12-step self-help groups. Effective therapy in this model includes building an alliance with clients, showing empathy for their experience, and giving them
control whenever possible. Najavits intends therapists to be engaged and creative, rather than use a mechanistic presentation with clients.

The loss of a loved one under traumatic circumstances is described by Margaret Stroebe, Henk Schut, and Catrin Finkenauer as **traumatic grief**. Stroebe, Schut, and Finkenauer assert that traumatic grief is composed of two distinct but overlapping stress reactions—separation distress due to bereavement and traumatic distress due to the traumatic circumstances of the loss—that have many symptoms in common. Stroebe, Schut, and Finkenauer conjecture that when the death is not traumatic, **pathological grief** (a parallel concept to complicated grief) may be related to the quality of the relationship between the survivor and the deceased.

George A. Bonanno et al. investigated how the quality of relationship between spouses affects how they grieved following the death of their spouse. Bonanno et al. conducted a longitudinal, quantitative study that assessed subjects while their spouses were alive, at six months following bereavement, then again 18 later. Bonanno et al. identified five distinct categories of grief reactions and found the largest group of subjects could be described as “resilient,” reporting low levels of grief and depression before and after bereavement. In contrast with the resilient group, a smaller “chronic-grief” group had lower levels of depression prior to loss, but sustained much higher levels of grief and depression following the loss of their partner. Subjects who were “chronically depressed” had high levels of depression both before and after loss, and sustained higher levels of grief than did the chronic-grief group. Members of the “depressed-improved” group were likely to have cared for a sick spouse, and to have a negative outlook on life. All groups showed declines in grief symptoms between six
and 18 months after loss, but both the chronically depressed and chronically grieving groups experienced the highest levels of grief throughout the study.

Malkinson’s short-term cognitive-behavioral therapy (CBT) for grief is modeled on Albert Ellis’s rational emotive behavioral therapy (REBT), and is based on the principle that cognition has a mediating effect on mental schemas (patterns of thinking), emotions, and behavior. In examining how patterns of thinking develop, Malkinson agrees with John Bowlby that attachment during childhood sets an enduring pattern for later relationships, and asserts that the ability to adapt to loss following death follows the quality of attachment to the lost loved one. Malkinson views complicated grief as a chronic maladaptive response to bereavement, involving an inability to adapt the “schema of attachment” to the reality of loss and resume involvement with other social relationships and activities.

Malkinson asserts that changing cognition is key to treating acute symptoms of grief, which involves providing information about the grief process, and teaching patients to use coping statements, thought stopping, cognitive rehearsal, guided imagery, and cognitive reframing. For complicated grief, Malkinson recommends disputing irrational beliefs to show the association between irrational beliefs and maladaptive consequences. She also suggests the patient write a letter or speak out loud, as if the deceased were present, to express irrational thoughts and provide impetus to move on to more adaptive thinking.

The Cognitive-Behavioral Perspective on Complicated Grief and Addiction as Co-occurring Disorders focuses on factors that contribute to these disorders (e.g., trauma and the quality of interpersonal relations). From this perspective, addiction and
complicated grief are understood as patterns of thinking and behavior that can be replaced by other, more adaptive alternatives. The cognitive-behavioral treatment models included in this Literature Review seek to promote awareness and choice as the means to accomplish change.

Among cognitive-behavioral treatments reviewed, Najavits’s treatment for addiction and PTSD and Prochaska and DiClemente’s stages of change in recovery from addiction were in use at the clinic where the subject of this study received treatment. Najavits’s model is significant because of its focus on resolving the client’s present difficulties, and on collaborating on treatment goals. Prochaska and DiClemente’s stages are relevant in group therapy because of the focus on raising the client’s awareness about addiction in early recovery.

**Psychodynamic Perspective on Co-occurring Disorders**

The Psychodynamic Perspective on Co-occurring Disorders identifies symptoms associated with addiction and complicated grief, and hypothesizes that underlying circumstances and personality types make some people more susceptible than others to these disorders. Psychodynamic researchers, such as Zweben et al., confine observations to presenting symptoms. Others, such as Bowlby and Kohut, propose that deficiencies in care during childhood lead to addiction and complicated grief. The theme of negative affect runs through the psychodynamic literature on co-occurring disorders, both in the experience of adult addicts, and as a precursor to addiction established during childhood. Similarly, in Bowlby’s opinion, distress during grieving echoes feelings of abandonment and loss during childhood, and chronic mourning results from inadequate
attachment to the mothering figure.\textsuperscript{98} Key interpersonal concepts developed by psychodynamic theorists are also introduced.

Some psychodynamic authors find that addicts take drugs for a purpose: Kohut believes addicts use drugs to compensate for low self-esteem, and Krystal understands drug use as a way to defend against unwanted and unpleasant feelings.\textsuperscript{99} The psychodynamic view of grief also includes purpose. Both Freud and Baker say the purpose of mourning is to adjust to the reality of loss, and view \textit{pathological mourning}, a parallel concept to complicated grief, as the inability to adjust to reality, and as an obsession with loss leading to depression.\textsuperscript{100} The psychodynamic perspective also includes diagnostic criteria for two models of grief that does not resolve with time: \textit{complicated grief disorder} (prolonged grieving in the absence of trauma), developed by Horowitz et al., and Prigerson and Jacobs’s \textit{traumatic grief} (prolonged grieving associated with trauma).\textsuperscript{101}

Zweben et al. report on a large-scale study of 1,016 methamphetamine addicts, which focused on the variety and extent of psychiatric symptoms their subjects presented.\textsuperscript{102} Assessments were made using self-report symptom checklists and inventories for the presence of various disorders, but did not seek to determine which disorder precipitated or preceded others.\textsuperscript{103} Overall, participants were found to have a high incidence of various psychiatric disorders co-occurring with methamphetamine addiction.\textsuperscript{104} In particular, Zweben et al. observed high incidences of depression, suicide attempts, anxiety, and psychotic symptoms (especially during intoxication and withdrawal).\textsuperscript{105} Symptoms were exacerbated by frequent methamphetamine use, and administration by injection, but duration of use did not affect severity of symptoms.\textsuperscript{106}
Participants frequently reported obsessively negative thoughts, feelings of failure, self-blame, and expectations of being punished.\textsuperscript{107} A high incidence of violence was reported among male participants, and women reported difficulty controlling anger.\textsuperscript{108} Zweben et al. conclude by emphasizing the importance of training clinicians and designing treatment programs to address the wide variety of psychiatric disorders co-occurring with addiction.\textsuperscript{109}

A broader theoretical view of addictions and their formation is offered by Kohut, who views addiction as an attempt to self-medicate a psychological defect.\textsuperscript{110} Kohut asserts that drugs are used to compensate for a lack of self-esteem and ability to self-soothe, due to inadequate care during early development.\textsuperscript{111} Kohut regards addiction as a personality disorder, and sees taking drugs as comparable to a narcissist seeking admiration and a delinquent demonstrating power—all forms of acting out to gain temporary gratification in compensation for unmet developmental needs.\textsuperscript{112} Kohut uses the term \textit{self-object} to denote the idealized qualities children see in their parents, and later develop in themselves, and he believes such implicit learning protects children from later becoming addicts and seeking external support for what they lack internally.

Krystal considers the affective (or emotional) consequences of trauma during childhood, and their contribution to addiction.\textsuperscript{113} He advances the principle that traumatic events are experienced as “overwhelming affects,” and that defenses (e.g., drug addiction) are formed to guard against further overwhelming feelings.\textsuperscript{114} Krystal describes the reactions of infants to excessive stress as an all-out “alarm” to prevent abandonment, and he asserts that the ability to feel pleasure is permanently diminished if the infant is stressed for too long or too often.\textsuperscript{115} Krystal finds that children who
experience trauma become sensitized to negative affects reminiscent of their trauma, and as adults become chronically depressed and unable to feel pleasure. His opinion is that drug addicts similarly lack the ability to feel positive affects, and in the absence of the ability to self-soothe, use drugs as an external substitute for mothering care. Krystal concludes addicts feel threatened by the prospect of quitting and experiencing feelings without drugs, because negative experiences of parenting leave them unwilling to internalize parental care, which was originally alloyed with harm. Krystal notes a corollary effect among addicts in therapy, who “expect disappointment and rejection” in reaction to the prospect of a positive reward.

Negative affects associated with addiction are common when grieving the loss of a loved one. Freud compares mourning and depression and says both involve disengagement from life and withdrawal of love. The difference Freud finds is that self-regard is diminished in depression but unaffected during normal mourning. Freud asserts the pain of grief is caused by the discrepancy between the objective fact that the loved one has been lost and the psychological need to preserve an attachment to the deceased. He adds that the work of mourning is a slow process of detaching the ego from memories of the deceased and longing for them. Although Freud considers mourning an unusual process (counter to the normal aim of seeking pleasure), he accepts common wisdom that it is an unavoidable response to loss, unlike depression, which he understands as frankly pathological. Freud distinguishes normal grief from pathological mourning, or “obsessional states of depression,” which he describes as a narcissistic loss to the ego, when grief is not for the loss of one held dear, but for the loss of support for the griever’s own immature sense of self. Freud’s principle is that
mourning is complete when the ego is reconciled to the reality of loss, and disidentified with the deceased.125

In contrast with Freud’s view of mourning, Baker describes grief as a process of transformation.126 This more recent approach emphasizes a continuing connection with the deceased, and focuses on the gradual “transformation of object relationships” (or inner relationships) during grief.127 Baker proposes that an internalized relationship with the deceased may offer continued comfort, help, and guidance, and a reassuring source of identity, through internal dialogue with the deceased.128 Distinct from the wide range of normal grief reactions, Baker conceptualizes pathological mourning as unchanging or obsessionally tragic pangs of grief extending beyond six to 12 months.129 He suggests that if the survivor is continuously preoccupied with thoughts about the deceased or busily preoccupied to avoid feelings, this may indicate depression or feelings of abandonment.130 Baker asserts that pathological mourning is indicated if the survivor accesses only favorable or unfavorable memories of the deceased, or if memories of the deceased do not change as time goes by.131

Baker’s opinion on the process of mourning is in concert with that of Bowlby.132 Bowlby hypothesizes that mourning is a gradual process of accepting loss, competing with defenses against the intrusion of “unwelcome information.”133 In his opinion, the course of mourning reflects experiences of attachment during infancy, childhood, and adolescence, and disordered mourning among adults reflects earlier experiences of grief due to inadequate attachment to or separation from the mothering figure.134

Bowlby observes that mourning normally progresses through four stages: numbing, yearning and searching, disorganization and despair, and finally, reorganization.135 He
finds that disordered mourning takes two related forms, each comprising early phases of normal mourning, without progressing to the final stage of reorganization. One form of disordered mourning features a prolonged absence of awareness of loss, in which numbing is extended through diversionary activities (e.g., caring for others). The other kind of disordered mourning is *chronic mourning*, which features the distress typical of the second stage of normal grief reactions (i.e., yearning and searching). According to Bowlby, the social bond of attachment between infant and caregiver is promoted by innate behaviors (e.g., sucking, clinging, following, and crying by the infant) to keep the infant safe by being close to the parent. The quality of this early bond forms the basis of personality, and shapes the quality of caregiving in adulthood.

The psychodynamic literature includes research into the diagnostic criteria for unusual patterns of grief. The first diagnostic criteria comprise what Horowitz et al. call *complicated grief disorder*, which focuses on stress reactions following non-traumatic loss. The second is Prigerson and Jacobs’s *traumatic grief*, which is distinguished from other stress reactions by symptoms of distress caused by separation due to loss.

Horowitz et al. identified seven signs and symptoms of complicated grief disorder in a quantitative analysis of a longitudinal study of bereaved subjects. Horowitz et al. used a structured interview to assess 70 subjects for a wide variety of grief symptoms found in previous studies, and identified a subset of seven symptoms of chronic distress. They claim these symptoms are distinct from depression and also unlike PTSD because they are not caused by traumatic circumstances. Horowitz et al. conclude that complicated grief is a distinct mental disorder and should be included as a stress disorder in a future edition of the *Diagnostic and Statistical Manual of Mental*
Disorders (DSM), using diagnostic criteria based on the signs and symptoms identified in their study. Horowitz’s assessment of complicated grief disorder includes:

Intrusive symptoms
- Unbidden memories or intrusive fantasies related to the lost relationship
- Strong spells or pangs of severe emotion related to the lost relationship
- Distressingly strong yearnings or wishes that the deceased was there

Signs of avoidance and failure to adapt
- Feelings of being too much alone or personally empty
- Excessively staying away from people, places, or activities that remind the subject of the deceased
- Unusual levels of sleep interference
- Loss of interest in work, social, caretaking, or recreational activities to a maladaptive degree

Holly O. Prigerson and Selby C. Jacobs report on research into traumatic grief. Starting with a set of criteria agreed on by a panel led by Prigerson, their quantitative study asked 306 participants to complete a questionnaire seven months after the death of a spouse. Prigerson and Selby propose a set of criteria, which was amended following the study, for traumatic grief, and recommend traumatic grief be included as a distinct stress disorder in a future edition of the DSM. Despite overlapping features with depression, adjustment disorder, and PTSD, Prigerson and Selby contend they are describing a disorder distinct from other stress disorders, based on their inclusion of criteria assessing the presence of separation distress, in addition to traumatic distress.

Prigerson and Selby’s refined criteria for traumatic grief include:

Criterion A
- Experienced death of a significant other
- Response involves 3 of the 4 symptoms below experienced at least sometimes:
  a) Intrusive thoughts about deceased
  b) Yearning for the deceased
  c) Searching for the deceased
  d) Loneliness as a result of the death (salient to separation trauma and distress)
Criterion B—In response to the death, 4 of the 8 following symptoms experienced as mostly true:

- Purposelessness or feelings of futility about the future
- Subjective sense of numbness, detachment, or absence of emotional responsiveness
- Difficulty acknowledging the death (e.g., disbelief)
- Feeling that life is empty or meaningless
- Feeling that part of oneself has died
- Shattered worldview (e.g., lost sense of security, trust, control)
- Assumes symptoms or harmful behaviors of, or related to, the deceased person
- Excessive irritability, bitterness, or anger related to the death

Criterion C
Duration of disturbance (symptoms listed) is at least two months

Criterion D
The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.

Psychodynamic research also reveals several interpersonal affective experiences that may become evident during therapy. Freud finds that strong and unwelcome affects are frequently defended against by attributing them to others, through projection, so instead of being part of subjective experience, they appear to be part of objective reality. Freud hypothesizes the propensity to project thoughts and feelings onto others is founded on the basic mental ability to construct a convincing external reality out of sensory perceptions. The related concept of transference was first used by Freud to indicate the tendency of clients to project experiences associated with people from their past onto their therapists, offering the opportunity for unconscious desires to be re-experienced with greater awareness in the present. Countertransference is the term used by Jung for a reverse phenomenon, whereby therapists identify qualities in their patients that are actually projections of their own unconscious. Jung considers “counter-transference evoked by the transference,” the mutual transference of unconscious identifications between clients and therapists, disastrous to the progress of
However, he asserts the doctor must be as involved in the therapy as the patient, each influencing the other, with the goal of achieving a “mutual transformation” in therapy. Jung finds progress in therapy depends on the therapist’s heightened level of awareness in the interpersonal exchange; he exhorts therapists to walk their talk: “be the man through whom you wish to influence others.”

A further permutation of these concepts is projective identification, which Melanie Klein used to describe how infants project negative affects onto their mothers, to protect their emerging sense of individuality against unpleasant feelings. She provides a succinct definition: “Identification by projection implies a combination of splitting off parts of the self and projecting them on to (or rather into) another person.” Bion reinterprets projective identification to include patients who deny an aspect of their experience, but confirm this quality in their therapist instead. Concerning a particular instance of projective identification, Bion states, “I think it is a situation in which the patient is projecting part of himself into me, so that I experience frustration but he does not.”

The Psychodynamic Perspective on Co-occurring Disorders examines a wide variety of psychiatric symptoms, notably negative affects, associated with addiction and complicated grief. The psychodynamic literature also examines underlying causes, particularly traumatic experiences of abandonment and abuse during childhood. Some of the research supports the principle that addiction can be understood as an attempt to self-medicate negative affects associated with inadequate care during development. Psychodynamic literature views mourning as a process of adjustment to the reality of loss, and complicated grief as an inability to let go or to adapt to loss.
psychodynamic concepts that informed the therapy are included. Proposals for definitive symptoms of both complicated grief disorder and traumatic grief conclude this psychodynamic Literature Review.164

Most informative to this Case Study are the negative affects found to be associated with addiction, and the glossary of concepts that informed relational aspects of the therapy. Also of relevance to the client in this Case Study are Bowlby’s observations that the quality of care giving and grieving echoes attachment experiences during early life.165

**Sociocultural Perspective on Co-occurring Disorders**

The Sociocultural Perspective on Co-occurring Disorders considers the social circumstances and cultural context in which people develop and live, and how these affect quality of life. Sociocultural research into drug-addicted and impoverished mothers who lose custody of children evaluates the quality and availability of help that society provides, and how this helps or hinders good health and well-being.166 Researchers note the traditionally disparate treatment cultures of addiction recovery and mental health services, and advocate for integrated services to effectively meet the needs of patients with co-occurring disorders.167 George De Leon introduces the therapeutic community (TC) model for self-help addiction treatment, and finds that a modified TC model is effective in treating co-occurring disorders.168

The sociocultural literature on complicated grief explores how failures in social support contribute to suffering. Boss discusses her concept of ambiguous loss, a parallel concept to complicated grief, following losses in the family that lack closure.169 Holli
Ann Askren and Kathleen C. Bloom review the scant literature on mothers who have relinquished their children to the care of others. Research into the lives of pregnant women and mothers who use drugs, and into their experiences of repetitive trauma and loss, is included. Sylvia Novac et al. report on the experiences of social service workers, and the trauma both mothers and professionals experience when children are removed from their mothers. Together, this body of research presents a web of social circumstance and cultural experience that is relevant to understanding the woman who is the subject of this Case Study.

Minkoff and Drake state that there is a growing awareness of the need to treat patients with both an addiction and an additional co-occurring mental disorder: “In many settings, the presence of such ‘dual diagnoses’ in the treatment population is so common that it must be considered to be an expectation, rather than an exception.” However, Minkoff asserts that mental illness and addiction have been administered by separate government agencies in the United States, and treatment for co-occurring disorders has required the coordination of traditionally disparate treatment cultures. Minkoff sums up the historical difference in treatment cultures for mental illness and addiction recovery as “care versus confrontation.”

Minkoff describes two models of treatment for co-occurring disorders: parallel treatment, and integrated treatment. Parallel treatment uses existing facilities that specialize in either addiction or mental health treatment, which places the responsibility for the coordination of services on case managers, and clients may experience “ping pong” treatment when coordination is lacking. Alternatively, the integrated treatment model regards both addictions and major mental disorders as chronic mental illnesses,
with some similarities in etiology and prognosis, and provides comprehensive services at the same site. Integrated treatment requires the cross-training of staff who previously received specialized education and training in either addiction or mental health treatment. Benefits of the integrated model include simplified case management and coordination of treatment for patients; difficulties include accommodating various degrees of ability presented by clients.

Treatment for co-occurring drug addiction and mental disorders can be achieved through immersion in the pro-social environment of a modified TC model, according to De Leon. He states that TCs work through “mutual self-help” in a structured community setting, in which staff and experienced participants model behavior for new participants. According to De Leon, the daily regimen in standard TC treatment programs for drug addiction includes group encounters with feedback from staff and participants, group therapy, individual counseling, psychoeducation on addiction, and the fulfillment of vocational and housekeeping tasks. De Leon explains that the modified TC model for the treatment of co-occurring disorders has a similar structure, but is less demanding and offers more individual support and encouragement, with a greater emphasis on psychoeducation and less emphasis on rules. Twelve-step meetings are often integrated into TC treatment programs, or participants may attend outside meetings as an adjunct to treatment. De Leon cites research supporting the efficacy of both TC models, with persistent attendance resulting in reduced psychopathology, drug use, and unsociable behavior, at less cost for residential programs than for hospital care or jails.

According to Boss, the absence of family members under uncertain circumstances can cause feelings of ambiguous loss (a parallel concept to complicated grief).
conducted qualitative research on inconclusive absences in family groups, and identified two kinds of ambiguous loss. The first can result when a family member is physically absent but psychologically present, and the second can result when a family member is psychologically absent but physically present. Boss asserts that ambiguous losses leave surviving family members oscillating between hope for the return of absent family members and despair that they will not return, which causes disabling stress and unresolved grief.

Boss finds that others may not be aware of hidden losses, or may dismiss them, leaving those suffering ambiguous loss “frozen” in “confusion” and grief. And she notes that to maintain belief in a just and predictable world, some people misattribute blame. Boss advocates listening to the stories of unresolved grief, and validating the accompanying mixed feelings, or the doubt about whether feelings are valid. She finds that unresolved losses can change despite lack of resolution; changes in perception can come after a personal crisis, or following the realization that feelings of helplessness are due to the uncertainties that have been endured. Finally, Boss asserts that change can also occur by taking action, helping others, or by finding solace in religious beliefs, spiritual practice, and family rituals, to make new meaning of loss and transform remaining ambiguities.

Many studies of grief examine bereavement following the death of a loved one, whereas Askren and Bloom specifically investigated experiences of grief among mothers who had relinquished children for adoption. The authors note that little research has been done on the birth mothers of adopted children, as interest tends to focus on the welfare of the child and the adoptive parents. Their method was to qualitatively review
12 extant studies on the reactions of adult mothers who had given up children for adoption. Askren and Bloom find the mothers’ grief was often protracted, sometimes becoming more intense as time passed, and that lack of cultural acceptance for their feelings contributed to their condition.\(^{198}\)

A qualitative study by Murphy and Rosenbaum focused on 120 women who were pregnant or had recently given birth, and used drugs; many had lost custody of their infants.\(^{199}\) Murphy and Rosenbaum’s study was conducted in San Francisco during the 1990s, with participants who were principally addicted to heroin, cocaine, or methamphetamine.\(^{200}\) Their method was to conduct interviews that gave participants the role of experts, choosing which subjects to discuss.\(^{201}\) The authors describe how many of the participants grew up in poor families where abuse and drug addiction were common, began using drugs as teenagers, and reached adulthood with limited options for employment.\(^{202}\) The authors present the dilemmas faced by drug users during pregnancy, such as whether to abort the fetus or continue the pregnancy, fear of harming the fetus if they continued using drugs, and whether to tell medical staff of their drug use as the birth approached.\(^{203}\) After abortions or having live children removed from their custody by “baby snatchers” (social workers), many of the women in this study reported diminished self-worth, followed by heavy drug use; some quickly became pregnant again, aspiring toward the socially acceptable identity of “good mother.”\(^{204}\)

Murphy and Rosenbaum conclude by discussing the idealization of the role of motherhood, and its value to many women in their study as a way to achieve adult feminine status.\(^{205}\) The authors offer a feminist critique, noting the contrast between the high social value of mothering and its low economic value, and the dependence of
mothers and their children on male partners or the paternalistic state for financial support. \(^{206}\) They note the decline of social services available to women and children since the 1970s, subsequent demonization by the press of pregnant women and mothers who have used drugs, and the concomitant rise in the number of children removed from their mothers by Child Protective Services. \(^{207}\)

Whereas the previous study reports on the firsthand experiences of women encountering health and social services with their children, Novac et al. elicited the experiences of health and social service workers, asking how they would improve services for young homeless mothers at risk of losing custody of their children. \(^{208}\) In reviewing the extant literature, Novac et al. find that “homeless mothers who are involuntarily separated from their children suffer from depression, despair, and grief that are characteristic of loss.” \(^{209}\) They also find that with reduced welfare services available to help impoverished mothers provide adequate care for their children, child protection is accomplished by “apprehending” the children, and there is little research on how best to support mothers who have children removed from their custody. \(^{210}\)

Novac et al. also present findings from their own qualitative study of the experiences of clinicians working with young homeless mothers facing forfeiture of custody of their children. \(^{211}\) Factors that militate against mothers keeping custody of their infants are drug use, mental health problems, lack of prenatal care, inadequate accommodation, and previously having lost custody of other children. \(^{212}\) Staff working with impoverished mothers report that supporting these women through pregnancy is emotionally stressful, particularly when the mother is likely to lose custody after the infant is born. \(^{213}\) Novac et al. state that these impoverished mothers are expected to
achieve idealized standards of care that are drawn from white, middle class models. In order to regain custody, mothers face an exacting legal process that requires time, money, legal knowledge, and emotional resources beyond the means of poor or working mothers. Novac et al. conclude that improvements in services and the availability of resources and can keep families together and ameliorate suffering.

