# Depth Psychology
# Applied to Addiction Counseling

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**Acknowledgements**

I would like thank Bob Lynn, Shane Phillips, and Jason Schwartz for their comments and encouragement during the composition of this manuscript.

## Preface

Historically, systems of medical and psychiatric care in the USA considered people with serious and longstanding SUD's as outside their scope of practice and would typically refuse to treat such patients. Thus, self-help models arose for alcoholism (with the help provided by those with drinking histories) and for substance addiction (with the help provided by those with serious histories of narcotics use). Those self-help models were later formalized as the Minnesota Model for alcohol problems and the Therapeutic Community model for those with serious prescription or street drug problems. And those models were themselves later professionalized. Eventually, the Evidence-Based Practice (EBP) movement regulated the provision of SUD treatment to the nearly exclusive use of methods such as cognitive-behavioral therapy, motivational enhancement interviewing techniques, medication algorithms, and similarly-derived and manualized methods for treating co-occurring substance use and psychiatric disorders. As a result of their origins and developmental trajectory, addiction treatment programs in the USA have been largely outside of the formal theory, knowledge, and practice methods derived from Depth Psychology.

My academic education in undergraduate psychology and master's program in community-clinical psychology were broad within psychology on the one hand. But they were so strongly rooted in the combination of the scientist-practitioner model, radical behaviorism, and the cognitive-behavioral psychology theoretical orientation for clinical work on the other hand, that we did not consider any information, concepts, or methods from depth psychology real or of any use.

I undertook my initial two decades of clinical work in addiction treatment (1988-2008) in a large multi-disciplinary community agency that had comprehensive residential and outpatient services for primary psychiatric patients and for primary substance use disorder patients as well. The leadership of that agency was strongly rooted in the ***evidence-based practice movement.*** This included an organizational commitment to fidelity within specific evidence-based practices, as well as maintaining a culture of managing change toward continuously conforming to evolving best practices. Much later I came to see, in hindsight, that in that environment my already-narrow perspective became strengthened and entrenched.

Later, I moved to an organization with smaller clinical scope, scale, and programming (my current clinical home base). That organization is characterized by a ***horizontal interdisciplinary model.*** It functions so not only at the level of clinical disciplines (nursing, medical, psychiatry, clinical psychology, counseling, and spiritual care) as one team, but also at the level of theoretical orientations within disciplines. For example, within the counseling discipline backgrounds included wilderness therapy, experiential methods for emerging adults, art therapy, psychodrama proper, action methods from psychodrama, psychodynamic therapy, mindfulness-based therapy, family therapy, family systems methods, creativity group, equine therapy, CBT, DBT, EMDR, and ACT (to say nothing of various and specific evidence-based counseling methods aimed at addiction per se such as MI, RPT and some elements of TSF). And I saw that regardless, the organization maintained a coherent model of understanding addiction illness, addiction treatment, and addiction recovery, while sustaining clinical rigor concerning service provision and team processes. Further, clinical psychology included the psychoanalytic tradition and its projective testing methods – as resources for patient assessment, case formulation,

treatment planning, individual psychotherapy, group psychoeducational methods, and group psychotherapy.

Given that much more open clinical ecology, my various assumptions, concepts, and impulses began to diminish, while at the same time I became exposed to other theoretical orientations, ***methods of understanding,*** and of helping people change. As a result, I eventually began to take a keen interest in what would generally fall under the heading of depth psychology.

My nature is to be a learner, so this interest drove me in the creation of opportunities for discussions, active listening within the team process, reading, and undertaking study from various schools of thought and method. Eventually this also resulted in some re-interpretation of previous academic learning content and (some) clinical experiences. Always a note taker and inclined toward writing, preparing materials helpful in delivering clinical supervision, promoting the learning of others, and creating content for professional continuing education events, I began to compile information that was helpful to me. That information took the form of ***visual models, prose, logic models, and simple notes.*** And I eventually compiled that information.