The Sociocultural Perspective on Co-occurring Disorders focuses on the social conditions and cultural beliefs that accompany and sustain addiction and complicated grief. The modified therapeutic community treatment model for co-occurring disorders is of interest because it was used at the clinic where the client in this Case Study received treatment. Also relevant to the client is research into mothers who lose custody of children because this research indicates this traumatic experience can result in complicated grief. Boss’s concept of ambiguous loss is also of note because it describes the nature of the loss experienced by the client in this Case Study.

**Humanistic Perspective on Co-occurring Disorders**

The Humanistic Perspective on Co-occurring Disorders includes psychological theory and therapeutic practice from several allied perspectives, which focus on current experience as a way to cultivate the freedom to grow and change psychologically and differentiate individually. The humanistic psychologies support the principles that human nature tends toward life and health when people are allowed to develop optimally, and that reflexive consciousness, an awareness of multiple points of view, is a developed human capacity.
Two humanistic psychological perspectives are examined in detail: *person-centered* psychotherapy, pioneered by Rogers, and existential psychology, developed by May. May discusses addiction and grief from an existential perspective.\(^2^{22}\) Also included is Yalom’s existential approach to therapy, which extends May’s existential psychology.\(^2^{23}\) Yalom proposes that grief following the loss of people we love is actually a presentiment of our own fears of isolation and impending death.\(^2^{24}\) Rogers’s person-centered therapy is founded on empirical research, whereas May’s existential psychology is derived from philosophy, literature, and mythology.\(^2^{25}\) Humanistic treatment for co-occurring disorders includes Miller and Rollnick’s motivational interviewing.\(^2^{26}\)

Rogers’s person-centered psychotherapy is based on the principle that a desire to grow and differentiate as an individual is inherent in everyone.\(^2^{27}\) Rogers claims that “the basic nature of the human being, when functioning freely, is constructive and trustworthy.”\(^2^{28}\) To support these claims, Rogers reports on several studies, including one that found person-centered therapy to be effective in treating alcohol addiction.\(^2^{29}\) Rogers emphasizes the primacy of experience in therapy, asserting that personal perceptions are more reliable than the opinions of others, either positive or negative; he states, “Experience is, for me, the highest authority.”\(^2^{30}\) Rogers finds that experience is transient, changing, complex, and incomplete; he says of experience, “It is always in process of becoming.”\(^2^{31}\) Rogers contends that experience is most reliable at a sensory and affective level, and as a therapist, he uses “deep organismic sensing” to inform his thoughts and guide his responses.\(^2^{32}\) Paradoxically, he finds that in sharing his unique personal experience, he echoes the deep experiences of others; as he states succinctly: “What is most personal is most general.”\(^2^{33}\)
Rogers finds that therapists who fulfill three basic conditions are most likely to precipitate beneficial change in the person they are treating. These conditions include behaving genuinely and without pretence, in congruence (or agreement) with inner experience; accepting the person in treatment with unconditional positive regard (or valuing them); and tracking and responding to the internal experiences of the other with empathetic understanding (or appreciation), without evaluation or comparison. Beyond these basic tenets, Rogers contends that self-acceptance on the part of the person in treatment is an important prerequisite for change. Self-acceptance emerges most readily when the therapist accepts the other’s feelings, attitudes, and beliefs, allowing the individual to experience their perceptions fully. Rogers states that understanding another person without evaluation and judgment gives them permission to change.

Miller and Rollnick developed motivational interviewing for treating addictions and other compulsive behaviors. They claim their model includes counseling techniques that research has found to be effective, primarily employing Rogers’s empathic, person-centered style of therapy, with the addition of directive interventions aimed at promoting change through increased knowledge and awareness. Motivational interviewing seeks a collaborative alliance with the person in treatment to develop their natural capacity for self-change.

Miller and Rollnick refute the principle that people in treatment for addictions necessarily have personality disorders and entrenched defenses (e.g., denial and resistance). Instead, they assert that people enter treatment with ambivalence about change, and that resistance during treatment can be attributed to the use of direct confrontation and lectures by the therapist. Miller and Rollnick find resistance signals
that the client does not accept what the therapist is saying, and that “rolling with resistance” by offering alternatives, rather than imposing solutions, honors the client’s ambivalence.\textsuperscript{243} Miller and Rollnick find support and empathy are effective at reducing ambivalence, and well-timed and appropriate directive interventions develop a positive motivation toward change.\textsuperscript{244} They recommend cognitive behavioral interventions intended to sharpen the person’s awareness of discrepancies between their beliefs and aims in life, and how they are actually living.\textsuperscript{245}

Another form of humanistic psychology is existential psychology. May contends that \textit{existential anxiety} is an inevitable companion in life, resulting from tension between the natural desire to be free to choose and be true to oneself, and the knowledge that freedom is limited by the prospect of death.\textsuperscript{246} May contends that therapy cannot eliminate anxiety, but can transform it from an unconscious source of inertia to a conscious source of power.\textsuperscript{247} May asserts that taking drugs to alleviate anxiety is unrealistic, given the dangers life entails.\textsuperscript{248} Addiction, according to May, is a way of life that suits people with a chronic sense of uselessness, since drugs provide temporary energy to alleviate lack of purpose in life, which originates with inadequate mothering or fathering.\textsuperscript{249} May finds feelings of abandonment in young adults are not from physical abandonment, but from the discrepancy between parents expressing their love without being able to demonstrate it.\textsuperscript{250} May finds overcoming fear of abandonment and death requires the courage to be affected, and to risk being vulnerable and intimate with others.\textsuperscript{251}

Yalom, an exponent of existential psychotherapy, says that existential anxiety is caused by what he calls, “the ‘givens’ of existence.”\textsuperscript{252} Yalom finds there are four
existential concerns in life: fear of death, fear of isolation, desire for meaning in life, and longing for freedom. Yalom describes two kinds of loneliness, the first being difficulty forming and sustaining close relationships with others. The second, existential loneliness, is more common in later life and consists of a growing awareness that each person has a separate existence from others; this awareness culminates in the ultimate separation at the moment of death. Yalom finds people who have the greatest fear of death often feel they have not lived life as fully as they wished.

He contends that a temporary means of escape from existential loneliness is to sacrifice self-awareness by becoming absorbed in another person, to merge in love: “Thus one sheds anxiety but loses oneself.” Yalom understands grief following loss as an acute experience of self-awareness, leading to distress at the awareness of separation from loved ones, and of one’s own mortality. To mitigate existential loneliness, Yalom suggests empathy and compassion are helpful in reducing feelings of distress. He stresses the value of being physically present with the other, experiencing anxiety along with them, but without identifying with their terror. In working with clients, Yalom seeks to build a robust and authentic therapeutic alliance: “I strive for connectedness above all else.” Yalom states that he focuses on the client’s current experience and in-the-moment interactions with the therapist, rather than seeking solutions for current dilemmas in the client’s history.

The Humanistic Perspective on Co-occurring Disorders includes person-centered therapy and existential psychology. Person-centered therapy is focused on the experience, perceptions, and needs of the client, to which the therapist responds with genuineness, interest, and acceptance, enabling clients to be more accepting of
themselves, to think more flexibly, and to work toward their own goals. Existential psychotherapy deals with fundamental anxiety about one’s inevitable confrontations with death, freedom, isolation, and meaning in life. The principles of humanistic therapy are of particular relevance to this Case Study because they were practiced at the clinic where the client received treatment, with the intention of providing collaborative learning conditions and retaining clients in treatment.

**Imaginal Approaches to Co-occurring Disorders**

Imaginal Approaches to Co-occurring Disorders include literature from several disciplines, including psychology, sociology, ethology, and biology. How an individual develops a sense of self is discussed, followed by an explanation of how this process can be distorted. The origins of the *adaptive personal identity* (adaptations of character to accommodate developmental trauma) and related concepts and principles from imaginal psychology are introduced and examined in relation to parallel concepts in the literature on complicated grief and addiction.

The literature presented in this section indicates a reciprocal relationship between addiction and developmental trauma. Addiction is associated with early developmental trauma, and trauma is associated with parenting by addicts. Researchers reach complementary findings indicating that development is affected by the quality of parenting: Suomi finds that inadequate mothering of monkeys makes them susceptible to alcohol addiction; Brown finds that adult children of alcoholics suffer from pervasive personality adaptations; and Allan N. Schore’s neurobiological research reinforces the importance of emotionally attuned mothering to child development.
The imaginal approach to the effects of addiction on the children of alcoholics is exemplified in Brown’s research on people who grew up with alcoholic parents. Brown reports on a decade-long qualitative group therapy research project with adult children of alcoholics (ACA) and identifies several processes affecting identity development under chronically traumatic conditions, in families with alcoholic parents.

One process Brown describes is the development of a defensive false self as an adaptation to the unusual stresses imposed by alcoholic parents. Brown’s observations of the false self are congruent with a parallel concept from imaginal psychology, the adaptive personal identity; this term is used to indicate the defensive personality distortions acquired in response to trauma during early development.

Associated with the false self or adaptive identity, Brown identifies several “cognitive schemas,” or “defensive adaptations,” including denial, splitting, an exaggerated sense of responsibility, and a need for control. Brown declares:

These defensive adaptations emerge in adulthood as central issues or even structures—dimensions of adult personality—coloring all aspects of individual development. Many of the major issues or problems brought to treatment, for example, depression, anxiety, problems forming close, intimate relationships, are related directly to these defensive adaptations.

Brown’s description of defensive adaptations evokes the parallel concept imaginal structures, used in imaginal psychology to indicate acquired adaptations that both comprise and delimit experience. Omer describes imaginal structures as follows:

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. During the individuation process, imaginal structures are transmuted into emergent and enhanced capacities as well as a transformed
identity. Any enduring and substantive change in individual or group behavior requires a transmuting of imaginal structures. This transmutation depends upon an affirmative turn toward the passionate nature of the soul.  

Brown espouses the principle that the defensive adaptations she observes in ACA originally served the imperative of maintaining attachment to alcoholic parents. Brown states that a child of an alcoholic may provide affective support to an otherwise emotionally “dead” parent, leaving the child’s own dependency needs unmet. Brown quotes ACA group members discussing their confused identities with their alcoholic mothers, their exaggerated sense of responsibility for the feelings of others, difficulty separating from their family of origin, and persistent longing to be cared for. A relevant principle from imaginal psychology is that imaginal structures, especially those acquired in the first three years of life with the mother, are pre-verbal and pre-conceptual, consisting of affective, cognitive, and sensory-motor adaptations. Brown finds that early experiences of attachment for ACA is laced with anxiety, which makes therapy a fearful prospect, and suggests the rapid exposure of defenses in cognitive behavioral therapy may be experienced as a threat. Brown proposes the principle that the intellectual, emotional, and social development of children in an alcoholic family is constrained by their parents’ level of development, and also that ACA become perpetual adolescents, unable to individuate as adults. 

Suomi presents ethological research indicating that developmental adaptations due to lack of maternal care can lead to behavioral problems and excessive alcohol use. Suomi presents findings from various studies on monkeys that he and others conducted (including his early work with Harry Harlow), indicating that attachment patterns established during early development in rhesus monkeys are similar to those of human
Suomi compares the attachment reactions of monkeys raised by their mothers in naturalistic settings with the effects of rearing them in a laboratory without mothers and socialized only in peer groups.

Suomi reports that in naturalistic settings, a minority of infants are either impulsively aggressive from an early age (usually males) or fearful and anxious (usually females), becoming despondent and socially withdrawn when separated from their mothers. Both anxious and impulsive monkeys drink more alcohol than their peers do during a “happy hour,” when alcohol is available, with binging more common among impulsive monkeys and maintenance drinking among anxious monkeys. In contrast, Suomi finds infant monkeys reared in laboratory conditions without their mothers, and socialized only among peers, become fearful or aggressive in greater numbers than do those reared with mothers, and usually form anxious attachments with others. Additionally, peer-socialized cohorts drink more alcohol than do those raised by their mothers.

Suomi reports a genetic variation that lowers serotonin levels was present in all the monkeys that preferred alcohol, but most interestingly, monkeys with this genetic trait were not attracted to alcohol if reared by their mothers. Suomi concludes that among rhesus monkeys genetic variation affecting fear and aggression and the propensity to drink alcohol are expressed according to the quality of early nurturing, and human development may be dependent on similar interactions between “nature and nurture.”

Imaginal psychology places great emphasis on the importance of the quality of maternal care during infancy, and chronic failure in getting one’s developmental needs met, especially during early life, results in developmental trauma. As Omer states,
“such chronic failures of the environment to meet the needs of the person cause adaptations that persist after the trauma passes, and result in the formation of the adaptive identity and associated imaginal structures.” 292

Allan N. Schore’s work is significant to an imaginal approach to co-occurring disorders as he integrates three psychological theories (i.e., attachment theory, affect theory, and trauma theory), which inform the imaginal approach to experiences of grief and addiction as adaptations following early trauma.293 Schore bridges the disciplines of psychology and neurobiology, drawing on his own research, studies by other neurobiologists, and Bowlby’s theory of attachment.294 Schore finds responses to stress are regulated by the orbitofrontal cortex in the right hemisphere, which develops in concert with an attuned mothering figure, and early attachment experiences become enduring unconscious models for interpersonal relations.295

Schore represents attachment as a process of emotional attunement through reciprocal facial expressions, which serve to synchronize the infant’s somatic and emotional states with those of the mother, or other mothering person.296 He asserts that when infants experience congruence between inner feelings and outer observations of their mother, it serves to regulate levels of arousal and both negative and positive affects.297 Schore asserts that difficulties regulating arousal and social stress are acquired as a result of developmental trauma during infancy, and passed from one generation to the next through mothering that lacks soothing skills.298

Schore integrates biological and psychodynamic perspectives, and traces susceptibility to various disorders, including addiction, to vulnerabilities in the orbital cortex.299 Schore suggests various mental disorders, including addiction, are associated
with unusual metabolic activity in the orbitofrontal cortex, and contends it is well established that mental disorders can be precipitated by the emotional stress of losing the support of loved ones. He locates the integration of arousal, affective and somatic states, and sensory perceptions in the right orbitofrontal cortex, where learning is implicit and procedural, and usually out of conscious awareness and control. Schore asserts that this brain area, along with the underlying limbic system that signals affects, develops between seven and 15 months after birth, the period of infancy when emotional attunement between mother and infant is established. Schore reports a second phase of maturation of the orbitofrontal cortex during the second year, when toddlers learn to attune their internal state to the emotional valence of a wider social environment.

Just as a sense of self is shaped by developmental experience, so corrective experiences in adulthood can transform the individual’s sense of self and relations with others. Winnicott asserts that an individual sense of self is an imaginative creation. He proposes that the emergent sense of self is formed as spontaneously playful actions are mirrored back by others, and that the self is remade in therapy as the creative imagination is reawakened through relaxed and unstructured playfulness. He postulates that during early development, life is experienced in an undifferentiated “intermediate area” between self and other. Winnicott postulates that interpersonal therapy tests and realigns inner and outer reality to include a greater awareness of new experiences. Likewise, Omer finds that an effective sense of self is cultivated through beneficial experiences with others, stating that “experiences of contact with the core identity are typified in participatory moments, moments of union with a larger sense of self and others.”
Imaginal Approaches to Complicated Grief and Addiction as Co-occurring Disorders indicate that formative experiences with caregivers affect development.  

Furthermore, emotional neglect by alcoholic, or otherwise unavailable, parents is found to prevent development from progressing to full maturity.  

Of particular interest to the etiology of complicated grief and its treatment is Winnicott’s proposition, echoed in imaginal psychology, that interpersonal processes shaping development early in life are active during adulthood in loosely structured therapy, thereby reawakening creativity and offering greater awareness of self and others.

**Conclusion**

This Literature Review explores the etiology and features of co-occurring disorders, specifically addiction and complicated grief, and psychotherapies used in treating them. Literature from six psychological orientations is presented, offering distinctive perspectives or approaches to the topic, with some overlap and disagreement between them.

The biological literature presents findings on brain functioning and the actions of monoamine neurotransmitters as they affect mental faculties associated with addiction and complicated grief.

The cognitive-behavioral literature promotes rational choice and new learning as the means of change. Research on factors that contribute to complicated grief is examined. Treatment for addiction and co-occurring disorders uses cognitive methods in combination with approaches from other psychological orientations.
The psychodynamic literature examines the symptoms and character features associated with co-occurring disorders. Drug use is understood as an attempt to self-medicate negative affects associated with poor attachment during infancy. Mourning is considered a process of adjustment to the reality of loss, and complicated grief is considered an inability to adapt, which echoes earlier relational experiences. Several models describing chronic forms of grief also are considered.

The sociocultural literature explores the social conditions and cultural beliefs that contribute to and sustain co-occurring disorders. Community treatment models for addiction emphasize self-help and social support. Social factors and intergenerational abuse and neglect are found to contribute to both addiction and grief at the loss of child custody. Complicated grief is attributed to unresolved longing for mentally or physically absent family members.

The imaginal literature approaches co-occurring disorders as defensive character adaptations that insulate the soul (or psyche) from present experience in order to defend against past harm. Research investigates how parenting and socialization of infants affects development.

Each of the six psychological orientations focuses on distinct aspects of the co-occurring disorders of addiction and complicated grief, reaching some compatible conclusions using different methodologies. For example, most of the biological literature investigates brain functioning and neurotransmitter irregularities, while the psychodynamic literature focuses on symptoms and developmental trauma. However, research bridging biological and psychodynamic perspectives finds biological evidence for changes in brain development following developmental trauma.
The literature indicates that both nature and nurture are involved in co-occurring disorders. Ethological studies find genetics, and corresponding temperamental traits, are associated with addiction in some cases, but the incidence of these traits and of addiction are far more frequent among monkeys raised without mothers and socialized amongst peers than among monkeys raised by their mothers.

Cognitive-behavioral treatments for co-occurring disorders seek to promote rational and informed thinking as the means to change maladaptive behavior. In contrast, humanistic therapies promote self-awareness as a prerequisite for change, encouraged by an empathic and authentic relationship with the therapist. Several therapies used in treating co-occurring disorders combine elements from both perspectives, providing empathy and acceptance, while also providing information and questioning assumptions that are inconsistent with the client’s own goals in treatment.

The literature considers the etiology of co-occurring disorders. Both cognitive-behavioral and humanistic treatment models focus on current thinking and feeling, whereas some biological, psychodynamic, and imaginal literature associates early experiences with subsequent mental development and well-being. Treatment at the clinic where the subject of this Case Study was enrolled focused on cognitive-behavioral and humanistic treatment models, which both focus on clients’ current perceptions and life circumstances. The sociocultural literature takes a wider view, exploring cultural and intergenerational factors that manifest as many social ills, including addiction and co-occurring disorders. The imaginal approaches to co-occurring disorders incorporate findings from various disciplines to synthesize a comprehensive etiology, concluding that
heritable traits, developmental trauma, and social influences shape expressions of the soul’s potential for growth and differentiation.

A broad understanding of both the client’s present difficulties and formative experiences is important to this Case Study, since the client spontaneously explored her personal history and how this influenced her present difficulties. The affective aspects of attachment in early development and later in therapy, as explored in the literature, are important to understanding what happened during the course of therapy. The literature also indicates how the client’s addictions frustrated her desire to overcome her grief, by intensifying her distress and limiting her creative imagination.
CHAPTER 3

PROGRESSION OF TREATMENT

The Beginning

Flora’s treatment began in December, 2006, and continued intermittently for nearly a year, ending inconclusively in October, 2007. The nature and poignancy of her difficulty became apparent at our first meeting. The first time I met Flora was at her second follow-up intake session, when I assisted her intake counselor as part of my training on intake and assessment procedures at East Bay Community Recovery Project (EBCRP), where I was working as a practicum intern.

At Flora’s second intake session, her intake counselor asked her to fill out several personal history questionnaires on her own, indicating she considered Flora capable of working independently. Some of the questions on the forms were written in technical language that obscured their meaning, so I was available when Flora needed help, while I was occupied with my own work nearby. Flora sat hunched over as she focused intently on the forms. Flora was then 50 years old, of medium stature, and slight build. She was dressed neatly and casually in a sweater, blue jeans, and clean training shoes. She wore no makeup, and her glossy, light brown hair hung down over the right side of her pale face.

Flora worked persistently through each form, and was eager to be accurate and truthful in her responses. She raised her head while asking questions, her eyes avoiding mine as she spoke. She often shook her head to one side, and passed a hand across her
face to push her hair from her eyes. As she repeated this tic, she stole glances in my
direction, observing without engaging. She spoke quietly but with urgency, in short
phrases, and I noticed her lower front teeth were rotten or missing.

When questions about history of arrests arose, Flora became agitated and
complained about her arrest and conviction for possession of a methamphetamine pipe
after a vehicle search. She insisted it was not her pipe, that she had hidden it for a friend,
and this was the first time she had ever been in trouble with the police. She completed her
defense with a pained look and a short exasperated laugh, which she subsequently used
on many occasions when talking of events that seemed unjust and beyond her ability to
control.

When asked if she had children, Flora became sad. She expressed pained
exasperation about losing custody of her three youngest children to her former husband.
She told me how well they were doing in school when they were taken from her, and how
she longed to get them back.

Intake at EBCRP often extends over several sessions and includes three different
sets of intake forms: one from the agency, another from the county board of mental
health, and a third from the funding source. The intake procedure concludes with the
counselor and client signing duplicate forms acknowledging patients’ rights, limitations
to confidentiality, counselor training and supervision, expectations of the client, and
limitations to the efficacy of treatment. The client also receives a handbook welcoming
them to treatment.

Flora worked with her intake counselor for five weeks, became very attached to
her, and was distressed when she unexpectedly left the agency. During this time, they met
twice for intake appointments, twice for counseling appointments, twice during group therapy sessions led by her counselor, and once at an evening holiday event at the clinic. Flora attended a total of 11 group therapy sessions on a variety of topics during her first five weeks in treatment. Her intake counselor made an initial assessment and treatment plan, and she gave Flora a letter to present to the court at the beginning of treatment. The letter echoed Flora’s own optimism about recovery from drug use and reuniting with her children. Before Flora’s first counselor left the clinic, she introduced me to Flora as her new counselor. At the beginning of my work with Flora, she spoke wistfully about how kind and empathetic her first counselor had been.

Flora’s first individual therapy session with me occurred five weeks after enrolling in treatment. We met in the children’s playroom because the counseling room was already in use. The overhead fluorescent lights buzzed, so I turned them off, and we managed with the warm glow of a desk lamp, and the winter sun filtering through colored curtains. Flora was quiet at first, then said she did not know what to say. I suggested this was a time she could speak about things on her mind that she did not get the chance to talk about at other times. Flora talked about how badly she missed her three children, and said they were all she thought about. She explained that the only relief she got was in doing vigorous yard work for friends. She looked distressed, anxious, and defeated. Flora complained she could not speak to anyone about how much she missed her children; even her friends no longer wanted to listen.

As our first session ended, Flora spoke very softly, explaining that the playroom in which we met brought back memories of her children, and how much she missed them. I suddenly saw our surroundings as she might, aware for the first time of the quietness,
the toys and small furniture, and the absence of children. The quietness and wan light seemed to intensify their absence. I said I was sorry the room brought back painful feelings for her, and that I would find another room for our meeting next week.

During the first counseling session, Flora also disclosed that her 18-year-old daughter posted a message on an Internet social networking site that her father had “shoved” her 14-year-old sister. Flora added that the children’s father was an alcoholic who had not drunk while they were married, but now drank despite serious liver disease. She thought the children were living in an unhealthy atmosphere, with arguments occurring frequently. I spoke about this with clinical staff, and subsequently made a report to CPS in the city where her children lived. I decided not to inform Flora because the CPS worker said the incident was not serious enough to require action.

Flora missed her appointment with me the following week, so I left a telephone message regarding our appointment and reminded her of our next meeting. This became a pattern for some months. At the start of our second counseling session, Flora told me she had replied to her daughter’s online posting, telling her that her father had no right to push anyone around. Her daughter then deleted Flora from her list of friends, preventing her from posting more responses and cutting off communication between them.

Flora was shocked her 18-year-old daughter excluded her and emphasized that they had been close when they were together as a family, cuddling on the couch in front of the TV in the evenings. I gently suggested her daughter’s needs probably had changed as she had grown, and that as a teenager she might want greater independence in practice for adulthood. Case notes from a women’s group therapy session around this time showed that Flora was concerned her children were no longer as emotionally connected
to her as they had been. Flora eventually visited her children twice during treatment, but was dismayed at her daughters’ anger toward her during those visits. Her son, then 12-years-old, more readily accepted Flora.

Flora revealed additional areas of distress during the next few counseling sessions. At our third meeting, two months after she enrolled, Flora said she was thinking of moving back in with her old roommate and leaving her boyfriend because he treated her inconsiderately. Flora saw this as a positive move for her recovery because she used methamphetamine with her boyfriend, but her roommate did not drink or use drugs.

Flora also reported that since our last meeting, her former husband had agreed to let her have the two youngest children for two weeks after they visited his mother in a town midway between them. She elaborated that her roommate might be willing to drive them down and back, and they could stay at her cousin’s house, which had more room. Flora added that she was afraid to get her hopes up in case of a change of plan, as had happened several times before.

At our third meeting a surprising revelation emerged. Flora casually mentioned that in addition to losing custody of the three children from her second marriage, she earlier lost custody of two other children after her first marriage failed. This additional history of loss seemed important, yet she never spoke of her adult children unless I asked her about them, and then supplied only sparse details. Later, after one of her younger daughters left her father’s house and moved in with her boyfriend, Flora focused her angst on her two remaining children, apparently freed from concern about her.

Although she had spoken quietly and with reticence at our first meeting, by our third session Flora spoke in a torrent of thoughts and feelings. However, she had
difficulty participating in groups. Case notes indicate that the day before our third session, Flora attended a group therapy session focusing on co-occurring disorders and PTSD, exploring the topic “taking back your power.” During this group, Flora made an attempt to speak but quickly became flustered and self-conscious. I asked her how she felt about speaking in groups, and she responded that she felt shy. Then she explained that as a child she had experienced terrible shame after being forced to read out loud in class. Flora also had difficulty tolerating other people’s experiences when they differed from her own. During a subsequent women’s group therapy session, a younger group member expressed anger at her mother for being an addict. Flora interrupted impulsively, challenged the other client’s statement, and asserted that she herself had been a good mother. Then, claiming she had another appointment, Flora left the group early.

During early therapy, we discussed her desire to stop using methamphetamine and cannabis, which she said was her long-term goal. I framed recovery at the clinic by saying that quitting was a process that was helped by participating in groups with others in recovery. I also stressed that reducing the harm she risked to her health while taking drugs was an important goal. I added that the clinic allowed clients to attend groups while still using, as long as they were not intoxicated at the time. Regular urine analysis tests for drug use were required during treatment, but I assured her she would not be penalized for testing positive for drug use during treatment. I added that testing was a way of being honest with oneself and others, which was an important skill to learn in recovery.

Flora tested, in counseling, how revealing she could be about her drug use. During her sixth counseling session, four months into treatment, she noticed a workbook on a shelf in the counseling room on how to quit using methamphetamine. I made a copy for
her to work on at home. At a later counseling session, I asked if she had looked at it. She replied that she was torn between a desire to be honest, and expose her shame at being “afraid to look at it,” or to say what was expected. I thanked her for being courageous in saying what was true for her and suggested we look at the workbook together. As she turned the pages, she was surprised to see a question asking what benefits she got from using methamphetamine, as well as problems it caused. She added that she enjoyed the energy she had while using it, which enabled her to act without worrying about consequences.

Flora opened her next counseling session with a joke: “What do they call someone who stays up for 14 days straight on methamphetamine?” And she gave the answer: “A two-weeker!” The punch line refers to the colloquial term tweaker, which means a methamphetamine user. Eventually she told me her pattern of drug use included smoking methamphetamine two or three times a week, alternating with marijuana. This was confirmed by the few drug tests she took while in treatment, in which she tested positive for either one or the other. Flora also smoked cigarettes, which she considered more threatening to her health than the other drugs she took, and was keen to quit.

**Treatment Planning**

Flora’s initial assessment was made by her first counselor one month after intake, using the *DSM-IV-TR*.¹

**Axis I**

- 305.2 – Cannabis Abuse
- 305.7 – Amphetamine Abuse (principal)
- 296.9 – Mood Disorder Not Otherwise Specified
- V61.2 – Parent-Child Relational Problem
Axis II
799.9 – Diagnosis deferred
Axis III
No diagnosis
Axis IV
Out of contact with children (principal)
Friends use drugs
Little work history
General Assistance – not enough money to see children
Uninsured – teeth rotten
Legal – Court mandated treatment
Axis V
General assessment of functioning in the last year – highest 40, current 40

The initial assessment accommodated Flora’s various presenting problems on five axes. Axis I included methamphetamine abuse as her primary presenting problem, and also cannabis abuse. Mood Disorder Not Otherwise Specified also was included on Axis I. This indicates Flora’s mood was of concern, but her symptoms did not fit the criteria for any category of mood disorder in the *DSM-IV-TR*.² Flora’s first counselor described Flora’s mood in the treatment plan as feelings of sadness, helplessness, and frustration at being separated from her children. Additionally, visiting her children was included as a goal of treatment. Flora’s separation from her children was indicated as a matter of clinical concern on Axis I as Parent-Child Relational Problem, a diagnostic category that can indicate a variety of relational difficulties.³ The absence of her children was listed on Axis IV as Flora’s primary psychosocial problem.

The deferred diagnosis of a personality disorder on Axis II is of note because it was the practice at EBCRP not to diagnose personality disorders while clients were actively using drugs or alcohol. This is because some drug-induced symptoms are considered difficult to differentiate from the features associated with personality
disorders until clients have been clean and sober for some time. No assessment was included on Axis III, where general medical conditions are listed.

Flora’s first counselor wrote the initial treatment plan one month after intake, focusing primarily on treatment for methamphetamine and cannabis use by attending group therapy to build the motivation to abstain from drug use, and learn to use the tools of sobriety. The priority of abstinence from drug use reflected accepted clinical practice, and also reflected the focus of the funding source paying for her treatment. The second element of the treatment plan addressed Flora’s mental health issues, including feelings of sadness, helplessness, and frustration at being separated from her children, by working with a counselor to rebuild her belief in herself, and to develop a plan to reunite her with her children. The third item on the treatment plan was to fulfill the requirements of the court order by attending groups regularly and testing clean for drugs weekly, or to assist Flora in transferring to a residential treatment program if she did not test clean in the first two months of treatment. Flora’s intake counselor also completed an application to enroll Flora in the county vocational program to assist her in finding work.

Following clinical practice at EBCRP, the treatment plan reflected Flora’s perceived needs as well as clinical objectives in order to engage her in treatment, to promote an alliance between client and counselor, and to provide the client with an incentive for achieving the plan’s objectives. In an interview conducted after treatment concluded, Flora revealed her overriding goal during treatment had been to regain access to her children, fulfilling the court order had been her secondary objective, and getting clean from drug use had been her third objective.
Flora complained of chronic lack of energy during the early phase of treatment. I suggested she get tested for AIDS and hepatitis C, to rule these out as contributing to her loss of energy. AIDS awareness training was listed on her court order, so counseling and testing for AIDS and hepatitis C could serve both purposes.

A diagnosis of depression was considered during the first few months of treatment. Flora scored near the middle on the clinic’s depression scale, both at intake and after six months of treatment, indicating moderate depressive symptoms probably attributable to methamphetamine use. Flora was adamant she was not depressed, and balked at the idea of getting a psychiatric evaluation and at the possibility of taking medications she thought would cover up her feelings. Conversely, she was convinced smoking cannabis elevated her mood but did not mask her feelings, arguing it was “natural.” My supervisor said many clients who use cannabis believe it does not have harmful effects because it is an herb, rather than a synthesized drug.

After six months of treatment, inpatient detoxification (detox) became a priority because Flora still was not testing clean. She acknowledged her need for inpatient detox because she had been unable to stop using on her own. She said her cousin had been through detox at a local clinic, and she was willing to enroll in this 45-day program.

After working with Flora for nearly six months, I made a reassessment of her condition. Working within the diagnostic criteria and nosology available in the DSM-IV-TR, I found that a diagnosis of drug dependence, rather than drug abuse, more precisely fit Flora’s use of amphetamine, cannabis, and tobacco. She met the criteria for dependence because of the impairment and distress that became evident during treatment. Notably, her daily activities had dwindled to the point that she accomplished little besides
maintaining her drug habit. Additionally, she continued to use amphetamine and cannabis in an alternating pattern, indicating she used each drug to buffer the side effects of the other, and had difficulty quitting or cutting down despite a desire to do so.

Anxiety was a prominent feature I observed in Flora during therapy, and that was not included in the original assessment. Her anxiety was evident in her difficulty speaking in groups, pervasive worries about events in her life, and obsessive preoccupation with her absent children and their safety. My hypothesis was that although several circumstances in her life might have caused anxiety, her overall level of anxiety and helplessness in the face of difficulties was heightened and maintained by her chronic use of methamphetamine and cannabis.

The revised assessment on Axis I after six months in treatment was as follows:

Axis I
304.4 – Amphetamine (Methamphetamine) Dependence
304.3 – Cannabis Dependence
292.89 – Substance-Induced Anxiety Disorder due to use of amphetamine and cannabis, with Generalized Anxiety and Obsessive Compulsive Symptoms
305.1 – Nicotine Dependence

Revisions to Axis I were made in consultation with clinical staff, and were included in a presentation I made on Flora’s progress after six months in treatment at a clinical meeting attended by EBCRP staff. Flora’s preoccupation with her missing children emerged as a key topic of discussion during the clinical meeting. I could not find a concise diagnostic category in the DSM-IV-TR to describe this aspect of Flora’s condition on Axis I, but being out of contact with her children was retained as the primary psychosocial stressor on Axis IV.
A revised treatment plan was developed in collaboration with Flora. Referral for inpatient detox became the primary objective in the revised treatment plan, with further treatment at the clinic after completing detox to support her recovery, and then smoking cessation. Establishing regular visits with her children was included among the goals of treatment.

**The Therapy Journey**

Over the course of Flora’s 11 months in therapy, the themes of addiction and loss of her children became interwoven, with the theme of loss predominating. Flora had little support for her recovery from friends or family, and did not readily make new friends among other clients at the clinic.

During our second session, Flora revealed a few details about how she lost custody of her children six years earlier. She explained that CPS removed her children after her former mother-in-law complained to CPS that Flora’s children had lice in their hair. I was unable to learn more about why Flora’s children were removed, but she was adamant they had been doing well in school while with her. She also felt she had been a good mother and her children had been happy. Flora described how she had kept the children following her divorce, and her husband had moved away and remarried. Then her children were taken from her and went to live with her former husband and his new wife. They lived far enough away that Flora could not reach them without financial help or transportation.

Flora said she continued to be on good terms with the children’s father and spoke with him by telephone, but had been unable to secure arrangements to see her children
during the previous two years. She added that her former husband would soon be taking their children to visit his mother, who lived midway between Flora and their new home, and that she was thinking of going up there to “camp out on their step, I am that desperate.” Flora realized this was unrealistic because she was not on good terms with her former mother-in-law. I encouraged her to find a way to see her children soon, but under circumstances agreeable to the children’s father, so she could feel pride rather than risk humiliation.

Over the next few sessions, Flora reiterated her pain and helplessness at losing her children, and told of other misfortunes extending from the present back into her family’s history. Despite my efforts to be empathic, I became resistant to hearing more about her losses. Her voice had a plaintive quality, like a child’s cry of distress, which I found distressing to hear. Near the end of our fifth session, I asked if it would be helpful if we made a ritual offering, such as lighting a candle or burning incense, to memorialize her suffering. Flora shook her head. I did not intend to reveal my frustration at hearing her painful feelings, but rather to offer a way to acknowledge her difficulties. As she fell silent, I thought of her friends who had tired of hearing about her grief, and I felt sad at the thought of letting her down, too.

During her first few months in treatment, Flora said she liked going to “classes,” as she called group therapy, though she often said little and left before the end of the session. Following her first counselor’s departure, one month into treatment, Flora gradually attended fewer groups and either missed or was late for individual therapy appointments. Seeking to make treatment more relevant, I offered a positive connotation for her court-ordered drug treatment, reframing it as an opportunity to get clean from
using drugs, show she was committed to being the best mom she could be, and
demonstrate her readiness to share custody of her children. Flora was unenthusiastic
about my reinterpretation, and expressed urgency to see her children before they had
grown and left home. “I can’t wait that long. Every day they get older. I don’t have time."

As we looked at the schedule of therapy groups available at the clinic, Flora was
confused by the statement “owning your own reality,” which described one of the groups,
and asked me what it meant. After reflecting for a while, I said it could mean that each of
us can be creative with what life gives us to work with, like a captain of a ship who uses
her skill to cross the ocean safely. Later in that session, Flora complained about how
unfair her former husband had been by preventing her children from visiting her. She
said, “I’m treated like a murderer or something; what did I do that was so bad?” I
suggested she was thinking like the captain who blames the weather, rather than taking
action to get to port safely. At the time, Flora did not seem to appreciate my analogy, but
she later overcame her frustrations by taking the bus to see her children, rather than
waiting for their father to bring them to her.

During our fourth and fifth sessions, about two months after starting treatment,
Flora responded to my interest in her family history. She told me her ancestors arrived in
California among the first Mormon settlers. She claimed with pride that one of them had
been a Pony Express rider. She complained her branch of the family later had been
ostracized, cheated out of inheritances, and struggled to survive. As details of her
childhood emerged, I began developing a genogram to record information about her
family members and relationships.
A new topic emerged during Flora’s third month at the clinic. At the beginning of our fourth meeting, Flora seemed subdued, and spoke quietly and thoughtfully. She said her aunt, who had been like a second mother to her, was in the hospital for alcohol detoxification. Flora and her cousin, with whom she had grown up, went to visit her aunt and then attended an AA meeting together after leaving the hospital. Her aunt’s illness and subsequent death reminded Flora of her mother’s death some years before, and Flora’s own mortality became a preoccupation, along with uniting with her missing children.

Flora reminisced about her childhood, recalling that her mother and stepfather frequently went drinking in bars in the evening with her aunt and uncle, and left Flora, her brother, and her cousin in the car while they drank. Flora recalled with obvious delight how the children imitated their parents while they were away, taking turns sitting in the driver’s seat, pretending to drive, and ordering the other children to behave. She recalled one occasion when the car started rolling, but they managed to stop it, and none of the adults seemed to notice that it had moved when they returned later. Flora mentioned that the police sometimes stopped to ask the children where their parents were, and seemed satisfied when told they were in the bar. Flora noted expectations of parents were very different in the 1960s, when this occurred, than they are today.

It emerged that her mother had been an alcoholic, as had her father. Flora described her father as a “mean alcoholic,” and her mother divorced from him when Flora was three years old. Flora said she lived with her aunt after her parent’s separation, and returned to live with her mother and new stepfather after they were married a year later. Flora said she adored her stepfather, whom she described as a “gentle alcoholic”
and fun loving, and said she became “best friends” with her mother. Flora considered both her aunt and uncle alcoholics, and noted her aunt also used methamphetamine. Looking at her family genogram, it was clear her parents’ generation all had been addicts.

Among Flora’s generation, her brother used both alcohol and drugs, and her cousin was a recovering alcoholic. Flora began using drugs as a teenager with her cousin. “We skipped classes to hang out with older guys and go to concerts, drinking beer, smoking pot; it was way more fun than high school.” After Flora’s treatment at the clinic ended, she told me her cousin had been in recovery for 18 years, and her brother recently had been released from jail, was living with his cousin, and attempting to stay clean and sober with her help.

During the course of our conversations about her family and friends, I learned that Flora knew several men who had the same first name as me, and she confided it was difficult to avoid saying things that showed she was confusing them with me. My supervisor said this was a sign she was becoming attached to me, and I later asked Flora if I reminded her of any of the men among her family and friends. She replied that I reminded her of her stepfather, the “gentle alcoholic” who had been fun and always ready to play games with her. I felt relieved to know she thought of me as a benign figure, and did not confuse me with her boyfriend.

Flora’s aunt died two months later—she was the last of her generation to go—and Flora said she felt very alone. Her aunt’s passing reminded her of her mother’s death some years before, which had been complicated by dementia and a gangrene infection. Her mother had been in a nursing home, confused and isolated from her family, and Flora was saddened she could not care for her mother at home, as her mother had cared for her
as a child. Flora’s own health became of concern to her, and she was fearful she might die in an institution without family near, as her mother had.

The transience of her own life became apparent to Flora, and she was saddened to think about how little she had accomplished in life. Flora confided she had once attended a high school reunion at which she felt all the other women had grown up and gone to college or started a career, while she had not changed. She married at 20 and then focused on being a mother, and felt sad she had not done more with her life. I was quick to affirm that raising children was a valuable accomplishment. Flora reflected in a quiet, wistful voice that as a girl she had wanted to become a marine biologist, but now at the age of 50 she felt it was too late for her to change. With my supervisor’s approval, I gave Flora a book for amateur naturalists, to revive her aspirations for growth.

Seeking to show that change is possible in middle age, I disclosed that I had begun my own recovery when I was in my 40s, and that my life had improved as a result. On future occasions Flora referred to me as an example that change is possible, but later became discouraged and said she could not see herself accomplishing anything, compared to me. I felt I had made a mistake by mentioning my own recovery. My supervisor assured me that my disclosure was a potentially useful intervention, but it was up to Flora to make use of the information I presented.

Flora’s health became a renewed focus of attention around the time her aunt was in the hospital. Flora reported a chronic lack of energy, but conceded she did have energy for doing things that were “fun.” I mentioned that fatigue was a symptom associated with methamphetamine withdrawal, and Flora responded that she first recalled feeling a lack of energy as a teenager, before she started using drugs. I asked if she had ever used
needles to shoot methamphetamine, because this would have raised her risk of becoming infected with HIV and hepatitis C. She said she had never used needles, but was willing to get tested at a local free clinic, which would help her meet one of the conditions of her court order.

She subsequently went to the free clinic, waited her turn in line and received counseling, but decided not to get tested because she was told testing was anonymous, and no proof of testing would be given. I was dismayed at hearing this because she apparently did not see this as an opportunity to learn more about her own health status or to demonstrate she had done her best to comply with the court order with the services available to her. Flora did eventually get tested for HIV and hepatitis C at EBCRP, which instituted testing on an occasional basis. While in treatment, she also managed to get her teeth cleaned at another free clinic, but this took several visits because her appointments were cancelled when services were overbooked.

During the first few months of treatment, Flora twice complained her current boyfriend was inconsiderate and unreliable. Six months into treatment, Flora discovered him in bed with another woman, and she left him to live in a spare room in her old roommate’s house. This old roommate had once been Flora’s boyfriend, but she had continued to live for free at his house after their relationship ended. Apparently this was a stable arrangement, and was vital during the two months her food stamps and General Assistance were withheld, and she had no income. Flora said that prior to her most recent relationship, she had been without a partner for two years. She confided that she had not missed having sex but had missed having someone to cuddle with, and added that the absence of physical contact had been hard to bear.
During our 10th counseling session, almost six months after beginning treatment, I introduced Flora to creative art therapy, using crayons and colored chalks on paper. I took a large piece of paper and tore it in two, half for each of us. She said she was not an artist, but was willing to give it a try, and I replied I was not an artist, either. We each worked in silence for a while: she drew tall pine trees on her paper, and I drew a comet on mine. Flora bent her head forward to focus on her drawing, brushed her hair out of her eyes every few seconds, and uttered the familiar voiceless sighs and tsk sounds that frequently punctuated her speech. Flora added a small cabin under the trees to her drawing, with smoke curling from a chimney, and I added a dark sky to highlight the flaming comet in mine.

While working on my drawing, I suddenly was overcome with the urge to cry. This feeling was so unexpected that I was confused and left the room, rather than burst into tears in front of Flora. I returned after a minute or so, feeling more composed, but wondering why I had been so affected. I realized this was likely an instance of projective identification, but did not know how to respond outwardly, and the incident passed without comment.

After I returned Flora quietly revealed she had made plans to see her children in two weeks, traveling up and back with a friend on his motorcycle. He would go on to Reno and pick her up on the way back. Flora said she was afraid to get too excited in case her plans fell through, adding that she had traveled to Reno with this friend before and felt confident riding with him. I said this was very good news and suggested she talk her plans through next week, to prepare for her visit.
As Flora’s 10th session concluded, we discussed her next court date, marking six months of court-ordered treatment. Flora asked if her attendance at EBCRP fulfilled the requirement for court-ordered treatment. I responded that I thought a judge would make that decision, but attending more groups before her appearance could make a positive impression. Flora attended four groups in the next 10 days, but failed to show up for her next two counseling appointments.

As Flora completed six months of treatment at EBCRP, I made a case presentation to staff at a clinical meeting in preparation for a review of her treatment plan. In collaboration with other members of staff, I updated the initial assessment to Substance Induced Anxiety Disorder on Axis I, to indicate how the pervasive anguish and helplessness she felt about her difficulties was maintained. I reported on her obsessive longing for her absent children, continued positive test results for drug use, and sporadic attendance at the clinic. A senior member of the clinical staff asked me to imagine I was Flora and express how she felt. I said, “I feel like a sad sack of shit,” and as her counselor I added, “I feel helpless to help her.” Some of the staff noted her low sense of self-worth in groups. One of the clinical staff said she thought Flora’s wish to visit her children was a red herring and asserted that a mother who truly wanted to see her children would go to any lengths to find a way. Inpatient detox was discussed for the treatment plan.

After I presented her case, as if by serendipity, Flora attended her next individual counseling session early, looking like the proverbial cat that ate the canary: she had visited her children for the first time in two years! Flora’s first weekend visit with her children occurred six months after intake and was the high point in her treatment. She looked radiant with pride and calm and thoughtful, rather than agitated and worried as
she usually did. She said she had borrowed money for the bus from a neighbor, and would pay it back somehow. I said I felt very pleased by her achievement. Flora said she expected me to disapprove of her visit. I was surprised because I had encouraged her to visit her children. I responded by saying I was proud of her for acting creatively to get what she needed, and suggested she buy a sheet of gold stars and stick one on a calendar at home each time she accomplished something of which she was proud. Later, I noticed she stuck a gold star on the drawing she made during an earlier counseling session.

Flora described what happened during her visit. The children’s stepmother confided in Flora about her anger and jealousy over her husband’s drinking binges with a female neighbor while the stepmother was at work. After Flora’s arrival, the stepmother moved into a motel to protest her husband’s drinking, leaving Flora to take care of the children. Flora said she herself also criticized her former husband for his drinking, despite terminal liver disease, and an argument ensued in which their daughters took his side. I asked if she had done the cooking while she was there, and she said that her former husband did all the cooking because he was on disability and did not work. I praised her for maintaining her boundaries by not taking sides in her former husband’s marital difficulties while she was there.

Flora expressed mixed feelings; toward the end of her visit, she was torn between staying and leaving. She said she was overjoyed at seeing her children again, and commented on how much they had changed since she saw them last, but all the pain of separation returned when she left. Flora asked if I thought it was a good idea for her to move so she could be near her children and help out when needed. I reminded Flora that she still had to complete her court order in the Bay Area, and that she might become
isolated without friends and family to support her. I suggested she check in with her former husband once a week to arrange another visit soon. Flora said her daughters were graduating from junior high and high school in a month, and she would like to see them graduate. I said that sounded like a good opportunity for another visit. I asked her whether she had used drugs during her visit, and she replied that she had been clean since leaving for her visit. I suggested she get tested after our session, to get a clean result. She approved of the idea, but in her excitement forgot to get the test before leaving.

Flora attended her next counseling appointment on time, a rarity. She seemed to have descended from the pink cloud she was on the previous week. She reported that her daughters asked her not to attend their graduation ceremonies, which was a bitter disappointment to her. Following up on from our previous conversation, she decided she would not relocate to be near her children. She expressed concerns about her former husband’s ability to care for them while he was drinking, and said he had endangered them while driving. Flora had made similar comments before, indicating he was less capable as a parent than she was. I turned the question around, querying Flora’s continued use of methamphetamine and cannabis. She did not acknowledge the parallel, but conceded she found quitting more difficult than she had thought. She said she was focused on seeing her children and did not see how getting clean could help her achieve that.

Although Flora considered her former husband’s drinking harmful to their children, she apparently did not think of her own drug use as a comparable problem. Up until this time, I had not confronted Flora so directly. My aim had been to support any progress she made in meeting her goal to see her children. I believed this would give her
a sense of achievement that could help her feel more capable about improving her life.

With her court date fast approaching, I felt her continued drug use was a liability that needed to be faced.