This monograph assembles some of the material from some of the learning opportunities I constructed, as well as related resources I encountered or built. Hopefully it makes two things relatively overt:

1. Content I have…
    - come to appreciate, study, and attempt to understand;
    - seemingly created, realized, or found.
2. And my own internal process as a continuous storyline – a narrative of my personal and professional development from clinical practices strictly centered in radical behaviorism, CBT, and the EBP movement to begin to include those in the area of Depth Psychology. That is to say, the content does reflect my journey and change process – a depth psychology entrance point concerning myself as a clinician, and as a person.

In this work I will provide content in the subject area of Depth Psychology especially as related to addiction counseling. I will also provide a story of sorts embedded within the content. My delivery of the material will partially describe my process of thawing out from the limitations of fidelity to observable-only, measurement-only, pre-packaged interventions-only, and that world view. But regardless of the story, a range of topics related to Depth Psychology will be reviewed, and their practical application to addiction counseling will be introduced.

**Disclaimers**

*Nothing in this document should be taken or held as clinical instruction, clinical supervision, or advisory concerning patient care.*

Generally speaking, the Scientist-Practitioner model of psychology – within which my academic education was strongly rooted – concerns itself with the scientific method as a point of primacy over clinical method. That philosophical grounding is practical, not odd, and can be summarized by what is known as "Classical Test Theory", with the following mathematical expression:

$$O = T + e$$

where O stands for observation, T stands for true variance, and e stands for error variance.

That is to say, any observation by its nature always includes some level of what is more or less real/true, and what is more or less error/false. The duty inside the concern is to limit error variance as much as possible, and use qualifying or probabilistic language in describing anything, and everything (e.g. data, information, results).

The version of this we were trained in was very strict. We were taught that anything other than behavior that can be measured either does not exist, or should be ignored as if it does not exist. Thus, the ideas, content, and methods from Depth Psychology were forbidden and ignored. They would all be considered "error variance."

For me that was, and remains, a lot to overcome on my path forward from radical behaviorism and reliance on objective quantification, across and beyond my next 3 decades. In some ways the house of cards fell in.

For those not familiar with that level of empiricism and related world view, I refer the reader to Carmines and Zeller (1979), Campbell and Stanley (1963), and Barlow, Hayes and Nelson (1984). The empiricists and experimental psychologists among us might know why I placed Carmines and Zeller's publication first (out of chronological and alphabetical sequence). And some might relate to having memories formed over many hours and years of reciting these citations while quoting or recalling their content – the kind of familiar musicality in reciting a poem or portion of very familiar sacred text.

The notion of including a section titled *"Disclaimers"* I also mean as an ironic thing – a sarcastic kind of pun – in the context of a work on the topic of Depth Psychology. Someone seeing a section listed in the Table of Contents with that name might be more likely to take the writing seriously, or give it relatively more credence – even if never reading it – only because a section called *Disclaimers* was present. How interesting.

But I also mean it at a deeper level. Do we not assert disclaimers or limits of the Scientific Method, observation, case studies, large-N double-blinded controlled trials, and the accumulation of "data samples", and "facts", and the weight of "confirmatory evidence"? ***We do.*** What disclaimers can we assert about thinking itself, or of certain ideas? In that way, I am comfortable asserting some notions as possibilities, and eager for them to be put to the test.

## Introduction

I would like to begin with an academic starting point: comparing and contrasting two particular words and introducing a certain concept.

The **two common words** I would like to compare are "holistic" and "wholistic". From *dictionary.com*:

- **Holistic**: "…describes an all-embracing approach that views every aspect of a matter as a cohesive *whole* rather than a collection of isolated entities. It refers to a mind frame that focuses on the big picture, or the "grand scheme of things," instead of getting too caught up in the details…Today, a *holistic* treatment might encompass Western medication and procedures, complementary therapy such as massage, and education on lifestyle changes for the patient. Essentially, the focus is on the patient's overall wellness and not just one disease."
- **Wholistic**: "Having 'whole' as a base, *wholistic* proves quite handy when you want to emphasize the entirety or wholeness of something."