Flora visited her children a second time two months later, and told me she did not feel as welcome as she had the first time. She complained that neither of her teenage daughters was interested in spending time with her, and that they sided with their father when Flora criticized his drinking, and he told her it was none of her business. Flora’s 14-year-old son was pleased to see her, but his father was wary of them spending time together. During the weekend Flora walked with her son to a nearby convenience store, and his father drove up in a fury after searching the neighborhood for them. Apparently he thought Flora had kidnapped the boy. Flora could not explain why his father was angry when he found them at the store, or why she felt less welcome during her second visit. My interpretation is that her second visit occurred when her former husband and his present wife were attempting to reconcile their conflict, and Flora was seen as divisive to family unity. Again, Flora returned home in confusion, torn between staying with her children and returning to face her difficulties in the Bay Area.

In the time between her first and second visits to see her children, Flora spoke about her difficulty participating in groups and making friends with other clients, and intimated that socializing with her usual circle of drug-using friends made abstaining from drugs more difficult. Flora said she felt alone, adding that among her friends, she did not know anyone who was clean. I suggested she might find support from other people attending the groups. She said she did not know whether to believe other clients
who said they had not used in several weeks, and that she did not say anything about her continued drug use in groups.

After Flora faced these uncomfortable topics, I felt the need to bridge the divide between us by putting myself in her situation. I said I would find recovery less appealing if I was ordered to get clean by a judge or anyone else. Flora warmed to my concern and said it was like jumping through hoops, that it was hard to put her heart into it, and that it was difficult to do all the court ordered. Flora recalled that her most recent relationship had begun optimistically when she and her boyfriend agreed to both quit using methamphetamine. But while she had been in treatment at the clinic, he had not made any changes, and she had continued to use with him.

Flora missed our next scheduled appointment, but attended the following week, two days before her court appearance, and seven months after enrolling in treatment. She telephoned to say she had slept late, so we met later than scheduled. We reviewed the treatment objectives from the beginning, including her first counselor’s original plan for inpatient treatment if Flora did not stop using after two months. Flora again recalled how caring her first counselor had been. I said it was time for a new treatment plan and asked her what help she needed now. She surprised me by saying she was ready to consider inpatient care in a detox facility because she had not succeeded in quitting on her own. I said I would put that in the new plan and would write a letter to the court that she could pick up the next day. Flora said she would get tested in the morning, anticipating that she would test clean. Flora also completed a depression inventory and scored in the middle of the scale, the same as at intake, with no serious symptoms.
Two weeks later, Flora returned to the clinic to say she had applied to the rehabilitation facility for admission, and she was on their waiting list. Flora surprised me by saying that her cousin, who was now clean and sober, had been through detox at that clinic. Flora said she had some confidence detox would help her quit using methamphetamine and cannabis by giving her time away from the friends with whom she habitually used. I showed Flora the new treatment plan, which included her wishes, and she responded to it positively. The new goals for treatment included establishing regular visits to see her children, referral to inpatient detox treatment, returning to EBCRP to support her recovery after completing detox, and then beginning smoking cessation.

During this session, I gave Flora a certificate of achievement for her work in recovery and her efforts to maintain contact with her children, reflecting the goals in the treatment plan. She had missed the evening event when these were awarded, which had been attended by many clients, family, and staff. Flora started crying and grasped my hands, saying she had never received an award for anything before. I felt touched by her response. My supervisor later said these certificates were the first acknowledgements many clients at the clinic had received in their entire lives.

Although Flora’s individual counseling at EBCRP formally ended eight months after she enrolled, we continued to work together to prepare her for a series of court appearances and to respond to requests from judges. The judge at her fourth hearing declared that Flora had completed her court-ordered treatment.
Legal and Ethical Issues

Several legal and ethical issues emerged during treatment. As Flora’s scheduled counseling sessions ended, legal issues involved her repeated court appearances to monitor her progress in treatment. An ethical issue emerged when I reported to the court on her positive drug test results, as required by the court. Flora’s trust in me appeared fractured after this disclosure, and she was further shaken when a judge later questioned the agency’s qualifications to treat her under the California Proposition 36 drug treatment program, which diverted drug offenders into treatment rather than probation or jail.

Another ethical issue was my supervisor’s directive to end counseling appointments after Flora stopped attending treatment regularly. I did my best to refer her for inpatient treatment at a detox facility, but her difficulty complying with the preadmission process prevented her from transitioning to an alternative treatment program.

The foremost ethical problem emerged seven months after Flora enrolled in treatment. She was required to appear in court, and I wrote a letter to the judge reporting on her attendance and progress at EBCRP during the six months of treatment she was ordered to complete. Flora was tested three times for drug use while at EBCRP, and all were positive for either methamphetamine or cannabis. I discussed Flora’s continuing positive drug test results with my supervisor, and she suggested I use the phrase “struggling to test clean” as an accepted way of saying she was continuing to use, while also stressing her efforts to quit. I included this phrase in my letter to the court, and added that Flora was applying for inpatient treatment to help her achieve abstinence. I made one copy for the court and another for Flora, as was the practice at the clinic.
Flora was furious when she read her copy of the letter intimating her positive test results. She reminded me that I had told her there would be no adverse consequences for testing positive at the clinic. I felt I had deceived her, but replied defensively that I had not anticipated she would continue to test positive. I did not add that, due to my inexperience, I had failed to anticipate that I would have to report her test results to the court. My recollection of what I had said earlier in treatment was that the clinic used a harm-reduction model, so clients did not have to test clean to participate in treatment, and there would be no adverse consequences for testing positive for drug use. I had not intended to generalize beyond treatment at the clinic. She sat slouched in her chair, silent, sullen, and angry. I felt it was prudent to say nothing for a while, so we both endured the ensuing silence, steeped in our own feelings. I felt ashamed, as though I had been exposed as a fraud.

Flora was absent from the next four individual counseling sessions, but attended one group on smoking cessation. I described Flora’s absence to my supervisor, and she suggested I write a letter to her, noting her absence from the clinic and informing her that since she continued to be absent from groups, she would be discharged from treatment. I followed the sample discharge letter my supervisor gave me, and ended it on a positive note, wishing Flora success in her recovery journey. My supervisor also said I should stop making counseling appointments with Flora because individual counseling was a privilege contingent on regular group attendance. My supervisor gave me permission to continue writing letters to the court, as needed, to describe Flora’s work at the clinic.

Six weeks after her last individual counseling session, eight months after beginning treatment, Flora made an unscheduled appearance at the clinic. She reported
that the judge at her court hearing six months into treatment had ordered her to return again in three months. I later learned from my supervisor that judges frequently require further court appearances if they are not satisfied with a client’s progress in treatment.

I asked Flora if she had received my letter saying she was about to be discharged. She confirmed that she had and defended her sporadic attendance, saying she had been busy trying to get back on welfare and food stamps. Following my supervisor’s directions, I explained that individual counseling at EBCRP was available to participants who attended groups regularly and wanted to work on additional issues, and since she had stopped attending groups, she was no longer eligible for counseling.

Flora looked stung, was quiet for a while, and then retorted, “So, you’re so busy that you don’t have time to see me?” I did not know how to reply. Flora seemed to have glossed over accepting any responsibility for her part, and gone straight to blaming me. I felt torn between accepting Flora’s inability to attend treatment as a symptom of addiction, and accepting my supervisor’s view that she had abandoned treatment. In either case, I was convinced referral to a detox clinic was the next step in treatment. I emphasized that she could attend groups as before, assured her I would continue to write letters to the court, and said we could talk when I was available. Flora seemed more soberly thoughtful than I had seen her before.

Flora attended one group therapy session for each of the next three weeks, which was far fewer than the three groups per week she agreed to in her treatment plan. She spoke to me after a morning community meeting to say her admission to the detox clinic had stalled because she had not telephoned them on the days she was required to check in while on their waiting list. I said I would telephone the clinic to see if I could get her back
on the list. Because Flora was still occasionally showing up at the clinic, I showed her the revised treatment plan I had written. I had incorporated her new treatment goals, including getting into detox, and we both signed it. She seemed pleasantly surprised and commented that it included just what she wanted.

I telephoned the manager at the detox clinic, to find out why Flora had been dropped from their waiting list. The manager explained this was because she had not telephoned each morning, as required. I explained that Flora was motivated to enter inpatient treatment after being unsuccessful at quitting while attending outpatient treatment, and added that her failure to check in regularly was indicative of the unmanageability of her daily life, not her lack of interest in treatment. As a result of my call, the manager reinstated Flora on their waiting list and said she would be called for admittance as soon as there was a vacancy. Then I called Flora to tell her to be ready for their call.

I telephoned and left a message for Flora two weeks later, after she had been enrolled at EBCRP for 10 months, asking if she had heard from the detox clinic. She called back the next day and said she was in communication with the detox facility and was expecting to start any day. She later told me she had a bag packed and was ready to go, but never received the call to be admitted, and had continued to use. My supervisor commented that other clients at EBCRP had experienced similar difficulties gaining admission to the same detox clinic, that county-financed detox services were oversubscribed, and the admission process was used to ration services.

Two days before her second court hearing, after completing six months of treatment, Flora asked me to write a letter reconfirming her participation, and added that
she had applied for residential detox treatment. I wrote the letter, and she picked it up to take with her to court. Flora came to see me a few days later, fearing her time at the clinic had been wasted. She reported yet another unfamiliar judge had reviewed her case and questioned whether EBCRP was qualified to treat her under the court’s drug diversion program. He had set another hearing in one month’s time. Flora reported she had given her letter to the public defender so he would have something to present on her behalf, but when her case was called, he just handed the letter to the judge without saying anything. Flora derisively called him a “public pretender,” a term I have heard other clients use.

I discussed this situation with my supervisor, and I was told that the clinic was qualified to treat clients under the California drug diversion program. She added that cases such as Flora’s often were extended to keep pressure on the client. My supervisor phoned the court and relayed to me the name of the person at the court who was knowledgeable about the Proposition 36 drug diversion program and also knew of EBCRP and our qualifications.

Before her third hearing, I telephoned Flora, and she came in to talk with me about preparing for it. I had written a letter responding to the last judge’s concerns and again outlining Flora’s work at the clinic. The plan was for Flora to contact the Proposition 36 liaison at the court the day before her hearing, and to secure a public defender to relay an additional copy of my letter to the judge in advance of the day’s proceedings. Just before her hearing, Flora telephoned and then met with me. She reported she had followed through with the court liaison and public defender’s office and felt confident she would be better represented at this hearing. In answer to my inquiry, Flora said she still had not received an admission date from the detox clinic.
Outcomes

Nearly one month after her fourth hearing, Flora came to the clinic and asked to speak with me. I was in a clinical meeting, but stepped out to talk with her briefly. She looked tired and disheveled, and was dressed in jeans and a black tee shirt, with “I love Reno” spelled out in plastic gems. Flora explained she had just gotten back from a trip to Reno with friends and had another court appearance the next day, her fourth. She reported the judge at her last hearing had requested more detailed information about the group therapy sessions she attended. I said I would write the letter for her to pick up the next morning, and asked her to check in with me again next week regardless of the outcome. I asked if she had seen her children during her trip, and she said she had not. Flora did not return to the clinic the next week or the week after that. I left a phone message with her roommate, but Flora did not respond.

I felt despondent as I returned to the meeting after talking with Flora, imagining she had been using heavily in Reno, and dismayed she had not included a visit with her children on the way there. One of the clinical staff invited me to talk about what had occurred, but I felt too distressed to answer. I talked about it later with my supervisor, saying I felt hopeless about Flora’s poor attempt at recovery. My supervisor said sometimes it is unrewarding to introduce people to recovery, but each client becomes willing to take sobriety seriously in their own time. Our job is to make the next counselor’s work look easy, after clients become ready for change.

Eight months after our last meeting, just as I successfully concluded lengthy negotiations with the clinical director at EBCRP to clear the way for Flora to become the
subject for my Case Study, I met Flora by chance as I walked from the clinic to a sandwich shop. I said, “hello” as we approached from opposite directions, and she looked up with what appeared to be an expression of unwelcome surprise. The street was noisy and hot, and she had the sun in her eyes. I realized she could not see me clearly, so I steered to the side and identified myself. She recognized me then and began to engage.

I asked how she was doing, and she said she was okay, and volunteered that she had visited her children several times since we last met. She smiled as she told me her former husband had been more accepting of her during these recent visits and had paid for an emergency tooth extraction while she was there. I asked if she was still willing to be the subject of my Case Study, and she said she was. We agreed to meet at the clinic the next day to discuss what this entailed and sign the informed consent forms. Taking no chances, I telephoned to remind her the next day, and she came to the clinic as arranged.

We met in the windowless counseling room we had used many times. I got out the paperwork for the informed consent, and was interested to know what had occurred in Flora’s life since we last met for therapy. First I asked if she had completed her court order. Flora expressed relief as she related how the judge at her fourth court hearing was a woman who had “taken pity” on her and discharged her as having fulfilled her court-ordered treatment. I said I had wondered if she was discharged by the court, but did not know because she had not come in to tell me after her last hearing. Flora excused her omission, saying she had intended to tell me the result but had been busy, and eventually she had forgotten about it. We moved on to other topics. I learned that her brother had been released from prison, was not drinking or using, and was living with his cousin in an
effort to stay clean and sober. For clarification, I asked if her brother and cousin were a couple, which Flora confirmed.

Then I asked Flora about her own progress in recovery. She said she was still using methamphetamine and cannabis, but feeling increasingly alienated from the few friends she had. She appreciated how her social circle was shrinking, and that spending time with these friends was not rewarding, yet she felt trapped in the subculture of methamphetamine users. I asked about her children, and Flora responded that her oldest daughter had moved to the Bay Area with her boyfriend. She was pleased she was living nearby, but saw her rarely. Flora continued that her youngest daughter, now 15, also had a boyfriend. Flora thought she was a too young to be in an intimate relationship, adding, “Kids grow up so fast now, they don’t have time to be children.” I asked if she still missed her remaining son and daughter, and Flora conceded she was feeling better after visiting them several times. She said she was accepted and treated well by her former husband and his wife, and she was looking forward to another visit soon.

We returned to the informed consent forms I had placed on the table. I explained I would be writing about our work together while she had been in treatment at the clinic. Flora asked if my study would involve us doing more work together, and she seemed both disappointed and relieved to hear she had already played her part in the work. I read aloud my cover letter that outlined how my study was to be about how her unchanging and consuming feelings of loss, together with her drug dependence, could help in understanding these difficulties and might be useful for others in similar circumstances. Flora seemed interested in what I was planning to do. As she signed the release forms,
writing neatly and with care, I was reminded of our first meeting during her intake, when she signed those forms with similar care.

Flora concluded our last meeting by reminiscing about her priorities during treatment. She said getting her children back was her main focus; then completing her court-ordered treatment; and lastly quitting methamphetamine, cannabis, and tobacco use. She asked if it would be possible to return to the clinic to quit smoking tobacco. I replied that she could enroll again when she was ready. Although EBCRP had a tobacco cessation group for clients who were addicted to other drugs, I knew of no funding that was available for treating tobacco use as a primary addiction, but that would be for Flora’s next counselor to negotiate with her. During Flora’s work at the clinic, she accomplished two of her three goals, an achievement that was arduous for both of us.
CHAPTER 4

LEARNINGS

What I learned during Flora’s ten months of therapy is presented in this chapter. Key concepts and principles that were drawn from the extant literature on co-occurring disorders, complicated grief, and addiction, and that informed my work with Flora, are presented. A brief explanation of each is given; then they are represented in the context of what happened during the course of Flora’s therapy. Together they form a web of meaning that brings significance to the events that occurred during treatment, and also they provide a context for understanding the imaginal structures that were evoked in both Flora and me as therapy progressed. The mythic backdrop to what happened during therapy contributed an additional dimension of meaning that speaks to Flora’s situation from the timeless perspective of deep human nature. My personal and professional development as a result of this work is examined. Finally, a view of the therapy from an imaginal perspective provides insight into approaches to the therapy from this psychological orientation.

Key Concepts and Major Principles

To inform my learnings about what happened during the therapy, I draw on key concepts and principles from the literature. These concepts and principles are first listed and then explained, and their particular relevance to Flora’s situation is indicated.
The key concepts and major principles that informed my work with Flora include the following: Boss’s concept of ambiguous loss; Askren and Bloom’s principle that mothers who lose custody of children experience a crisis in life comparable to their deaths; Bowlby’s concept of chronic mourning and his principle that the course of mourning mirrors early losses; Brown’s principles that adult children of alcoholics do not develop to psychological maturity, and that they have difficulty separating from their mothers; Suomi’s principle that peer socialization promotes anxiety, aggression, and alcohol addiction; Chambers, Taylor, and Potenza’s principle that adolescents are developmentally prone to drug use and addiction; Murphy and Rosenbaum’s principle that motherhood, as a way to establish a socially valued adult identity, leaves women economically vulnerable; Miller and Rollnick’s principle that clients begin treatment for addictions with ambivalence, rather than resistance; May’s principle that people take drugs to overcome difficulties acquired in their first families; Yalom’s concept of existential loneliness, and his principles that loss brings awareness of separation and death, and that an unfulfilled life intensifies the fear of death; Dursteler-MacFarland, Cereghetti, and Wiesbeck’s principle that resistance during treatment for drug addiction can be reinterpreted as an impairment of cognition; Zweben et al.’s principle that methamphetamine users experience pronounced negative affects; Krystal’s principle that addicts expect negative reactions when praise is due; and Prochaska and DiClemente’s concept of stages of change in recovery from addiction. These diverse ideas bring breadth of meaning to Flora’s life experience and to the therapy.

Additional concepts and principles informed my understanding of the **intersubjective field** (interpersonal experiences) during therapy: Freud’s concept of
transference; Jung’s concepts of countertransference and mutual transformation; Bion’s use of the concept of *projective identification*, or the transfer of unintegrated material from patient to analyst; and Omer’s concept of imaginal structures, which shape subjective experience. These related psychological concepts bring depth of meaning to the interpersonal experiences of client and therapist, as participants in therapy.

My understanding of Flora’s complicated grief is enhanced by Boss’s concept of ambiguous loss, which signifies unrelenting grief caused by the absence of family members under inconclusive circumstances. Boss describes two alternative cases when a family member is physically absent but psychologically present, and when a family member is psychologically absent but physically present. Boss finds that others may not give credence to this kind of loss, and may leave those with an ambiguous loss alone in a chronic state of what Boss calls “frozen grief.” This was true for Flora; she had been unable to resolve her distress over the psychological presence, yet physical absence, of her children, and friends left her disconsolate.

Also pertinent to my understanding of Flora’s distress is Askren and Bloom’s principle that mothers who relinquish custody of children experience grief as though their children had died. Askren and Bloom find that loss of custody causes normal grief reactions, which tend to persist and may even grow more pronounced over time. They conclude, “The relinquishing mother has experienced a life-changing event that may profoundly affect her mental and physical health and her relationships at the time of relinquishment and far into the future.”

Consistent with my observations of Flora’s grief reactions, Bowlby identifies a state of chronic mourning that features “yearning and searching” and “disorganization
and despair,” which typify the intermediate phase of Bowlby’s stages of grief. Regarding etiology, Bowlby offers the principle that the course of mourning mirrors experiences during infancy, childhood, and adolescence, and that disordered forms of mourning reflect earlier experiences of grief due to inadequate attachment or separation from the mothering figure.

The importance of attachment to my understanding of Flora’s development is supported by Brown’s principle that adult children of alcoholics have difficulty separating from their original families. This is based on Brown’s observations that the intellectual, emotional, and social development of children within the alcoholic family are constrained by the inverted parent / child caretaking roles. Brown finds that children growing up with alcoholic parents often have a “merged” bond with their mother, in which the child experiences their mother’s feelings as their own and assumes parental responsibility by taking care of their mother’s emotional needs. Brown finds that children from alcoholic families grow to adulthood still longing for the elusive bond of attachment to an emotionally unavailable, or “dead,” parent. Brown’s secondary principle is that adult children of alcoholics tend to remain perpetual adolescents, unable to form viable identities of their own, having had no adequate model.

Suomi’s principle that peer-socialized monkeys are susceptible to addiction to alcohol is helpful to my understanding of Flora’s reminiscences of her childhood among her peers, within an alcoholic family. Suomi asserts that peer-socialized monkeys reared by lab assistants are more likely to become fearful or aggressive than are those reared by their own mothers, and more likely to become anxious outside their peer
Additionally, Suomi finds monkeys deprived of mothers and socialized among peers drink more alcohol when it is available.\(^\text{18}\)

Chambers, Taylor, and Potenza’s biological theory aids my understanding of why Flora began a life-long habit of drug use during adolescence. These researchers find that novelty seeking and impulsivity among adolescents are heightened by developmentally timed changes in neurotransmitter levels, along with immaturity of the executive functions of the brain.\(^\text{19}\) They propose that this explains why experimentation with drugs is common during adolescence, and why addictions among adults frequently are established then, too.\(^\text{20}\) Chambers, Taylor, and Potenza sum up their position by stating that “substance use disorders constitute developmental disorders,” with permanent effects.\(^\text{21}\)

Murphy and Rosenbaum’s research into mothers who use drugs broadened my understanding of Flora’s choices in life, and some of the difficulties she faced following her separation from her husband.\(^\text{22}\) Murphy and Rosenbaum give voice to women who, like Flora, have limited education and employment opportunities, and are attracted to marriage and motherhood as a way to achieve adult status as women. These authors find the disparity between the high social value of women’s unpaid work as mothers and its low economic value leave women vulnerable and financially dependent on their male partners or the paternalistic state welfare system.\(^\text{23}\)

Motivational interviewing is a counseling model that was practiced at the clinic, and which I applied in my work with Flora.\(^\text{24}\) Miller and Rollnick assert that people enter treatment for addictions and other compulsions with ambivalence about change rather than resistance, and that resistance in treatment can be attributed to the use of direct
confrontation and lectures by the therapist. They find resistance signals that the therapist is moving ahead of the client and needs to ask more about the client’s present understanding and beliefs. The authors find expressing empathy and building self-efficacy (e.g., developing treatment goals in collaboration with the client) can reduce resistance and develop motivation for change. Miller and Rollnick recommend providing well-timed feedback and advice, and encouraging an awareness of discrepancies between the client’s intentions and the results they are getting.

Together with Miller and Rollnick’s motivational interviewing, Prochaska and DiClemente’s model of “intentional” self-change was used at the clinic to determine clients’ progress in recovery during treatment. Four stages are included in this model: precontemplation, contemplation, action, and maintenance. The fact that Flora was thinking about quitting methamphetamine and tobacco during treatment indicates she was at the contemplation stage, and according to Prochaska and DiClemente, needed information and accurate feedback in order to commit to the next stage of recovery.

May’s existential view on addiction informs my understanding of Flora’s dependence on drugs and lack of vitality, and her fears of abandonment and death. Addiction, according to May, is a way of life that suits people with a chronic sense of uselessness because drugs provide temporary energy to alleviate lack of purpose in life, which originates with inadequate mothering or fathering. May finds feelings of abandonment in adults are not the result of physical abandonment, but are from the discrepancy that results when parents verbalize love for their children without demonstrating it. May asserts that overcoming fear of abandonment and death requires the courage to be affected, and to risk being vulnerable and intimate with others.
Yalom’s concept of existential loneliness deepened my appreciation of Flora’s concern about the loss of her children, the illness and death of her mother and aunt, and her own fear of dying. Yalom holds that existential anxiety is caused by four primal concerns in life: fear of death, fear of isolation, the desire for meaning in life, and the longing for freedom. Yalom asserts that most of the time we avoid facing these issues, but life circumstances can bring them forcefully to awareness and can deepen our appreciation of life and vivify how we live.

Dursteler-MacFarland, Cereghetti, and Wiesbeck offer an explanation for Flora’s erratic attendance at the clinic and why she had difficulty making meaning of events during her second visit to see her children. These authors assert substance users are difficult to retain in treatment and have poor outcomes because neurocognitive deficits acquired from drug use affect attention, comprehension, memory, and decision making. Dursteler-MacFarland, Cereghetti, and Wiesbeck state their position on treating addicted clients as follows:

Given the accumulated evidence of mild-to-moderate brain dysfunction in a substantial proportion of these patients, this apparent treatment resistance can be understood not simply as psychodynamically or interpersonally based psychopathology but something in the realm of an existing brain impairment. From this point of view, the patient who ‘won’t’ then becomes the patient who ‘can’t’. These patients, often viewed as unreliable, uncooperative, manipulative, distractible, unwilling, and so on, can thereby be more usefully seen as incapable and struggling, in need of empathic support and alternative treatment strategies rather than persistent psychodynamic interpretation, stern confrontation, or even dismissal from treatment.

My comprehension of Flora’s pervasively negative outlook is informed by Zweben et al., who researched symptoms associated with methamphetamine use. These authors find that methamphetamine users often experience “severe” obsessively negative thoughts, feelings of failure and self-blame, and expectations of being punished. They
report women who use methamphetamine frequently have difficulty controlling their anger.\textsuperscript{44} Zweben et al. also observed high incidences of depression, suicide attempts, anxiety, and psychotic symptoms.\textsuperscript{45} Symptoms were exacerbated by frequent use, but duration of use did not affect severity of symptoms.\textsuperscript{46}

Krystal finds addicts in therapy often react negatively at the prospect of reward for their achievements.\textsuperscript{47} Repeated experiences of being disparaged or rejected when expecting acknowledgement or praise cause addicts to react with fear when praise is due. A traumatic reaction leads addicts to expect a negative reaction by their therapist to guard against the pain of disappointment.

Regarding the intersubjective field, Freud’s concept of transference gave me an appreciation of what was happening when Flora found she confused me with friends and relatives. Freud used the concept of transference to indicate the tendency of clients to project experiences associated with people from their past onto their therapist.\textsuperscript{48} Freud finds this an unavoidable but problematic phenomenon, in which clients recreate past relational difficulties with their therapist. However, he states the transference also offers the opportunity for unconscious desires to be re-experienced with greater awareness in the present, after the illusion of the transference is understood by the client as a presentiment from their past.\textsuperscript{49}

Jung’s concept of countertransference helped me understand why I felt the need to disclose my own recovery history to Flora.\textsuperscript{50} Whereas Freud describes transference as the client’s unconscious projections onto the therapist, Jung observes countertransference, the reverse phenomenon, occurring when the therapist projects unconscious images onto the client.\textsuperscript{51} Jung describes countertransference as an “unconscious identity,” which he
considers potentially disastrous to the progress of therapy. Moreover, Jung finds “counter-transference [sic] evoked by the transference” is a professional pitfall. However, Jung’s concept of mutual transformation, as an objective in therapy, requires therapists be as involved in the therapy as are their clients, each influencing the other. He states that for mutual influences to be beneficial, the therapist must have a high level of awareness in the interpersonal exchange; the therapist must already have achieved clarity in areas of experience where the client is still confused.

An explanation of my unexpected feeling of distress while working with Flora on an art therapy project is found in Bion’s interpretation of the concept of projective identification. Bion explains projective identification as an unconscious process by which clients deny an aspect of their own experience, and project this quality onto their therapist instead. Concerning a particular case of projective identification, Bion clearly states the therapist may experience affects (in this case, frustration) the client is unable to feel: “I think it is a situation in which the patient is projecting part of himself into me, so that I experience frustration but he does not.”

My understanding of the content and origins of projected ideations evoked in Flora and myself during her therapy are informed by Omer’s imaginal psychology concept of imaginal structures. Imaginal structures are similar to mental schemas, which shape experience so an emerging situation does not register as experience but as a preset reaction loaded with particular beliefs and expectations. Omer defines his concept as follows: “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.”

The concepts and principles described here contributed to my understanding of what happened during the therapy.

**What Happened**

In this section, the relevance of each concept and principle is examined in the context of events during Flora’s treatment, adding significance to each circumstance.

Beginning with her first counseling session, Flora dwelt on how she missed her children and longed to have them living with her again. Flora’s children had been removed six years before she entered treatment, and she had not seen them in two years. Flora’s distress is consistent with Boss’s concept of ambiguous loss because her children were clearly psychologically present for Flora, while they were physically absent. Boss’s concept of frozen grief is an apt image of Flora’s chronic state of longing.

Flora’s distress following the removal of her children by CPS did not abate with time, but was a consuming preoccupation that caused her almost constant misery. This state of intense and chronic grief is consistent with Askren and Bloom’s principle that mothers who relinquish custody of children experience chronic grief that may grow more pronounced over time. During her prolonged separation, Flora’s attempts to see her children were repeatedly frustrated by the children’s father, who changed plans so visits failed to occur. In desperation, Flora contemplated an unannounced visit to her children while they were staying with her former mother-in-law, who had initiated their removal
from Flora’s care. This pattern of grieving is congruent with Bowlby’s concept of chronic mourning, typified by chronic searching and despair.\textsuperscript{64}

Two months after enrolling in treatment, Flora began to relate her family history to me. It became clear her early life had been disrupted by conflict and separation between her parents. During infancy, Flora’s mother had little support from her alcoholic husband, whom Flora described as “mean.” Conflict between her parents led to their divorce when Flora was three years old. After her parents’ separation, Flora was sent to live with her aunt until her mother remarried a year later. Parallels between Flora’s grief over the loss of her children and the circumstances of her early life are informed by Bowlby’s principle that the course of mourning mirrors early losses, and that compulsive care giving is due to inadequate or intermittent care during childhood.\textsuperscript{65}

Flora confided to me that she found herself reacting to me as though I were one of the men she knew. When I reported this to my supervisor, she said this was an indication Flora was becoming attached to me. I later asked Flora whom I reminded her of the most, and she said I reminded her of her stepfather, the kind alcoholic who was caring and good fun. This can be understood as an example of Freud’s concept of transference, and his principle that transference provides an opportunity for the patient to bring associations with people from the past into present awareness.\textsuperscript{66}

It became apparent that all the adults in Flora’s extended family had been addicted to alcohol. During treatment, Flora’s aunt was hospitalized for alcoholism, and Flora and her cousin visited her several times before she died in the hospital two months after admission. Flora was especially distressed by her aunt’s illness and death because she had been like a second mother to Flora. Flora was reminded of her mother’s
hospitalization 15 years before and the distressing circumstances of her death. Flora said she and her mother “had always been best friends,” and she had wanted to nurse her mother at home, as she had cared for Flora as a child. These circumstances evoke Brown’s principle that adult children of alcoholics have merged identities with their mothers, perpetually seeking gratification for their own unmet dependency needs, while caring for the needs of their parents.\textsuperscript{67}

Flora grew up in the context of alcohol, and spent her childhood shuttling between the homes of her mother and aunt. She related how she, her brother, and their cousin often played in the car while their parents drank in bars. She recalled with evident delight the fun she and the other children had together. Flora and the other children in her extended family all went on to develop addictions. Flora’s development is informed by Suomi’s principle that peer-socialization in monkeys makes them susceptible to alcohol addiction.\textsuperscript{68} Flora began drinking alcohol and using drugs with her cousin when she was 15 years old. Her cousin developed an addiction to alcohol but had been clean and sober for many years by the time Flora entered treatment. Flora’s brother also drank and used other drugs. Chambers, Taylor, and Potenza offer the principle that teenagers are susceptible to drug use because of a biological predisposition toward novelty and excitement, and that adult addicts often begin using during adolescence.\textsuperscript{69}

Flora had never worked for a wage, having first married in her early twenties, and had five children with two husbands. Both marriages ended in divorce, and each husband took custody of their children. After Flora’s second divorce, she lost both her home and her identity as a mother, but lived in hope of regaining custody of her children and reclaiming her mothering role. Flora’s precarious social circumstances evoke Murphy
and Rosenbaum’s hypothesis that the idealization of motherhood leads women with few options for social advancement to rely on the role of mother to attain social standing as mature women, and that failure in this role leaves women vulnerable to losing both their identity and financial stability.\textsuperscript{70}

Flora’s preoccupation with the deaths of her aunt and mother brought up fears about her own mortality. She expressed concern she might die as her mother had—alone, confused, and distressed in an institution. Flora felt she had accomplished little in life compared with others, and that her life had become an unremitting struggle. This resonates with Yalom’s concept of existential loneliness, and his principle that an unlived life makes the prospect of death more terrifying.\textsuperscript{71}

I perceived in Flora a profound state of uncomprehending demoralization that reminded me of my own feelings some years earlier. In an attempt to give her hope, I revealed I had also suffered from addiction, and had found that change for the better was possible in mid-life. My identification with Flora’s hopelessness about her prospects can be understood as an example of countertransference, Jung’s concept of a projection by the therapist onto the client.\textsuperscript{72}

During treatment, Flora appeared uncommitted to quitting methamphetamine and cannabis. After she noticed a recovery workbook on a shelf, I suggested we look at it together. In looking through the book, Flora was surprised by a question about the positive consequences of using methamphetamine. This is consistent with Miller and Rollnick’s principle that people enter treatment with ambivalence rather than resistance.\textsuperscript{73} Flora took a copy of the book home, but admitted later she was fearful of looking at it. I praised her for expressing mixed feelings and responding authentically. I was intent on
fostering trust and collaboration with Flora during treatment, and on avoiding an authoritarian confrontation, which Miller and Rollnick predict will result in resistance by the client.\textsuperscript{74} Looking at the workbook opened the door for Flora to consider why she used methamphetamine. She asserted that she got energy when using methamphetamine. It enabled her to escape her problems and general lack of interest. She added that she naturally felt inhibited, but that under the influence of methamphetamine she felt free to act spontaneously. Flora recalled first feeling lethargic as a teenager, before she began using drugs. May offers the pertinent principle that people use drugs to overcome a lack of energy due to insufficient structure in their family of origin.\textsuperscript{75}

Five months into treatment, Flora and I made colored drawings as an experiment in creative arts therapy. Flora drew a tiny cabin under pine trees on her paper, and I drew a comet traveling through dark space on mine. As we worked, I unexpectedly became flooded with feelings of sadness and loneliness. These affects appeared suddenly, with no identifiable cause, and I became confused. I felt it would be unhelpful to cry in front of Flora because she had done nothing to cause my tears. To account for sadness and loneliness I draw on Bion’s elaboration of the concept of projective identification.\textsuperscript{76} With no verbal distractions as Flora and I each focused on our drawings, I became more emotionally aware of her consuming feelings of sadness.

Six months after intake, Flora arrived early one day for counseling, and her face glowed with pride. She announced that she had visited her children for the first time in two years. I expressed pleasure at hearing of her achievement, but she said she had expected I would disapprove. I did not understand how she came to this conclusion because I had encouraged her to arrange a visit. Freud’s concept of transference offers an
explanation for why she anticipated my disapproval. Applying the concept of transference, Flora’s expectation of disapproval resides in her own unconscious expectations, which she misattributed to me as a stand-in for others who had judged her negatively. Krystal observes that addicts have “a fear of the positive transference” in therapy and “expect disappointment and rejection” as a traumatic reaction.

Another rationale for Flora’s negative expectation is a principle proposed by Zweben et al., that methamphetamine use increases negative thoughts. Flora appeared anxious during many counseling sessions, and frequently spoke of the seemingly continuous difficulties she faced. Although she contended with many real-life problems, her anxiety was incapacitating and caused her problems to compound rather than resolve. Zweben et al. observe that anxiety is prominent among methamphetamine users. To codify Flora’s anxiety in terms of Zweben et al.’s finding, I included the DSM-IV-TR diagnostic category of Substance-Induced Anxiety Disorder on Axis I in a revised assessment of her condition.

Flora’s irregular attendance during treatment and lack of insight into cause and effect can be attributed to cognitive impairment from using drugs. For instance, during her second visit, she could not understand why her former husband was furious after finding her with their son at a convenience store. Flora was unable to consider that he might have thought she had kidnapped the boy. Dursteler-MacFarland, Cereghetti, and Wiesbeck postulate that patients in treatment for drug addiction have cognitive impairments that make it difficult to stick with treatment and understand interpretations during therapy, which leads to poor outcomes.
Seven months after starting treatment, Flora was scheduled to attend a hearing to confirm she had completed court-ordered treatment. Reporting on her progress in a letter to the court, I indicated she had failed drug tests during treatment, and I used the phrase “still struggling to test clean.” Flora was furious and accused me of lying to her about the consequences of testing. She evidently felt betrayed. I felt ashamed I had inadvertently deceived her, and replied defensively that I had not anticipated she would continue to test positive. Testing was a condition of treatment and was required by the court, but I did not anticipate needing to report the results.

This was a crisis in the therapy; any pretense was abandoned, and we sat in silence for what seemed a long time. I imagined Flora’s mind flooding with all her previous experiences of betrayal as she read my disclosure of her drug use to the court. This encounter can be seen as an example of what Jung describes as “counter-transference evoked by the transference,” leading to “mutual transformation.” My feelings of inadequacy and fear of being seen as incompetent were evoked by Flora’s suppressed anger and disappointment, thus leading to a clearer differentiation of our identities and a sharper delineation of our respective responsibilities.

Omer’s concept of imaginal structures can be applied in this situation to illuminate how the projections of each participant within the intersubjective field conform to learned patterns of adaptation. During that long moment, it seemed that both Flora and I became disillusioned, each comprehending our unreasonable expectations of the other more clearly: Flora’s longing to be understood and have her needs taken care of by her parents, and my longing to be acknowledged as competent and worthy of love by mine.
The last phase of therapy tested both Flora’s persistence and my own, as we responded to separate judges at four successive hearings reviewing her court-ordered treatment. Counseling sessions ended at my supervisor’s request, but we met briefly, as needed to address issues presented by the judges. Flora attempted to get into a 45-day residential detox program, but failed, despite my attempts to get her back on the waiting list. My last meeting with Flora was distressing for me. She needed a letter for her fourth hearing, the next day. She had just returned from a weekend in Reno, and looked exhausted and jittery. I asked if she had visited her children, and she admitted she had not. I felt disappointed, and that our work had been for nothing.

Eight months after our final meeting during treatment, Flora met with me to give her informed consent to become the subject of my Case Study and to update me on her progress. She reported further visits with her children and was anticipating another visit soon. Although she was still using methamphetamine and cannabis, the despair in her voice was gone. Flora said a female judge at her fourth hearing “took pity” on her, decided she had fulfilled her court order, and released her from further obligation. She said her small circle of so-called friends, with whom she used drugs, did not satisfy her anymore. She said she was ready to quit smoking cigarettes and asked about enrolling again at the clinic to quit smoking. It appeared her desire for recovery had not diminished during her difficult work at the clinic. In Prochaska and DiClemente’s stages-of-change model, Flora was at the contemplation stage of recovery, considering what action she was ready to take.85
Imaginal Structures

How I Was Affected

Flora’s narrative was evocative, and I experienced mixed feelings of empathy and frustration. The primary affects I felt during therapy with Flora included interest, distress, anger, and shame. I also felt sad for her losses, joy at her humor, pride after she visited her children, and frustration when she missed appointments and was unable to get into rehab. I experienced alternating interest and distress at the beginning of therapy, frustration and pride during the middle part of therapy, and sadness and shame toward the end of treatment.

During the early phase of therapy, I was interested in Flora’s story, but as she continued to express her distress, I began to feel distressed, too. I felt mixed interest and sadness as I learned more about Flora’s family history, and imagined her growing up with her brother and cousin in an extended family with alcoholic adults. My sadness deepened as Flora mourned the death of her aunt, recalled the death of her mother, and then imagined her own death approaching. As the therapy deepened, we built a rapport that reflected greater trust. I felt empathy for Flora’s helplessness and hopelessness. I responded with caring by encouraging her to visit her children under conditions that she could feel pride rather than humiliation, and I disclosed a little of my history in hope of kindling her interest in changing her life for the better.

Around the middle of treatment, I felt disappointed and frustrated when Flora declined to get tested for HIV and hepatitis C, after waiting in line and receiving preliminary counseling. I felt frustration and anger when she failed to show up for
scheduled counseling appointments. Later, I felt suspicious after she sabotaged the opportunity to get into residential detox treatment, and thought she was dishonest and manipulative. I felt disillusioned at our last meeting during treatment, and thought she was as deeply into her addiction as at the beginning of treatment.

My feelings of disappointment were tempered by compassion for Flora as she struggled with her difficulties. After she missed appointments, she always was apologetic and told me what she had accomplished since our last meeting (e.g., getting her teeth cleaned, getting back on welfare and food stamps). I appreciated her persistence in working toward her objectives, despite disappointments, interminable waits for service, and opaque bureaucratic requirements.

While working on a creative arts project with Flora, I became overwhelmed by an alien feeling of sadness and powerful urge to cry. I suspected this might be an instance of projective identification, but was unable to respond, except by leaving the room until the sadness subsided. When I returned, I did not say anything. I did not know what to say, and Flora seemed unaware that anything out of the ordinary had occurred.

Two weeks later, Flora proudly announced she had successfully visited her children. I felt joy and interest to hear she persevered creatively when her ride fell through, and took the bus instead. I felt excitement, knowing this was a high point in the therapy. Toward the end of treatment, I felt fear and shame when Flora accused me of misleading her about the consequences for testing positive for using drugs. At the beginning of treatment, I recall saying people often test positive during treatment, and the clinic uses a harm-reduction model that does not penalize clients for using drugs.
However, I still felt guilty for inadvertently misleading her, and reacted defensively to Flora’s accusation.

Following a prolonged absence from treatment, I informed Flora I would no longer be available to meet with her for scheduled counseling sessions, but could otherwise meet with her as needed, and write letters to the court confirming her participation in treatment. Flora responded caustically, but she had missed many counseling appointments, and I felt relieved to be placing a limit on my availability. I had not said anything to Flora before, despite my feelings of anger and disappointment when she missed appointments, because I did not want my expectations to exceed her abilities. I felt dejected after my last meeting with Flora, at which she urgently requested a letter for a court appearance the next day. I felt profoundly sad as I returned to the meeting I had left to speak with her, and rejected requests from a colleague to report on what had occurred. I spoke with my supervisor later and felt consoled I had done my best, but I finally let go of the hope that Flora would become clean and sober during treatment.

**My Imaginal Structures**

The main imaginal structures that became activated during my work with Flora include my Abandoned Child, my Recovering One, my Vulnerable One, and my Reliable Ally. The first three structures I previously encountered during graduate work. They came forward in response to interpersonal stressors during coursework, when I was unable to remain present and slipped into defensive patterns of thinking and reacting. My Reliable Ally structure was useful in my own early recovery, and I wished to extend this
to Flora and others who feel guilt and shame for falling short in their attempts at recovery.

My Abandoned Child structure was reactivated whenever Flora expressed hopelessness and helplessness at reuniting with her children, echoing early feelings of distress when my needs for soothing and care went unmet. This structure is reminiscent of losses in my own childhood, when my mother avoided contact with me when I was distressed, for fear I would grow up dependent on her. Contrary to my mother’s intentions, I did become dependent on her and felt separate from other children. I associate strong feelings of distress with my Abandoned Child; anger at the regimen of conditional affection I received at an early age; and extended depressive moods during adolescence, when I felt alienated from my family.

My Abandoned Child was activated when Flora missed counseling appointments, and when she eventually dropped out of treatment. I felt frustrated and disappointed when she failed to show up, but more subtly, I felt the pull of an uncomfortable bond with Flora that was cued by memories of my mother’s unpredictable availability. My Abandoned Child hoped Flora would show up more reliably if I was consistently available and contained my negative reactions, as I did to try to earn my mother’s attention.

My Recovering One structure was aroused as Flora explored her fear of death in therapy. My Recovering One sought to inspire Flora with the hope her life was not over and there was a way out of suffering and isolation. Throughout my early adulthood, I believed change was impossible after reaching physical maturity, and thought I was bound to a fate that was set during my childhood. It was a revelation to find transformation was possible, even at mid-life, and that I could find companionship with
others in 12-step recovery. As Flora’s fear of isolation grew following the death of her aunt, and intensified with the memory of her mother’s miserable death, I recalled similar pessimistic feelings from my past.

As my Abandoned One began to identify with Flora’s distress, my Recovering One came forward to assuage my uncomfortable feelings by suggesting she could recover from addiction and improve her life as I had. This was unhelpful because my recovery did not address Flora’s profound sense of isolation in the absence of her children, and the deaths of her mother and aunt. On the positive side, my disclosure placed me, along with her cousin, among the few people she knew who were clean and sober, countervailing her perception that everyone she knew was addicted to something.

My imaginal structure of the Vulnerable One is associated with feelings of shame. As a child, I had intense shame when my needs for acceptance and inclusion were rebuffed, and I learned that neither my parents nor strangers could be relied upon to accept me as I was. In adulthood, I came to dread novel social situations, anticipating rejection and fearing shame. My Vulnerable One structure surfaced when Flora accused me of lying to her about the consequences of testing for drug use at the clinic. This incident caused me to feel shame, which led me to better understand the expectations of confidentiality by clients in therapy.

Throughout the last part of the therapy, I became aware of the presence of my Reliable Ally structure, which attempted to respond consistently to Flora’s ad hoc requests. I first identified my Reliable Ally during my early recovery in 12-step programs, and applied this structure as a positive personal resource for self-acceptance after I fell short of my intentions by saying, “I am in early recovery, and I am still
learning.” This structure is an adaptation to the minimal level of authority my parents exerted while I was growing up. Beyond being fed and housed by my parents, I felt I had to find my own way, with maximum autonomy and minimum resources. Through 12-step work, I learned my inner resources were similar to what others called their higher power, and I realized my inner Reliable Ally more fully as I saw it reflected in collaborative relationships with others.

From my experience at the clinic, I learned addicts often have difficulty staying in treatment. After Flora stopped attending counseling and groups, I wanted to be consistently available when she needed letters for court hearings or phone calls to support her application for detox. My Reliable Ally structure was willing to compensate for Flora’s inability to be consistent, although I felt I had not set my limits clearly and that she was using me inconsiderately. Similarly, I had once used other people out of need, unaware of how to relate to them with greater mutuality.

**The Client’s Imaginal Structures**

During therapy Flora evinced four main imaginal structures: the Bereaved One, the Helpless One, the Manipulative One, and an emergent structure of the Resourceful One. The structures of the Bereaved One and the Helpless One were most evident during the first half of therapy, as Flora first grieved for the loss of her children, and then the deaths of her aunt and mother. The Resourceful One emerged with Flora’s first visit to see her children, and the Manipulative One crept in toward the end of our work as Flora defended her claim she had completed six months of treatment.
Flora’s chronic and intense preoccupation with the absence of her children during the early part of therapy can be personified as the imaginal structure of the Bereaved One. Flora found meaning in her role as a mother and felt life was devoid of purpose after her children were unexpectedly removed from her custody. She was in communication with her former husband by phone and with her children through a social networking site on the Internet, so her children were at once tantalizingly close, yet out of reach. Flora’s identification with her structure of the Bereaved One was intensified by a succession of disappointments, as her hopes for contact with her children alternately rose when visits were planned and fell when they were canceled.

Flora’s structure of the Bereaved One was evoked by the illness and death of her aunt, whom she regarded as a second mother. Her aunt’s death reminded Flora of her mother’s passing some years earlier, which left Flora feeling unprotected by her parents’ generation and exposed to thoughts of her own mortality. These losses left her feeling isolated and empty, without the consolation of witnessing the continuity of life through her children and without support for her grief from peers.

Another structure closely related to Flora’s Grieving One is her Helpless One. Flora was despondent about her present circumstances and felt helpless to improve her prospects in the future. The imaginal structure of the Helpless One was evident throughout the first half of therapy, as a succession of negative events she felt she had not caused and could not change impinged on her life. Flora often cried, “It’s not fair!” or “It’s not right!” feeling that she had been treated unjustly. Her voice of the Helpless One discounted opportunities that did not meet her immediate needs. For example, her former husband was dying from liver disease, which she saw as an opportunity to resume caring
for her children. But she was unwilling to commit to improving her standing as a responsible parent by focusing on her recovery. She exclaimed desperately, “But I can’t wait that long. They grow up so fast, I don’t want to miss out on being with them while they are still kids!”

Flora initially said my disclosure about being in recovery gave her hope she could quit using drugs, but she eventually felt discouraged when she perceived the relative difference between us on the path of recovery. She said despairingly, “I can never hope to get anywhere like you.” Flora’s cousin and I provided the only examples of people she knew who did not use drugs. Her boyfriend did not seek recovery as she had hoped, and she continued to use drugs with him.

Another imaginal structure I identified during Flora’s therapy was the Manipulative One. Flora was aware of this structure and disclosed her ambivalence about being “honest” in her responses when we discussed her drug use. She had been discharged from another drug treatment program for being too outspoken, and did not want to jeopardize her chances of completing treatment at EBCRP. I attempted to avoid placing Flora in situations in which she would face adverse consequences for expressing her needs or saying what was true for her. Conversely, she thought I deceived her when I reported to the court she was still using drugs. I felt this eroded Flora’s trust in me and reinforced her belief that the Manipulative One protected her. Although Flora had a genuine desire to quit using drugs, I thought her interest in detox was in part intended to convince the court she maintained a commitment to recovery.

Flora’s Manipulative One was active in her relationships with men. During a group therapy session, Flora asserted she thought all women use sex to get what they
want from men. After Flora’s husband left and her children were taken, she lost her home and adapted to life with very little money. Based on her expressed beliefs, she manipulated lovers to secure access to resources she needed, lacking other ways to secure them.

Although Flora resorted to the Manipulative One in situations in which she felt helpless, she displayed unexpected resourcefulness in traveling to see her children. Her Resourceful One structure was demonstrated toward the middle of treatment, when she traveled to see her children, rather than waiting for their father to bring them to her. She displayed initiative by borrowing money to take the bus to visit her children. I felt Flora’s resourcefulness was an antidote to the helplessness and hopelessness she expressed about many circumstances in her life. She later persevered to regain access to food stamps and General Assistance, got her teeth cleaned, and eventually convinced a judge she had fulfilled court-ordered treatment. Each of these accomplishments gave Flora a sense of hope and fulfilled her need to be treated with care and respect.

**New Learnings About My Imaginal Structures**

During the therapy, I learned more about my imaginal structures, particularly when countertransference was cued by complementary structures. I learned that my sympathetic feelings for Flora’s losses brought forward similar structures in me. After we colluded in the fiction that she was in recovery, I learned the shame of disappointment could lead to more realistic expectations. I also learned that Flora could not benefit from my experience, but only my example, and that when the limits of my abilities were exposed I saw my role more realistically.
Although I empathized with Flora’s distress, I found my ability to listen was hampered when I identified too closely with it, and my own Abandoned Child was awakened. As I became acquainted with my Abandoned Child during counseling, I was better able to replace images from my past with an awareness of Flora’s frustration at being unable to get the contact and care she craved. My Abandoned Child structure was reactivated at my last meeting with Flora, when I despaired that she was still deeply immersed in her addictions and that my efforts had been in vain. I later realized this final meeting gave me an opportunity to differentiate my needs from those of Flora, and to see her as a separate person with her own path in life.

Flora’s angry accusation that I had betrayed her trust by reporting she was “still struggling to test clean” to the court immediately evoked feelings of shame in me that I associate with the structure of my Vulnerable One. In addition to shame, I felt vulnerable and unlovable. I usually felt comfortable counseling Flora because she took on the role of being vulnerable as she talked about her distress and hopelessness, which left me feeling relatively secure. The detachment usually afforded by my role as counselor was dispelled when my vulnerabilities were exposed during this encounter. This episode marked a turning point in the therapy by revealing how we had colluded, with Flora feigning interest in recovery, and me pretending she was making adequate progress. I think this humbling experience prompted each of us to take more responsibility for our own work and to seek changes that were realistically possible.

My understanding of the Recovering One and the Reliable Ally developed as a result of the therapy. I learned that my Recovering One functioned in support of my own recovery, but did not directly help Flora. Regarding disclosure of my own history of
recovery, I learned that my Reliable Ally helped me, but could not directly help Flora. I wanted to be reliable to counter the lack of support Flora experienced in her life, but I found it impossible to meet all her expectations. I suspect my Reliable Ally became useful to Flora after I reported her drug tests to the court and set a limit on my availability, after which we began to work more collaboratively to accomplish the more realistic goal of addressing the court’s questions about her treatment.

**Primary Myth**

Flora’s therapy revealed a succession of painful experiences that started after she lost custody of her children. These included betrayal, separation, grief, longing, and partial restitution. Flora’s experiences have a mythic, or timeless, quality, in that women throughout history have experienced similar losses under more or less dire circumstances. The *Hymn to Demeter*, a myth from ancient Greece, traces a similar arc of experience. This myth provides a lens for perceiving Flora’s individual experiences, set in a collective, or archetypal, context. I use the translation by Helene P. Foley as the source for my synopsis of the *Hymn*, which covers the progress of the goddess as she works through her distress after her daughter is abducted, but omits the section set in Eleusis.

One sunny day long ago, Persephone, the graceful daughter of the goddess Demeter, went to gather wild flowers with her friends in a lush meadow. As Persephone wandered, a flower among flowers, she noticed a magnificent cluster of daffodils. But the scene was a deception—a trap set by her father, Zeus, who planned to give Persephone to her uncle Hades without consulting her mother. As her friends wandered, they did not hear Persephone scream to her father for help when the earth gaping open and the god
Hades rode out in his chariot. He grabbed her and took her to the underworld, where he ruled over the dead, to make her his queen.

Demeter heard her daughter’s cries echoing everywhere, and became so agitated that none of the witnesses dared tell her what they had seen. Distraught, Demeter searched furiously for her daughter, lighting her way with a blazing torch in each hand. She searched frantically for nine days, without eating, drinking, or bathing. At dawn on the 10th day, Demeter met Hekate, who also was carrying a flaming torch and searching for Persephone after hearing her cries. Together they called out to the god of the sun, Helios, as he flew by in his chariot, and Demeter pleaded with him to tell her if he had seen her daughter. Out of respect for the goddess, and pity for her distress, Helios told Demeter he had seen Hades take Persephone. Then, before rushing off, Helios advised Demeter to stop lamenting, for Hades was a good match for her daughter, and from the same good family as Zeus. Upon hearing Zeus’s name in connection with her daughter’s abduction, Demeter grew dark with anger as her grief took on a savage edge.

Demeter brooded sullenly over her loss and this deception. Now in mourning, she avoided the company of other gods, and disguised as an old woman, sought seclusion among the fields and cities of mortals. In her distraught state, she prevented grain from sprouting in the fields of the mortals, causing a terrible famine. Because nothing grew in the fields, the mortals were unable to make offerings to honor the gods, so they suffered, too. Observing that Demeter was causing serious havoc, Zeus sent Iris to ask her to end her mourning and return to live among the gods; but Demeter was unmoved. Eventually, each god and goddess begged her to relent, but still she sat smoldering with anger,
embittered by the desire for revenge. At last she declared she would not return to live among the gods or allow seeds to sprout until she saw her daughter again.

Hearing this, Zeus immediately summoned Hermes and ordered him to make a deal with Hades to return Persephone, and to use any ruse he could devise. Hermes found Hades lying in bed with Persephone, who still missed her mother. Hermes addressed Hades courteously and blamed Demeter for maliciously withholding fertility to deprive the gods of honor, all because she missed her daughter. Hades was quick to appear conciliatory and urged Persephone to go to her mother.

Upon Persephone’s return, Demeter was overjoyed, and they embraced with pleasure at being reunited. But as she held Persephone, Demeter sensed a trick, and fearing she might lose her daughter forever, asked if she had eaten anything while she was in the underworld. Persephone conceded that in her joy at the news from Zeus, she was unprepared to resist when Hades suddenly forced a pomegranate seed into her mouth and made her taste it (thereby formalizing their marriage according to Greek custom).

Meanwhile Zeus approved the deal made by Hermes, whereby Persephone would spend two-thirds of the year with her mother among the gods, and one-third with Hades in the underworld. Then he sent for Rheia, Demeter’s mother, and ordered her to convince Demeter to accept the compromise. After greeting each other warmly, Rheia explained the terms of the arrangement to Demeter, and assured her Zeus had approved it and would keep his word. Then Rheia gently urged her child to forgive her father and return to Mount Olympus as an immortal.

Demeter relented, and immediately the seeds in the earth sprouted, grew vividly green, and flowered more abundantly than ever. She taught the leaders of the mortals to
perform her secret rites, so those they initiated would be spared from the murky depths of the underworld after death. Then the three goddesses returned to Mount Olympus, from where they blessed the mortals with their love.

I see several parallels between Flora and Demeter. In both cases, a series of dramatic events unfolded within the context of the family. Each lost a daughter, who was taken without their consent. Both felt betrayed and believed their rights as mothers were violated, and both suffered during the prolonged absence of their children. Both Flora and Demeter were unwavering in their demands to see their children again. Finally, both Flora and Demeter accepted occasional contact with their children as sufficient restitution to resolve their grief.

In her commentary on the *Hymn*, Foley stresses the importance placed on sensory contact between the characters in the *Hymn*, especially seeing. Demeter heard her daughter’s cries, and searched for her by torchlight. Similarly, Flora heard from her children via social networking sites on the Internet, but still longed for physical contact with them. According to Boss, ambiguous loss can be caused by circumstances, such as that of Demeter and Flora, in which absent or missing children are psychologically present but physically absent. Ambiguous loss is indicated for both women because after their children were taken, they experienced prolonged frozen grief (i.e., Boss’s key descriptor for ambiguous loss caused by chronic distress).

Boss believes divorce can cause ambiguous loss because the non-custodial parent is at once alive and part of the family history and yet also absent from daily life. Boss asserts that the meaning we attach to a loss is more cogent than are objective circumstances in determining its psychological impact, and that our ability to adapt to a
loss is dependent on how we interpret the circumstances of loss. This is the case with both Flora and Demeter: both were surprised their children had been taken, both felt betrayed by members of their family, and both keenly felt an injustice had occurred. Eventually both women set aside their indignation and began to heal from their grief after the fathers of their children modified their no-contact position.

Marylin Arthur offers a psychodynamic interpretation of the relationship between Demeter and Persephone that correlates the struggle between matriarchal and patriarchal authority in the Hymn with the early stages of female psychosexual development. Arthur interprets the relationship between Demeter and Persephone at the beginning of the Hymn, before Zeus’s intervention, with the symbiotic stage of development, in which the identities of daughter and mother are undifferentiated. Arthur postulates that as differentiation proceeds, the frustrations and disappointments that intrude upon the child’s fantasy of fusion with the mother are projected onto the person of the father. Arthur portrays the gods in the Hymn as distant or fleeting authoritarian figures, while the goddesses are intimately present, indicating the narrative reflects an early phase of psychological symbiosis. Arthur asserts that separation and individuation from the mother continue into adulthood, and echoes of this process are found in Persephone’s and Demeter’s longing for each other. The lifelong individuation process Arthur describes has a parallel in Flora’s longing for symbiotic union with her children. For example, Flora’s fondest wish was to cuddle with her children on the couch. Although Flora keenly missed the gratification of symbiotic merger with her children, she saw her husband as a divisive force because he withheld her children and caused her intense longing and distress.
A parallel process of early development is postulated by Omer in imaginal psychology. Omer’s model holds that under adequate circumstances, the *symbiotic mode of experiencing* is initiated by the mothering person (usually the infant’s natal mother). Omer states that around three years of age, development progresses to the *bureaucratic*, or *centralized*, mode of experiencing, which is initiated by the fathering person (often the natal father in the nuclear family).

Omer elaborates on these modes of experiencing and asserts that through early experiences of symbioses, the mother principle engenders the capacity to experience both mutuality and autonomy. Omer says that with adequate care, the symbiotic mode of experiencing is retained during later development and is re-experienced in adulthood as intimacy. When toddlers encounter limits that are imposed with care and sensitivity, the father principle activates experiences of otherness. Omer states that the father often is experienced as “the first other.” Returning to the mother principle, Omer asserts that unmitigated interruptions of symbiotic mutuality divide experience into longing and hate, and that such splitting represents a primitive way of coping with unpleasant experiences.

In light of Omer’s imaginal model, Demeter’s grief during Persephone’s absence and her desire for revenge against Zeus can be interpreted as a split in the father principle, caused by the rupture of her symbiotic mutuality with her daughter. Arthur notes that girls married as young as 14 in ancient Greece, which partly explains Demeter’s distress at her daughter’s premature departure. Similarly, Flora’s daughters were separated from her when they were 12 and eight years old, and her son was six, far below the age when children usually leave their mother. Flora’s longing for her children
was, like Demeter’s, expressed as unmitigated grief. Flora’s anger at the interruption to her symbiotic relationship with her children was expressed as exasperation with her former husband, while Demeter’s anger was directed at Zeus. Both Flora and Demeter began to find resolution of their distress and resentment after being reassured by the presence of their children. Demeter was persuaded by her mother to accept her daughter’s marriage to Hades and her absence for part of the year. She then signaled the passing of her grief by the arrival of spring. Flora said she was relieved of much of her distress after several visits with her children, even though her daughters rejected her attempts to be close to them.

The final parallel between the myth of Demeter and Flora’s case history is the theme of transitions in life and aging. I understand the myth of Demeter and Persephone as a metaphor for the differentiation of mother and daughter. After being reunited with her daughter, Demeter became reconciled to future separations from Persephone during part of each year. At the beginning of the Hymn, Demeter identified closely with her daughter, and at the end, she allied with her own mother. Similarly, as therapy progressed, Flora’s concern shifted from her daughters to her mother and aunt. After Demeter learned the fate of her daughter, she abandoned her identity as an immortal and lived as an indigent old woman among mortals. Likewise, Flora faced a shift in identity from a mother of young children to an older woman without home or money. While Demeter eventually accepted Persephone’s marriage to Hades and was reconciled to live among the gods, Flora felt alienated from her daughters, felt she had accomplished little in life, and despaired at the prospect of death. The different outcomes represent profound differences between Flora’s existence and the ideal, represented by Demeter.
Yalom addresses existential fears of abandonment and death following the loss of a loved one. He contends a temporary means of escape from the existential loneliness that accompanies feelings of separateness is to sacrifice self-awareness by becoming absorbed in another person, to merge in love: “Thus one sheds anxiety but loses oneself.” He understands grief following loss as an acute experience of self-awareness, accompanied by distress at being separated from loved ones and awareness of the inevitability of death. Yalom asserts that existential loneliness and fear of death develop as we age and become increasingly aware of the approaching limit to our existence. Yalom adds that existential loneliness is especially acute for those who feel they have not lived life as fully as they might, as was true for Flora.

**Personal and Professional Development**

My personal and professional development progressed as a result of the frustrations and difficulties in my work with Flora. My personal development included a better understanding of my own strengths and limitations, enabling me to develop the capacity for empathy. My professional abilities grew as I understood more clearly the boundaries between my Flora and myself, and began to trust my own feelings and to be more realistic in my expectations of the therapy.

My personal development centered on learning more about my fears of criticism and rejection, anger at perceived injustices, and anxiety when pressured to perform. Flora apparently had similar fears, and witnessing her find the courage to transform some of these difficulties helped me take greater personal responsibility for problems I had created in my relationships. I also benefitted by learning the value of disillusionment as a
path to holding more realistic expectations of others and myself. I felt disappointed and angry for having my time wasted when Flora repeatedly failed to show up for appointments, and felt shame when her expectations of confidentiality in therapy proved unrealistic. I learned that my feelings of disappointment, shame, and anger were more protracted when I suppressed them or did nothing to understand their origins. In working through these affects, I learned to be more reflexive and to feel empathy when faced with disappointment.

My professional development benefitted from working with Flora. This was my first clinical fieldwork placement, and I gained valuable experience in developing assessments and treatment plans in collaboration with my supervisor and other staff at the clinic. I also practiced working collaboratively with Flora in negotiating treatment goals, addressing the judges’ concerns following hearings, and referring her for further treatment at a residential detox clinic.

When my empathy failed, I learned to look more closely at the similarities between Flora’s experience and my own, especially experiences from my early life that were reactivated when Flora became persistently distressed. I learned to look more discerningly at my own experience of distress and grief and to see that helping Flora required a quality that Omer calls *objective caring*—tangible empathy, rather than sympathetic feelings.\(^{105}\)

As a result of my experience of projective identification, I began to pay more attention to my feelings in the moment, and to make space for emerging revelations. I also began to discern the limitations of my counseling skills and effectiveness at bearing witness to Flora’s struggles, and the value of acknowledging progress and creativity.
Applying an Imaginal Approach to Psychotherapy

Imaginal approaches to psychotherapy include a wide variety of therapeutic modalities that develop the faculties of imagination and creativity, and that extend awareness beyond the limitations imposed by the adaptive identity and associated imaginal structures. Imaginal psychology holds that the core identity is attuned to present experience and relations with others, but exposure to traumatic experiences at any age produces an adaptive identity, which limits experience and inhibits change.

Imaginal approaches to psychotherapy cultivate the interior psychological world of images and playfulness. A parallel therapeutic state of mind is found in unstructured imaginative play, which D. W. Winnicott describes as existing “in an area that is intermediate between the inner reality of the individual and the shared reality of the world that is external to individuals.” In the language of imaginal psychology, the value of cultivating this mediating area is that “imagination amplifies and integrates the sensory, emotional, and cognitive dimensions of our experience.”

To apply an imaginal approach to Flora’s therapy I will examine the emotional, cognitive, and sensory dimensions of her experience, to show how her imagination and creativity amplified and integrated these factors during the course of therapy. I will examine how Flora moved beyond ruminations about past losses to pursue her relational needs in the present, and transcended limitations imposed by inner thoughts and outer expectations to take creative action.

At the beginning of therapy, Flora’s attention was consumed with the emotional dimension of experience. First she expressed her grief about losing her children. Then
Flora broadened the scope of her narrative to include her family history, the deaths of her mother and aunt, and her own fear of death. After two visits to see her children, Flora began to think of them as teenagers, rather than as the young children she had known. Thus, she gradually replaced longing for the past with present relationships that included complex feelings of both joy and sadness during each visit.

Flora’s emotional experiences during therapy are consistent with O’Connor’s meaning-making model of grief therapy. O’Connor proposes that healing occurs through integration, as losses are gradually reconsidered in more complex cognitive and affective terms, involving both positive and negative feelings. The emergence of additional thoughts and feelings described by O’Connor parallels the concept of psychological multiplicity in imaginal psychology; Omer states, “The term psychological multiplicity refers to the existence of many distinct and often encapsulated centers of subjectivity within the experience of the same individual.”

Regarding the cognitive dimension of experience, Flora struggled to accommodate new ideas during therapy. She had very little tolerance for reflective thought during therapy, and had difficulty understanding other people’s points of view. For example, after a younger client in group therapy expressed anger at her own mother for being an addict, Flora insisted that she herself had been a good mother. Flora also had difficulty comprehending abstract, symbolic thought (e.g., when she dismissed my simile that each of us was like the captain of a ship). I considered these difficulties in comprehension to be due primarily to her drug use, a conclusion supported by research into the effects of methamphetamine by Rogers et al., who find methamphetamine use slows thinking and limits the ability to respond flexibly when solving problems.
Accommodating unfamiliar cognitive experience is the focus of Malkinson’s cognitive approach to grief therapy. Malkinson advocates challenging clients’ irrational beliefs in cases of complicated grief, with the intention of changing maladaptive cognitive schemas, emotions, and behavior. A parallel imaginal approach is to cultivate greater awareness of imaginal structures. An example was Flora’s Helplessness One, which prevented her from gaining access to her children, but also avoided confrontation with their father. During therapy, Flora abandoned the passive strategy of waiting for her children to visit her, and found the courage to visit them.

Regarding the sensory dimension of experience, Flora frequently spoke of her longing for physical contact with her children. Flora’s drawing of a lone cabin on the forest floor, just before her first visit to her children, can be interpreted as an expression of her physical isolation. Flora reported she felt pleasure at being close to her children during a visit, and pain when she left at the end. Boss uses the term ambiguous loss for the distress caused when family members we hold dear are absent either in body or mind. Following divorce, Boss argues for greater continuity and flexibility in the structure of the family, especially when children are present, because relationships can change but not be erased from memory. Flora’s exclusion after her former husband remarried and took custody of their children can be seen as an ambiguous loss. This was resolved after the reformed family accommodated her continuing need for physical contact with her children, restoring harmony between her inner and outer experience.

Despite cognitive limitations due to her addictions, Flora made progress during therapy toward integrating the emotional, cognitive, and sensory dimensions of her experience. Flora’s imagination was generally inhibited, but her joke about the “two-
“weeker” indicated her ability in therapy to play imaginatively. Despite feeling shy in groups, she endured new cognitive experiences with other clients to glimpse a sense of community with others that lay beyond her isolation. By visiting her children, she advanced her ability to act creatively, quelled her longing for renewed sensory contact, and restored congruity between her interior images and shared outer reality. As Omer states, “Through the labor of imagination, it is possible to craft our experience towards truth, joy, and effectiveness.”

My interpretation of what happened at each phase of my work with Flora was informed by concepts and principles drawn from the literature. Also, I learned from examining my affective responses, and from an appreciation of imaginal structures—both mine and those of the client. As a result of my work with Flora, I learned more about the limitations imposed by my imaginal structures, especially in instances when both Flora and I reacted complimentarily to past developmental traumas.

In the *Hymn* to Demeter, I found close parallels with Flora’s prolonged distress after her children were taken from her, and also the relief she found following renewed contact. The significance of myth to this case study is that it highlights the collective, archetypal nature of Flora’s experience.

My personal development progressed as a result of the difficulties I faced in my work with Flora, which included noticing my feelings and working toward reflexive responses. My professional development included learning to work collaboratively and demonstrate objective caring, rather than feeling sympathy. An imaginal approach to therapy for complicated grief seeks to stimulate awareness of affective, cognitive, and sensory modes of experiencing, and restore present experience and contact with others.
CHAPTER 5

REFLECTIONS

Reflecting on what I learned in writing the Clinical Case Study, I identified areas of personal growth, a deeper understanding of my work with Flora, and an increased knowledge of the topic of complicated grief and addiction. Reflecting on the literature also enhanced my understanding of how symptoms associated with complicated grief and addiction interact when these disorders occur together. The literature illuminates the personal, cultural, and archetypal dimensions of Flora’s experience, which added significance to what happened during therapy. Among the literature I examined, the Hymn to Demeter enhanced my appreciation of the collective, or archetypal, parallels to Flora’s individual experiences. I subsequently identified a folk story, “Robert the Bruce and the Spider,” which symbolically represented my struggles to make progress with Flora during therapy, and my struggles while writing the Clinical Case Study.

Upon further reflection, I saw that Flora’s therapy provided a good example of an imaginal approach to psychotherapy for the co-occurring disorders of complicated grief and addiction. The imaginal approach to psychotherapy in Flora’s instance revealed that her strong affective reactions in the absence of her children motivated her to find resolution, despite cognitive difficulties attributable to drug use. I also reflected on how imaginal approaches to Flora’s treatment were compatible with the disparate clinical orientations of the staff I worked with at EBCRP. Finally, as a result of the reflective
process, I noticed important aspects of Flora’s therapy that are not adequately addressed in the literature, which could be explored through further research.

**Development of Personal Awareness**

Areas of personal awareness I developed as a result of working with Flora, and later while writing the Clinical Case Study, included negative reactions prompted by what appeared to be unfamiliar. Looking more closely, I found my painful feelings were associated with experiences from my past. During the therapy, I experienced notable instances of transference and countertransference with Flora. These were new to me, and I grappled to make sense of what occurred and to understand the significance of these interpersonal experiences in therapy.

During Flora’s therapy, and later as I worked on the Clinical Case Study, I struggled to become more aware of my psychological blind spots and be open to the unfamiliar. On the topic of personal and cultural transformation, Omer (paraphrasing Freud) states, “Where there is other, there I shall be.”¹ Flora was the other I encountered during the therapy. Feelings elicited during Flora’s therapy reminded me of painful feelings of abandonment and alienation from my past. Tracing the implications of these feelings helped me discern Flora’s presence more clearly, and write about her more objectively. I also encountered the other in myself. By examining my reactions, I identified imaginal structures that stood as gatekeepers, distorting my experience.²

During the therapy, I found my longstanding fears of abandonment and alienation surfaced when Flora did not show up for appointments, and these prevented me from appreciating her situation clearly. By working through my underlying feelings of grief
and loss, which were reminiscent of experiences of abandonment during my childhood, my frustration with Flora’s unpredictability was partially transformed into a greater appreciation for her losses. As a result, I was able to demonstrate objective caring after formal counseling appointments with Flora ceased, without my fears disrupting the work that still could be done. My willingness to meet with Flora when she needed letters of support for court appointments allowed us to maintain a therapeutic relationship, which helped her work through difficulties rather than give up in exasperation.

As a result of working with Flora, I gained a better understanding of how intersubjectivity, including interpersonal factors such as transference and countertransference, affect the quality of the therapeutic relationship, and how crises in the transference signal changes in the course of therapy. My supervisor stressed that the quality of my relationship with clients was important to the healing process. When Flora confused me with other men she knew who shared my first name, my supervisor took it as sign that Flora was becoming attached to me, which my supervisor believed was a prerequisite for healing to proceed. Additionally, I think that by revealing her confusion to me, Flora trusted me to accommodate both negative and positive projections safely.

I experienced an instance of projective identification during the counseling session prior to Flora’s first visit to see her children. Bion describes projective identification as the transfer of patients’ unwanted feelings directly into the person of the therapist, feelings that patients then feel free to deny in themselves. I did not know how to respond when I experienced a sudden and alien feeling of intense sadness during creative arts therapy, so I left the room for a minute, and the feeling rapidly subsided. After I returned, we finished our drawings, and then Flora disclosed that she intended to
visit her children, rather than wait for them to visit her. My interpretation of what happened is that, as we worked on our drawings, Flora and I co-created a feeling of calm in which our feelings were free to surface. I do not think Flora gave me feelings she was unable to feel, as Bion suggests; instead, through affective attunement, I picked up on Flora’s feelings. I agree with Winnicott, who suggests that therapy is a form of creative play in which inner and outer reality are tested and realigned to produce experience.7

An example of the transference of negative affects occurred after Flora’s triumphant first visit with her children, when she thought I would disapprove of her taking the initiative. I was quick to assure her I applauded her action, and she accepted my assurance. I felt telling me about her visit and revealing her expectation that I would disapprove demonstrated Flora’s trust in the therapeutic relationship, and I quickly helped reconcile her disparate feelings.

Another instance of negative transference occurred when I reported that Flora was still “struggling to test clean.” Flora experienced this as a betrayal of trust, accompanied by shame and anger on her part, and fear and shame on mine. This abrupt confrontation with the fact that Flora was still using drugs removed the illusion that she would stop using drugs during treatment. This event brought changes in the quality of transference and countertransference that constituted a crisis in the therapeutic relationship, and changed the quality of our work together.8 After this incident, Flora’s attendance at groups and individual therapy ceased for a month.

After this encounter, Flora contacted me prior to each of her subsequent hearings and asked me for letters, in response to the judges’ requests for information. Although she spoke with candor when we met for impromptu counseling sessions after that
encounter, I thought Flora had more realistic expectations of what I could do for her, and she took on a more active and independent role in resolving her legal difficulties. My role changed, too, when I was responding to requests for information by the court, and talking with my supervisor about how Flora could get better representation from the public defender. At each subsequent meeting with Flora, I made time for a counseling session, and we rebuilt some of the trust that had been lost, but Flora was more reserved about confiding in me about her drug use.

How the Learnings Affected My Understanding of the Topic

My understanding of addiction and complicated grief as co-occurring disorders developed as I worked with Flora, and later as I searched the literature for research on each disorder. Flora’s difficulties included both addiction and complicated grief, and I discovered how symptoms from one area affected the other, producing a co-occurring disorder that then affected individual, cultural, and archetypal dimensions of experience.

Prior to working with Flora, I had a basic understanding of addiction, both from my studies and personal experience. I learned more during Joan Zweben’s training sessions while I was an intern at EBCRP, and later through researching the literature on addiction. In particular, Zweben et al. gave me a better understanding of how negative affects are accentuated among methamphetamine users; Rogers et al. showed that cognitive deficiencies can result from methamphetamine use; and Dursteler-MacFarland, Cereghetti, and Wiesbeck reinterpreted resistance in treatment for drug use as a cognitive impairment. These principles gave me a better understanding of Flora’s intense negative
affects, her difficulty understanding abstract ideas and adopting new approaches to her problems, and her inability to attend treatment regularly.

Although I have personal experiences of grief, my understanding of this topic was gained mostly after I started work with Flora, when I began to search the literature on grief and bereavement to better understand her distress. Of particular relevance to Flora’s situation, I learned that grief reactions are not caused only by the death of loved ones. Boss’s concept of ambiguous loss is fitting because it applies to prolonged and intense grief caused by the loss of a family member in uncertain circumstances. More specific to Flora’s situation, Askren and Bloom find that mothers who have children removed by social service workers experience prolonged grief reactions that can become more intense as time passes. Flora’s relentless longing and searching for her absent children is consistent with Bowlby’s concept of chronic mourning, which he associates with inadequate attachment or traumatic separation during childhood.

The literature I examined helped me differentiate aspects of both complicated grief and addiction that previously had been obscure, and better understand how these co-occurring problems are interrelated. Reflecting on how Flora’s difficulties were related, I found I could organize them into expanding fields of meaning according to individual, cultural, and archetypal areas of significance.

At the personal level of significance, the prominence of negative affects among methamphetamine addicts observed by Zweben et al. indicates that Flora’s grief was exacerbated by her drug use. Research indicates that methamphetamine users tend to persevere with habitual ways of thinking and responding, which can appear as resistance
during treatment.\textsuperscript{15} This knowledge helped me understand why Flora tended to dwell on past losses, rather than find ways to improve her present situation.

Reflecting on the cultural level of significance, I found research on the reciprocal causes and effects involving ineffective parenting, emotional difficulties, and addiction. In particular, Suomi’s research shows that inadequate parenting contributes to anxiety, aggression, and addiction to alcohol among troops of captive monkeys; among humans, Bowlby finds that mourning mirrors early experiences of attachment and separation.\textsuperscript{16} Conversely, research by Brown, and by Krystal, indicates that inadequate parenting by alcoholics limits the social and emotional development of children.\textsuperscript{17} Because Flora grew up in an extended family of alcoholics and was exposed to family violence and separation from her mother at an early age, my synthesis of the literature led me to think she was predisposed to both anxiety and addiction, that she was limited in her ability to mature into full adulthood, and that her grief was colored by memories from early childhood.

At the cultural level, the research literature indicates Flora’s experience of loss is common among women who lose custody of their children. Askren and Bloom’s review of extant research shows that mothers who relinquish custody of children are likely to suffer chronic grief reactions.\textsuperscript{18} More specific to Flora’s circumstances, Murphy and Rosenbaum find motherhood is considered an important way for women to attain an adult identity and social standing; among mothers who use drugs, losing custody leads to heavy drug use to alleviate feelings of guilt and shame at failing to be a good mother.\textsuperscript{19} Together, these findings indicate the grief Flora experienced following the loss of her children is common among women who use drugs in our culture, and also among a larger group of women who give up custody of children.
Mythic Implications of the Learnings

I found that the myth of Demeter and Persephone parallels the major themes of Flora’s story. Reflecting on the *Hymn to Demeter* led me to a greater understanding of Flora’s grief at being separated from her children and her drive to be reunited with them.20 The *Hymn to Demeter* tells of a mother’s grief at the loss of her daughter, symbolically represented by the image of the failure of spring growth, followed by prolonged drought and famine. Similarly, Flora lived an arid existence, devoid of interest, after being separated from her children.

Although Demeter and Flora lived in different cultures, separated by history and geography, there are notable parallels from a maternal perspective. The myth of Demeter and Persephone focuses on the bond between mother and child, and parallels Flora’s experience of prolonged and intense distress and longing until she renewed contact with her children. The *Hymn to Demeter* involved a prototypical custody dispute, in which the father sought to remove his daughter from her mother. Demeter’s daughter was abducted by her uncle, while the removal of Flora’s children was instigated by her mother-in-law. Both Demeter and Flora burned with betrayal and the injustice of having their children taken from them, they became obsessed with their children’s absence, and they relentlessly sought to make contact with their missing children. After protracted struggles with their estranged husbands, both Demeter and Flora were reunited for a limited time with their children, which mollified each woman’s distress.

The significance of this myth is that it ennobles Flora’s grief as a deeply human experience. Omer goes further, stating the archetypal level of awareness is associated
with pre-human experience. I concur with Omer, and now understand Flora’s searching and longing for her missing child as a vital expression of mammalian parenting.

Reflecting on the challenges I experienced working with Flora, and later difficulties I had writing the Clinical Case Study, I recalled a folk story from my childhood that contains an image of perseverance and making use of opportunities. The story is “Robert Bruce and the Spider,” which is associated with a 14th century Scottish king. This tale tells how The Bruce (as he is popularly known) took refuge in an isolated hut after killing one of his Scottish adversaries. Reflecting on the slaughter of family and friends who had stuck by his cause, he considered abandoning his quest for a unified Scotland. Then he noticed a spider attempting to build a web. The spider repeatedly tried and failed to attach a thread to the next roof beam, but it persevered until it succeeded and could build the rest of its web. The Bruce was impressed by the spider’s persistence, and went on to follow its strategy by gaining small victories when and where he could. After five years of guerrilla insurgency, The Bruce built the support he needed to win a decisive victory against English expeditionary forces and rule an independent Scotland.

Like The Bruce, I persevered as Flora’s counselor, despite disappointments and limitations, and refocused on opportunities for progress, rather than dwelling on past losses. I worked with Flora despite her intermittent attendance, and adapted to more limited contact after her individual therapy sessions were suspended. My progress in researching the topic of the Clinical Case Study also mirrored the lessons The Bruce learned from the spider. I was unable to find published research on complicated grief and addiction as co-occurring disorders, but I did find research on each part of Flora’s
diagnosis. In writing the Clinical Case Study, I sought to construct a web of meaning to inform readers about how Flora’s difficulties interacted as co-occurring disorders.

**Significance of the Learnings**

What I learned from the literature is pertinent to understanding complicated grief and addiction, and how they interact as co-occurring disorders. These learnings also are useful in understanding and treating other co-occurring disorders. Many of the difficulties Flora experienced during treatment were due to cognitive limitations associated with her addiction to methamphetamine.

My reading of the literature on addiction suggests that Flora’s methamphetamine use made it difficult for her to understand new ideas and contributed to her irregular attendance during treatment. Her hopelessness about the prospect of change and her distress at being separated from her children may have been intensified by her methamphetamine use. Conversely, her grief consumed what hope she had for her recovery from addiction. Flora frequently appeared perplexed and unable to understand other people’s reactions and motives. She also felt people were unfair and hurtful to her, and she did not consider how she might have contributed to their reactions or how she could improve the situation. Helplessness and hopelessness were major features of her outlook. Flora’s literal, inflexible thinking and irregular attendance at the clinic appear to be related to methamphetamine use, rather than resistance to treatment. Of particular note, Rogers et al. find that methamphetamine users tend to persist in using the same problem-solving strategies, even when these repeatedly fail, rather than adapt their responses to changing conditions.
The cognitive deficits associated with methamphetamine addiction made Flora’s progress in counseling slow. During treatment, I tried two compatible models of addiction counseling that were in use at EBCRP. These helped me address Flora’s addiction, without undermining her interest in recovery, but did not speak to her overriding feelings of grief. Employing Miller and Rollnick’s motivational interviewing techniques and Prochaska and Clemente’s methods of advancing intentional change helped Flora engage in discussions with me about her addiction, which fostered her interest and trust in the counseling process. These approaches are intended to foster increased self-awareness and build confidence in the prospect of change. Although Flora expressed an interest in quitting drugs, our discussions did not help reduce her drug dependence. Both models (i.e., motivational interviewing and the stages of change) rely heavily on insight, which Flora seemed to lack or was slow to realize.

The negative affects Flora experienced as a result of being separated from her children likely were intensified and prolonged by the use of methamphetamine. Zweben et al. find that strong and pervasive negative affects are noted symptoms among methamphetamine users. Flora told me her hopeless and helpless feelings about being separated from her children led her to rely on methamphetamine and cannabis to escape her pervasive sorrow. Flora’s comment is congruent with Murphy and Rosenbaum’s research, which indicates that many addicted women use their drugs of choice to assuage negative feelings after losing custody of children. After seeing her children, Flora said she expected me to disapprove of her visit. Negative transference is addressed by Krystal, who finds addicts often expect negative reactions when they are proud of something. He
finds that addicts transfer their fear of a negative response onto their therapist as a traumatic reaction to prior experiences of disapproval.28

Interactions between complicated grief and methamphetamine addiction make these co-occurring disorders difficult to treat. Cognitive deficiencies associated with methamphetamine use appear to have reduced Flora’s insight into how her drug use contributed to her problems, and prevented her from adopting new ways of responding that could have led her to quit drug use. These deficiencies also reduced the effectiveness of counseling techniques (e.g., motivational interviewing and stages of change) that rely on insight and self-motivation. Negative affects common to both addiction to methamphetamine and complicated grief contributed to Flora’s slow progress in counseling. Negative affects associated with methamphetamine use also intensified her grief and distress while she was separated from her children. Adding to the cyclic nature of her problems, she self-medicated the pain of loss through use of amphetamines and cannabis. Flora’s expectation that I would disapprove of her visit may have been due to negative reactions by others when she felt proud of an accomplishment.

The Application of Imaginal Psychology to Psychotherapy

Imaginal psychology is primarily concerned with soul.29 Omer defines the concept of soul, which is comparable to psyche or spirit, as “mysterious aliveness that lies at the core of being.” 30 He asserts that “the soul’s transformative imperative is to grow and differentiate.” 31 Omer adds that community is essential for the human soul to flourish, and a person without community “will do harm.” 32 Omer states that association with others in a collaborative community is the way for deeper potential to emerge.33
The central axiom of imaginal psychology is that the soul has an inherent desire to grow and differentiate, which Omer calls the *transformative imperative*. This includes the natural desire to move toward complexity, authentic power, and ecstatic experience (unfamiliar experience). The transformative imperative is diminished when an individual’s sovereignty, or sense of integrity, is violated, and the protective functions of the adaptive identity develop to preclude similar intrusive experiences. Omer adds that the transformative imperative is promoted by the presence of a positive sense of self-efficacy and self-worth, which is personified as the *I-friend*, and which develops to the extent that dependency needs are met during childhood. Imaginal approaches to therapy rekindle the client’s I-friend through objective caring, which enables the client to be more open to new experiences. As Omer says, “We don’t diminish gatekeepers [protective expectations associated with the adaptive identity], we cultivate the I-friend.”

Imaginal approaches to therapy are concerned with the quality of the relationship between the client and therapist. Melissa Schwartz employs the concept of *radical peerness* to denote a therapeutic relationship that enables the therapist and client to pursue a peer relationship—except that the therapist has the expertise, so peerness is relative rather than absolute. An example of radical peerness in action is when client and therapist make a collaborative diagnosis. Jay Rice notes that this means clients are the experts on their own experience. Omer asserts that the experience of truth is deepened through engagement with others, and that sharing meaning is the way out of narcissistic self-absorption. Therapy in which participants compare notes on their experiences and discuss their reactions with others helps promote self-awareness and the ability to choose how to respond, rather than react based on unexamined beliefs.
Imaginal approaches to therapy attend to the client’s affective experiencing. Omer asserts that the nature of the soul is passionate, meaning that it needs to be affected, and that others are needed to catalyze emotional experiencing. Rogers’s humanistic, person-centered therapy and Najavits’s cognitive behavioral treatment for co-occurring disorders are two treatment models that address the client’s need to be met affectively, and both were in use at EBCRP while Flora was in treatment. Rogers’s person-centered therapy cultivates awareness of experience primarily through the therapist’s emotional attunement and responsiveness to clients’ feelings. At EBCRP, the person-centered approach enabled clients to feel heard and respected, which helped them stay in treatment. Najavits’s cognitive behavioral model for treating co-occurring PTSD and addiction also influenced treatment at EBCRP. Najavits’s model combines cognitive psychoeducation to raise clients’ awareness of PTSD and the effects of addiction, with a humanistic approach to exploring their current difficulties through empathetic, nonjudgmental inquiry.

**Bridging Imaginal Psychology to Other Orientations**

Imaginal psychology is a distinct orientation within the discipline of psychology and is concerned with soul, transformative practices, initiation, experience, imagination, and integration. Imaginal psychology has much in common with other psychological orientations, including depth psychology and humanistic psychology. Imaginal psychology’s approach to learning and therapy also has parallels with treatment models from social psychology and cognitive behavioral therapy, which were practiced at the clinic where Flora received treatment.
Concern for the soul is the primary focus in imaginal psychology. Thomas Moore states, “‘Soul’ is not a thing, but a quality or a dimension of experiencing life and ourselves. It has to do with depth, value, relatedness, heart, and personal substance.” Discussing the difference between soul and the similar concept of spirit, Omer asserts that while spirit seeks to attain the “peaks” of experience, soul follows in the “valleys,” or depths, of experience. Pertinent to treatment is the principle that the soul may not take the easy path. As Omer says, “It takes difficult experiences to build human capacities.”

Caring for the soul is analogous to working toward *individuation* in depth psychology, or becoming a whole, unique person. Writing from the perspective of depth psychology, Jung asserts that individuation involves developing a relationship between the conscious sense of self, or ego, and the contents of the unconscious, or “collective life,” which is evident in dreams and moments of imaginative insight. From the humanistic perspective, caring for the soul is expressed as progress toward *self-actualization*. Rogers states that person-centered therapy is based on the principle that a desire to grow and differentiate as an individual is inherent in everyone.

Transformative practices are an important aspect of imaginal psychology. The intention is to transform experience by developing consciousness. The principal transformative practice in imaginal psychology is called *imaginal process*, Meridian University’s approach to transformative learning. Omer states, “In this approach, human capacities are cultivated through diversifying, deepening, embodying, and personalizing experience.” A similar but more basic concept in Gestalt therapy is the *continuum of awareness*, which is the practice of becoming aware of what requires attention in the present moment, and responding to it effectively. Dialoging with an empty chair is a
technique used in Gestalt therapy to increase awareness of unexamined thoughts and feelings associated with people who have affected the client deeply, and to deepen experience in the present moment.\textsuperscript{57} Empty chair work also is used as an imaginal process to expand awareness of thoughts and feelings that shape current experience.

Initiations are important in imaginal psychology because they mark transitions in the individual’s life within the community. Initiations also serve to integrate the individual by fulfilling the need to belong in society. Priscilla Taylor asserts that marginalized people exist in a liminal state, which prevents them from moving forward in life, and that a rite of passage can initiate reintegration into the community.\textsuperscript{58} Omer states that deeper human potential emerges through collaborative community, which is transformative learning practiced among dedicated groups of peers.\textsuperscript{59}

A parallel concept to collaborative community is therapeutic community. Therapeutic community is a social psychology model for addiction treatment, which includes 12-step recovery programs and residential treatment centers (e.g., Delancy Street in San Francisco). De Leon states that the therapeutic community model for drug and alcohol treatment emphasizes “mutual self-help,” and that a modified therapeutic community model is suitable for the treatment of addiction and co-occurring disorders.\textsuperscript{60} While Flora was enrolled in treatment, EBCRP used a modified therapeutic community treatment model that followed De Leon’s prescription. At EBCRP, this included both experiential group therapy and learning about addiction and recovery within a supportive and collaborative environment, facilitated by a person-centered approach that enabled clients of various abilities to participate and feel included.
Experience is an important focus of imaginal psychology, particularly the quality of experience, and how experience is shaped by imaginal structures. Omer defines this concept, stating, “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.” 61 A parallel but more narrowly defined concept used in cognitive therapy is cognitive schema. Aaron T. Beck and Marjorie E. Weishaar define this concept: “Cognitive schemas are structures that contain the individual’s fundamental beliefs and assumptions. Schemas develop early in life from personal experience and identification with others.” 62

Imaginal structures are pertinent to Flora’s condition, particularly in regard to how her outlook initially was shaped while living with alcoholic parents. Brown finds that adult children of alcoholics develop defensive structures, a parallel concept, which cause many difficulties in adulthood. 63 Brown states, “Many of the major issues or problems brought to treatment, for example, depression, anxiety, problems forming close, intimate relationships, are related directly to these defensive adaptations.” 64

Imagination is of primary importance to imaginal psychology because it is the mental faculty that enables coherent meaning to emerge from experience. As Omer states, “Imagination amplifies and integrates the sensory, emotional, and cognitive dimensions of our experience.” 65 Omer equates imagination with creative play, which has a parallel in Winnicott’s psychodynamic perspective on psychological development. 66 Winnicott asserts that imagination is an intermediate area, between self and other, where inner and outer perceptions are compared to distinguish between subjective and objective reality. 67
He postulates that during early development, life is experienced in an undifferentiated “neutral zone” between internal and external reality, containing affective, motor, and sensory experience, and that the nascent sense of self emerges as spontaneously playful actions are mirrored back by others. He adds that the self can be remade in therapy when the creative imagination is reawakened through relaxed and unstructured playfulness.

From the depth perspective, Jung believes that imagination and intuition are indispensable in both the sciences and the arts. He maintains that imaginative insight can be backed up with reasoning, and that together they can provide a sound basis for knowledge.  

Similarly, Shaun McNiff finds that creative imagination resolves the dichotomy between art and science. Writing about research on art therapy, McNiff states, “Creative discovery is based on putting previously separated entities into new relationships with one another.”

**Additional Reflections**

In rereading the sociocultural literature, I was drawn to Murphy and Rosenbaum’s research into motherhood and addiction, which reveals that social and cultural influences limit choices for women. Murphy and Rosenbaum’s views contributed to my understanding of how Flora’s options and circumstances were shaped by cultural values and social policy. Murphy and Rosenbaum argue from a feminist perspective that cultural mores uphold the value of motherhood, but the mother is denied any intrinsic economic worth. Murphy and Rosenbaum’s research on mothers who use drugs indicates that women who grew up with abuse and addiction in their family, and who have few job skills, frequently establish an adult identity through motherhood, which leaves them
financially vulnerable. Flora’s life circumstances paralleled this scenario. As an adult, Flora invested her identity in being a mother and was financially dependent on each of her husbands. After separating from each of her husbands, she lost her home and custody of her children because of interventions by social services, which Murphy and Rosenbaum describe as “that invisible male provider.”

Murphy and Rosenbaum argue that as a result of changes in public policy, the social services available to mothers have declined, and the number of children removed from their mothers by CPS has risen. They argue that without a partner to provide financial resources, mothers who use drugs are at once less able to care for themselves and their children and more likely to lose custody of their children. Like many of Murphy and Rosenbaum’s research subjects, Flora followed a pattern of increasing dependence on drugs to self-medicate her grief about losing her children and her mothering role.

Murphy and Rosenbaum argue that the choices of mothers who use drugs are circumscribed by sociocultural influences. From the sociocultural perspective, cultural influences and social policy set the stage for the drama that played out in Flora’s therapy. As Flora struggled to reclaim her identity as a mother and to assert her right to be with her children, she struggled against oppressive beliefs and circumstances, in addition to the limitations imposed by her addiction.

Areas for Future Research

The extant literature provides a comprehensive view of how development affects complicated grief and addiction, from childhood influences to recovery during adulthood, but there are gaps in the research.
Further research could reveal more about the conditions that support recovery from co-occurring addiction and complicated grief. O’Connor’s study on complicated grief finds that yearning for reconnection with a lost one is biologically similar to the craving experienced with addiction. This finding holds out hope for clients who suffer from addiction and complicated grief as co-occurring disorders because finding relief from one source of distress may make it easier for them to find relief from the other.

Although Flora resumed drug use after returning from visits with her children, she did not use while visiting her children, indicating that both her longing for her children and her craving for drugs were temporarily assuaged while with her children. Further research into ways of addressing distress common to both complicated grief and addiction could help therapists facilitate healing for clients with these and other co-occurring disorders.
APPENDIX 1

INFORMED CONSENT FORM

To [name of client subject]:

You are invited to be the subject of a Clinical Case Study on the treatment of complicated grief and addiction. The purpose of the study is to better understand people who experience unchanging and consuming feelings of loss, together with drug dependence. It is also to better understand how these two difficulties affect the lives of people who have difficulty finding support or consolation from others in their grief.

This study is of a research nature and may not offer you any direct benefit. However, the published findings may be useful to people who suffer inconsolable losses, and may benefit the understanding of both complicated grief and 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 in ways that could potentially distract you from your primary focus in therapy. 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 materials, any 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 for any reason, up until the publication of this study. Please note as well that I may need to end your role as subject of the study at any time 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 Academic Services Coordinator at the Institute of Imaginal Studies, 47 Sixth Street, Petaluma, CA, 94952, telephone: (707) 765-1836.
I, [name of client subject], understand and consent to be the subject of, and to be referred to in, the Clinical Case Study written by David Westwood, on the topic of complicated grief and addiction. I understand private and confidential information may be discussed or disclosed in this Clinical Case Study, I have had this study explained to me by David Westwood. 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 David Westwood will not disclose my name, the names of any persons involved with me, or information that could identify me in this Clinical Case Study.

Signed this ______ day of ____________________, 20 ____, at ____________________, ______
State Date Month Year City

By: ______________________________________________

Client’s signature

_________________________________________________

Print client’s name legibly and clearly on this line
Chapter 1


6. Ibid., 204.


15. For example, see Minkoff and Drake, eds., Dual Diagnosis of Major Mental Illness and Substance Disorders.


18. Boss, Ambiguous Loss, 8, 9.


23. The concept of imaginal structures was explained to students by Aftab Omer, course at Meridian University, author’s notes, September 12, 2004.


31. Omer’s definition of imaginal structures was distributed to students attending Meridian University, e-mail sent by Andrea Lambert, October 19, 2005.


34. Course at Meridian University, syllabus, Fall Quarter, 2004.


36. Omer, course at Meridian University, author’s notes, July 8, 2005.


39. Course at Meridian University, syllabus, Fall Quarter, 2004.


Chapter 2


http://www.drugabuse.gov/pdf/monographs/download12.html (accessed November 18, 2009); Murphy and

2. For example, see Carl R. Rogers, *On Becoming a Person: A Therapist’s View of Psychotherapy* (Boston: Houghton Mifflin, 1961); Malkinson, *Cognitive Grief Therapy*.


9. For example, see Kohut, introduction to *Psychodynamics of Drug Dependence*; Krystal, *Integration and Self-Healing*.


12. De Leon, “Modified Therapeutic Communities for Co-Occurring Substance Abuse and Psychiatric Disorders.”


15. Rogers, *On Becoming a Person*, 16, 17, 60-66


19. Aftab Omer, lecture at Meridian University, author’s notes, October 14, 2005.


25. For example, see Rogers et al., “Dissociable Deficits in the Decision-Making Cognition of Chronic Amphetamine Abusers, Opiate Abusers, Patients with Focal Damage to Prefrontal Cortex, and Tryptophan-Depleted Normal Volunteers.”

26. O’Connor et al., “Craving Love?”


29. Ibid., 247.

30. Ibid., 244, 249.

31. Ibid., 244, 245, 249.


34. Ibid., 334.

35. Ibid., 339.

36. Ibid., 339.

38. Ibid., 1041.

39. Ibid., 1048.

40. Ibid., 1043, 1044.

41. Rogers et al., “Dissociable Deficits in the Decision-Making Cognition of Chronic Amphetamine Abusers, Opiate Abusers, Patients with Focal Damage to Prefrontal Cortex, and Tryptophan-Depleted Normal Volunteers.”

42. Ibid., 322, 334.

43. Ibid., 325–327.

44. Ibid., 324, 334.

45. Ibid., 334.

46. Ibid., 334.

47. Ibid., 334.


49. Ibid., 120-123.

50. Ibid., 116, 117, 120, 121.

51. Brady and Sinha, “Co-occurring Mental and Substance Use Disorders.”

52. Ibid., 1484-1486.

53. Ibid., 1484, 1490.

54. O’Connor et al., “Craving Love?”

55. For example, see London et al., “Orbitofrontal Cortex and Human Drug Abuse”; Rogers et al., “Dissociable Deficits in the Decision-Making Cognition of Chronic Amphetamine Abusers, Opiate Abusers, Patients with Focal Damage to Prefrontal Cortex, and Tryptophan-Depleted Normal Volunteers.”

56. Ibid.


58. For example, see Dursteler-MacFarland, Cereghetti, and Wiesbeck, “Neurocognitive Impairment”; Rogers et al., “Dissociable Deficits in the Decision-Making Cognition of Chronic Amphetamine Abusers, Opiate Abusers, Patients with Focal Damage to Prefrontal Cortex, and Tryptophan-Depleted Normal Volunteers.”

59. Brady and Sinha, “Co-occurring Mental and Substance Use Disorders.”
60. O'Connor et al., “Craving Love?”

61. For example, see Prochaska and DiClemente, *The Transtheoretical Approach*; Najavits, *Seeking Safety*.

62. Ibid.

63. Najavits, *Seeking Safety*.


65. Malkinson, *Cognitive Grief Therapy*.


67. Ibid., 2, 97.

68. Ibid., 2, 3.

69. Ibid., 33-43.

70. Ibid., 35-37, 44.

71. Ibid., 46, 47.


73. Ibid., 5-7.

74. Ibid., 6.

75. Ibid., 8.

76. Ibid., 14.

77. Ibid., 11.

78. Ibid., 13.

79. Stroebe, Schut, and Finkenauer, “The Traumatization of Grief?”

80. Ibid., 187-189.

81. Ibid., 198.

82. Bonanno et al., “Resilience to Loss and Chronic Grief.”

83. Ibid., 1156, 1157.

84. Ibid., 1156, 1157.

85. Ibid., 1159.

87. Ibid., 4,5, 143.

88. Ibid., 144.

89. Ibid., 63, 64, 156.

90. Ibid., 156.

91. Ibid., 157.

92. For example, see Prochaska and DiClemente, *The Transtheoretical Approach*; Stroebe, Schut, and Finkenauer, “The Traumatization of Grief”; Malkinson, *Cognitive Grief Therapy*.

93. For example, see Prochaska and DiClemente, *The Transtheoretical Approach*; Malkinson, *Cognitive Grief Therapy*.

94. For example, see Najavits, *Seeking Safety*; Prochaska and DiClemente, *The Transtheoretical Approach*.

95. For example, see Zweben et al., “Psychiatric Symptoms in Methamphetamine Users”; Horowitz et al., “Diagnostic Criteria for Complicated Grief”; Prigerson and Jacobs, “Traumatic Grief as a Distinct Disorder.”

96. For example, see Bowlby, *Attachment and Loss*, vol. 3; Kohut, introduction to *Psychodynamics of Drug Dependence*.

97. For example, see Zweben et al., “Psychiatric Symptoms in Methamphetamine Users”; Kohut, introduction to *Psychodynamics of Drug Dependence*; Krystal, *Integration and Self-Healing*.


103. Ibid., 182, 183.

104. Ibid., 187, 188.

105. Ibid., 181, 184-188.

106. Ibid., 185.

107. Ibid., 188.
108. Ibid., 185.
109. Ibid., 188.
110. Kohut, introduction to *Psychodynamics of Drug Dependence*.
111. Ibid., vii, viii.
112. Ibid., viii.
114. Ibid., 142.
115. Ibid., 145-147.
116. Ibid., 147, 148.
117. Ibid., 170-174
118. Ibid., 188, 189.
119. Ibid., 171.
120. Freud, *Mourning and Melancholia*.
121. Ibid., 244.
122. Ibid., 244, 245.
123. Ibid., 243, 244.
124. Ibid., 250, 251.
125. Ibid., 244, 245.
128. Ibid., 65, 69.
129. Ibid., 67.
130. Ibid., 66.
131. Ibid., 67.
133. Ibid., 140.
134. Ibid., 32, 216, 217.
135. Ibid, 85.
136. Ibid., 137, 138.
137. Ibid., 152-169.
138. Ibid., 138, 139, 141-152.
140. Horowitz et al., “Diagnostic Criteria for Complicated Grief.”
141. Ibid., 904, 905.
142. Ibid., 909.
143. Ibid., 908, 909.
144. Ibid., 909.
145. Prigerson, and Jacobs, “Traumatic Grief as a Distinct Disorder.”
146. Ibid., 625.
147. Ibid., 616-619, 623.
148. Ibid., 629.
150. Ibid, 81.
153. Ibid., 72, 329, 330.
154. Ibid., 71, 72.
155. Ibid., 73.
157. Ibid., 311.
160. For example, see Zweben et al., “Psychiatric Symptoms in Methamphetamine Users”; Krystal, *Integration and Self-Healing*; Horowitz et al., “Diagnostic Criteria for Complicated Grief.”
162. Kohut, introduction to *Psychodynamics of Drug Dependence*. 


167. Minkoff and Drake, eds., *Dual Diagnosis of Major Mental Illness and Substance Disorder*.

168. De Leon, “Modified Therapeutic Communities for Co-Occurring Substance Abuse and Psychiatric Disorders.”


170. Askren and Bloom, “Postadoptive Reactions of the Relinquishing Mother.”

171. Murphy and Rosenbaum, *Pregnant Women on Drugs*.

172. Novac et al., *A Visceral Grief*.

173. Minkoff and Drake, eds., *Dual Diagnosis of Major Mental Illness and Substance Disorder*, 1.

174. Ibid., 14, 15.

175. Ibid., 15.

176. Ibid., 1.

177. Ibid., 15, 19.

178. Ibid., 17.

179. Ibid., 14, 15.

180. Ibid., 15.

181. De Leon, “Modified Therapeutic Communities for Co-Occurring Substance Abuse and Psychiatric Disorders.”

182. Ibid., 139, 143-146.

183. Ibid., 139.

184. Ibid., 144, 151.

185. Ibid., 148.

186. Ibid., 140, 153.

188. Ibid., 8, 9.
189. Ibid., 8, 9.
190. Ibid., 11, 21, 59.
191. Ibid., 10, 59, 60.
192. Ibid., 126, 127.
193. Ibid., 60, 76, 92.
194. Ibid., 106, 107.
195. Ibid., 106, 119, 120, 123, 124, 128.
196. Askren and Bloom, “Postadoptive Reactions of the Relinquishing Mother.”
197. Ibid., 395.
198. Ibid., 397, 398.
199. Murphy and Rosenbaum, *Pregnant Women on Drugs*.
200. Ibid., 163.
201. Ibid., 159-162.
202. Ibid., 26, 27, 41-45, 130.
203. Ibid., 60-99, 130-134.
204. Ibid., 64, 65, 133, 134.
205. 65, 135, 138,
206. Ibid., 134-138.
207. Ibid., 139-145.
208. Novac et al., *A Visceral Grief*.
209. Ibid., 20.
210. Ibid., 10, 14.
211. Ibid., 38-56.
212. Ibid., 43.
213. Ibid., 55.
214. Ibid., 50.
215. Ibid., 51, 54, 57-62.

216. For example, see Askren and Bloom, “Postadoptive Reactions of the Relinquishing Mother”; Murphy and Rosenbaum, *Pregnant Women on Drugs*. 
217. De Leon, “Modified Therapeutic Communities for Co-Occurring Substance Abuse and Psychiatric Disorders.”

218. Novac et al., A Visceral Grief.


221. Ibid, 119.

222. May, The Courage to Create, 57, 58.


224. Yalom, Staring at the Sun, 37.


226. Miller and Rollnick, Motivational Interviewing.

227. Rogers, On Becoming a Person, 26, 27.

228. Ibid., 194.

229. Ibid., 46, 47, 243-268.

230. Ibid., 23.

231. Ibid., 27.


233. Ibid., 26.

234. Ibid., 60-66.

235. Ibid., 16, 17.

236. Ibid., 20-22.

237. Ibid., 18, 19.

238. Miller and Rollnick, Motivational Interviewing.

239. Ibid., 3-5.

240. Ibid., 62.

241. Miller and Rollnick, Motivational Interviewing, 9, 10.

242. Ibid., 11, 12.

243. 60, 101.
244. Ibid., 52, 53.
245. Ibid., 56.
247. Ibid., 18, 19.
248. Ibid., 18, 19.
250. May, _The Courage to Create_, 57, 58.
251. Ibid., 17-19.
252. Yalom, _Staring at the Sun_, 201.
253. Ibid., 201.
254. Ibid., 120.
255. Ibid., 121, 122.
256. Ibid., 49.
258. Yalom, _Staring at the Sun_, 37.
259. Ibid., 124, 125, 130.
260. Ibid., 206, 217.
261. Ibid., 221-224.
262. For example, see Rogers, _On Becoming a Person_; May, _The Courage to Create_.
264. Yalom, _Staring at the Sun_, 201.
265. Anne Coelho stressed the multidisciplinary approach in Imaginal Psychology, course at Meridian University, author’s notes, April 20, 2007.
266. Omer defines the adaptive personal identity as follows: “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 subsequent contexts where they are maladaptive and barriers to the unfolding of Being,” received in an e-mail from Karen Jaenke, November 13, 2007.
267. For example, see Suomi, “How Gene-Environment Interactions Influence Emotional Development in Rhesus Monkeys.”


270. Ibid., 96, 104-106.

271. Ibid., 102-104.

272. Omer states, “The adaptive personal identity is a dissociative adaptation to adverse, traumatic conditions, which limit identity and the ability to experience,” and he adds, “Adaptations are inevitably incorporated into mental abilities as they develop in each of us, otherwise we would be overwhelmed by experience,” course at Meridian University, author’s notes, September 12, 2004.


274. Ibid., 102.

275. Omer’s definition of imaginal structures was distributed to students attending Meridian University, e-mail sent by Andrea Lambert, October 19, 2005.

276. Ibid.


278. Ibid., 145, 159; In addition to Brown’s use of the concept of the “dead” parent, the term has also been used in imaginal psychology in reference to the principle that the child of a psychologically unavailable or “dead” mother continues to seek to reconnect with the lost mother throughout life, Karen Jaenke, course at Meridian University, author’s notes, September 29, 2007.


280. Omer, course at Meridian University, author’s notes, October 14, 2005.


282. Ibid., 169, 171, 181


284. Ibid., 37, 38.

285. Ibid., 39-42.

286. Ibid., 41, 43.

287. Ibid., 43.

288. Ibid., 44.

289. Ibid., 43, 45.

291. Omer, course at Meridian University, author’s notes, September 15, 2005

292. Ibid.

293. Theories of attachment, affect, and trauma are considered informative to the practice of transmuting affects into psychological capacities and qualities in imaginal psychology. Anne Coelho, course at Meridian University, author’s notes, June 21, 2007; Isoko Femi considers grief one of the primary affects, course at Meridian University, author’s notes, November 12, 2004; furthermore, Omer considers grieving a process of seeing the pain of acquired adaptations to chronic trauma, course at Meridian University, author’s notes, September 15, 2005; addiction, according to Karen Jaenke, is necessitated by early experience of a psychologically unavailable, “dead” mother, course at Meridian University, author’s notes, October 20, 2007.

294. Schore, “Attachment and the Regulation of the Right Brain.”

295. Ibid., 26, 32, 33, 36, 39.

296. Ibid., 26, 27.

297. Ibid., 27, 31, 34.

298. Ibid., 36.


300. Ibid.

301. Ibid., 29, 30, 31, 32.

302. Ibid., 30.

303. Winnicott, *Playing and Reality*. 2, 3, 64.

304. Ibid., 2, 3.

305. Omer, course at Meridian University, author’s notes, September 12, 2004.

306. Schore, “Attachment and the Regulation of the Right Brain.”


308. Winnicott, *Playing and Reality*.

**Chapter 3**


2. Ibid., 410.

3. Ibid., 737.
4. For a brief discussion on the differentiation of drug induced symptoms and personality disorders, see ibid., 688, 689.

5. Ibid., 228, 238-239.

Chapter 4

1. Regarding Boss’s concept of ambiguous loss, see Boss, Ambiguous Loss, 9; regarding Boss’s concept of frozen grief, see ibid, 3, 4; regarding custody of a child as a life-changing event, see Askren and Bloom, “Postadoptive Reactions of the Relinquishing Mother,” 395, 399; regarding Bowlby’s concept of chronic mourning, see Bowlby, Attachment and Loss, vol. 3, 137, 138, 142; regarding Bowlby’s principle of the course of mourning, see ibid., 32, 222; regarding Brown’s principles of adult children of alcoholics and difficulty separating, and their lack of maturity, see Brown, Treating Adult Children of Alcoholics, 160, 161, 181; regarding Suomi’s principle on the consequences of peer socialization, see Suomi, “How Gene-Environment Interactions Influence Emotional Development in Rhesus Monkeys,” 43; regarding the principle of adolescents and drug use, see Chambers, Taylor, and Potenza, “Developmental Neurocircuitry of Motivation in Adolescence,” 1041; regarding the principle of motherhood as both valued and undervalued identity, see Murphy and Rosenbaum, Pregnant Women on Drugs, 134-138; regarding the principle that clients begin treatment with ambivalence, see Miller and Rollnick, Motivational Interviewing, 12; regarding the principle of drug use and first families, see May, Power and Innocence, 34; regarding Yalom’s concept of existential loneliness, see Yalom, Staring at the Sun, 121, 122; regarding the principle of an unfulfilled life and the fear of death, see ibid., 49; regarding the principle of resistance as a cognitive impairment, see Dursteler-MacFarland, Cereghetti, and Wiesbeck, “Neurocognitive Impairment,” 117; regarding methamphetamine use and negative affects, see Zweben et al., “Psychiatric Symptoms in Methamphetamine Users,” 188; regarding negative expectations, see Krystal, Integration and Self-Healing, 171; regarding the concept of stages of change, see Prochaska and DiClemente, The Transtheoretical Approach, 2, 3.

2. Regarding Freud’s concept of transference, see Freud, “A Case of Hysteria,” 116-119; regarding Jung’s concept of countertransference, see Jung, The Practice of Psychotherapy, 71, 72, 329, 330; regarding Jung’s concept of mutual transformation in therapy, ibid., 71, 72; regarding Bion’s use of the concept of projective identification, see Bion, “Language of the Schizophrenic,” 225, 226, and also Bion, The Tavistock Seminars, 60; regarding imaginal structure, Omer’s definition was distributed to students attending Meridian University by e-mail, sent by Andrea Lambert, October 19, 2005.


4. Ibid., 8, 9.

5. Ibid., 3, 4, 59.


7. Ibid., 397.

8. Ibid., 399.


10. Ibid., 32, 216, 217.

13. Ibid., 160, 161.
15. Ibid., 181.
17. Ibid., 43.
18. Ibid., 44.
19. Ibid., 1043, 1044.
21. Ibid., 1048.
22. Murphy and Rosenbaum, *Pregnant Women on Drugs*.
23. Ibid., 134-138.
25. Ibid., 11, 12,
26. Ibid., 101.
27. Ibid., 23, 26, 34, 53, 119.
28. Ibid., 20, 26, 33, 56, 118.
30. Ibid., 23.
31. Ibid., 27, 28.
32. May, *Power and Innocence; The Courage to Create*.
33. May, *Power and Innocence*, 34.
35. Ibid., 17-19.
37. Ibid., 201.
40. Ibid., 116, 117, 120, 121.
41. Ibid., 117.
42. Zweben et al., “Psychiatric Symptoms in Methamphetamine Users.”
43. Ibid., 188.
44. Ibid., 185.
45. Ibid., 181, 184-188.
46. Ibid., 185.
49. Ibid., 116-119.
51. Ibid., 329.
52. Ibid., 329, 330.
53. Ibid., 72.
54. Ibid., 71, 72.
55. Ibid., 73.
58. Omer, course at Meridian University, author’s notes, October 14, 2005.
59. Omer, course at Meridian University, author’s notes, May 20, 2006.
60. Omer, *Key Definitions*, Meridian University, e-mail from Karen Jaenke, November 13, 2007.
62. Ibid., 3, 4.
65. Ibid., 32, 222.

70. Murphy and Rosenbaum, Pregnant Women on Drugs, 134-138.

71. Yalom, Staring at the Sun, 49, 121, 122.


73. Miller and Rollnick, Motivational Interviewing, 12.

74. Ibid., 12, 13.

75. May, Power and Innocence, 34.


78. Krystal, Integration and Self-Healing, 171.


80. Ibid., 184.

81. DSM IV, 479-483.


84. The concept of imaginal structure was introduced to students by Omer, course at Meridian University, author’s notes, October 14, 2005.


86. John Conger, personal communication with the author, October 20, 2010.


88. Ibid., 38, 39.

89. Boss, Ambiguous Loss, 8.

90. Ibid., 20-22.

91. Ibid., 30, 31.

92. Ibid., 27, 28.


94. Ibid., 219.

95. Ibid., 220, 223.
96. The four modes of experiencing were introduced to students by Omer, lecture at Meridian University, author’s notes, July 8, 2005.

97. The mother principle was described to students by Omer, course at Meridian University, author’s notes, October 14, 2006.

98. The father principle was described by Omer, course at Meridian University, author’s notes, January 20, 2007.

99. Ibid.

100. Omer, course at Meridian University, author’s notes, October 14, 2006.


102. Yalom, Love’s Executioner, 11.

103. Yalom, Staring at the Sun, 37.

104. Ibid., 49.

105. The concept of objective caring was introduced to students by Omer, course at Meridian University, author’s notes, October 14, 2005.

106. Omer, course at Meridian University, author’s notes, December 10, 2005.

107. Omer, course at Meridian University, author’s notes, September 12, 2004.

108. Imaginal psychology and images were equated by Omer, course at Meridian University, author’s notes, October 16, 2004.

109. Winnicott, Playing and Reality, 64.

110. This statement is included in the description of a course at Meridian University, September 10, 2005.

111. Ibid., 53, 59.

112. Omer’s definition of psychological multiplicity was distributed to students attending Meridian University by e-mail, sent by Karen Jeanke, November 13, 2007.


114. Malkinson, Cognitive Grief Therapy, 2, 63-66, 156.

115. Boss, Ambiguous Loss, 8, 9.

116. Ibid., 31-33.

117. Course description, Meridian University, September 10, 2005.
Chapter 5

1. Omer, course at the Meridian University, author’s notes, December 10, 2005.

2. Gatekeeping, as an adaption that mediates chaotic circumstances and filters experiencing, was discussed by Courtney Lubell, course at the Meridian University, author’s notes, February 15, 2008.

3. My experience parallels that of Omer, who states that by deeply owning personal experiences of grief, and disidentifying with them through the practice of reflexivity, the affect of grief is transmuted into the capacity to experience compassion, course at Meridian University, author’s notes, February 19, 2005.

4. The concept of objective caring was introduced to students by Omer, course at Meridian University, author’s notes, October 14, 2005.


8. For an explanation of counter-transference evoked by transference, and mutual transformation, see Jung, *The Practice of Psychotherapy*, 71, 72.


13. Omer asserts that imaginal structures associated with the adaptive identity operate in concentric spheres, extending from the personal at the center, to the cultural, and out to the encompassing archetypal sphere of influence, course at the Meridian University, author’s notes, March 17, 2007.


15. For methamphetamine use and cognitive deficiencies, see Rogers et al., “Dissociable Deficits in the Decision-Making Cognition of Chronic Amphetamine Abusers”; regarding resistance in treatment as a cognitive impairment, see Dursteler-MacFarland, Cereghetti, and Wiesbeck, “Neurocognitive Impairment,” 117.

16. For examples of developmental trauma on negative emotions and susceptibility to addiction, see Suomi, “How Gene-Environment Interactions Influence Emotional Development in Rhesus Monkeys”; for the effects of the quality of attachment during childhood on the course of mourning in adults, see Bowlby, *Attachment and Loss*, vol. 3.

17. For the effects of alcoholic parents on the development of children, see Brown, *Treating Adult Children of Alcoholics*; Krystal, *Integration and Self-Healing*. 


20. Foley, *The Homeric Hymn to Demeter*.


23. For example, see Rogers et al., “Dissociable Deficits in the Decision-Making Cognition of Chronic Amphetamine Abusers”; and Dursteler-MacFarland, Cereghetti, and Wiesbeck, “Neurocognitive Impairment.”


30. Omer, course at Meridian University, author’s notes, September 10, 2004.

31. Omer, course at Meridian University, author’s notes, October 14, 2005.

32. Omer, course at Meridian University, author’s notes, June 22, 2007.

33. Omer, course at Meridian University, author’s notes, July 8, 2005.

34. Omer, course at Meridian University, author’s notes, July 24, 2006.

35. Omer, course at Meridian University, author’s notes, February 15, 2008.

36. Ibid.

37. Melissa Schwartz, course at Meridian University, author’s notes, June 21, 2008.


39. Omer, course at Meridian University, author’s notes, July 30, 2006.

40. This statement refers to the imaginal concept of the participatory paradigm applied in therapy, Omer, course at Meridian University, author’s notes, March 19, 2005.

41. Omer, course at Meridian University, author’s notes, September 12, 2004.

42. Omer, course at Meridian University, author’s notes, June 22, 2007.


45. Ibid., 8, 11.

46. For imaginal psychology as a distinct psychology, see *Meridian University 2009-2010 Academic Catalogue*, 22; for the concerns of imaginal psychology, see Omer, course at Meridian University, author’s notes, September 10, 2004.

47. For a full list of psychologies that imaginal psychology derives meaning from, see “Meridian University,” Internet, available at http://www.meridianuniversity.edu/index.php/psychology (accessed January 31, 2011).


49. Omer, course at Meridian University, author’s notes, October 16, 2004.

50. Omer, course at Meridian University, author’s notes, April 15, 2005.


52. Raskin and Rogers, “Person-Centered Therapy,” 130-165.


54. Omer, course at Meridian University, author’s notes, July 8, 2005.

55. Course at Meridian University, syllabus, Spring Quarter, 2005.


57. Ibid.

58. Priscilla Taylor, course at Meridian University, author’s notes, May 11, 2008.

59. Omer, course at Meridian University, author’s notes, July 8, 2005.

60. De Leon, “Modified Therapeutic Communities for Co-Occurring Substance Abuse and Psychiatric Disorders,” 139-151.


64. Ibid.

65. Course at Meridian University, syllabus, Fall Quarter, 2004.

66. Omer, course at Meridian University, author’s notes, December 10, 2005.


70. Murphy and Rosenbaum, *Pregnant Women on Drugs*.

71. Ibid., 134-138

72. Ibid., 26, 27, 65, 135.

73. Ibid., 138.

74. Ibid., 139-145.

75. Ibid., 134.
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