Here's the concept I would like to introduce. From *Wikipedia*:

> **Solipsism:** "…(from Latin *solus* 'alone', and *ipse* 'self') is the philosophical idea that only one's mind is sure to exist. As an epistemological position, solipsism holds that knowledge of anything outside one's own mind is unsure; the external world and other minds cannot be known and might not exist outside the mind."

Related to the treatment of complex, severe, and chronic substance use disorders, this brings many things to mind for me. For example, consider what we normally call denial or resistance. Solipsism raises more clearly *the individuality* or *the heterogeneity* of "denial" and "resistance" across various people. Is all denial the same? Is all denial created equal? Is all resistance the same? Is all resistance created equal?

And so I ask myself, of what is the person we are attempting to help ***most sure***…

- …in the fog of intoxication?
- …in the fog of withdrawal?
- …in the fog of craving?
- …in the fog of post-acute withdrawal?
- …in the fog of self-centeredness?
- …in the fog of social disconnection?
- …in the fog of guilt, shame, and stigma?
- …in the fog of survival?

…during the fog of counseling?

Afterall, in their solipsism, "most sure" might be what we call denial or resistance.

Hopefully this monograph will help the reader be able to:

1. Define various limitations of empiricism and the evidence-based practice movement
2. Understand the types and locations of latent content present with routine patients presenting for addiction treatment
3. Apply the 12 Steps and 12 Traditions in a non-linear and wholistic approach

4. Analyze internalizing and externalizing factors during the patient's personal change process
5. Create in-the-moment counseling responses supportive of the individual's entire and unique change process
6. Recall a phenomenological and wholistic model of personhood and apply the components of that model to information gathering
7. Consider personality factors as they relate to progression of addiction illness and promotion of personal wellbeing
8. Apply elementary concepts from Object Relations theory toward maximizing the intangible qualities of empathy and active listening

To achieve those objectives, the **major topics** of this work are as follows:

- Disillusionment with, and some limits of, empiricism
- Types & locations of latent content
- The Steps & Traditions considered wholistically
- Internalizing & externalizing factors
- Non-linear change process
- A model of personhood
- Personality and addiction illness
- Considering object relations

And as the work proceeds, the reader will be asked to consider the **application** of the material to the following **addiction counselor core functions**:

1. Screening
2. Intake
3. Orientation
4. Assessment
5. Treatment planning
6. Counseling
7. Case management
8. Crisis intervention
9. Client education
10. Referral
11. Report and recordkeeping
12. Consultation

**Part 1: Disillusionment with "empiricism-plus nothing"**

In terms of formal content, I would like to start with part of my own background as context. Here are some examples of the extent of ***the primacy of empiricism*** and of evidence-based practice as it was taught to me, and formed within us, during academic and clinical training.

- "If you can't measure it, it doesn't exist."
- "If you can't measure it, don't treat it."
- "Never say, 'depression'. The patient doesn't know what you mean when you say it, and neither does your colleague. Never use any hypothetical construct. To the colleague say, 'The patient's Beck Depression Inventory score dropped from 24 a week ago, to 12 today.' If the patient tells you that they are depressed, ask them what they mean, and see what they tell you. Work with what they tell you."

We were taught radical behaviorism. That included the notion that we should only attend to observable behaviors. That meant we should not be distracted by words people say. We were taught behavior therapy. And in behavior therapy as we learned it, discussions with the patient were mainly considered a convenient way of cuing behaviors – using language as cues.

We were also taught to not attempt to peer within the patient's internal world of subjective experience. Ultimately, such content is not accessible and can only be approximated by the patient as they attempt to use words. We were taught this was so fraught with error variance it should be ignored. We were taught that in the same way digestion is an internal and invisible process, cognition or "thinking" is an internal process analogous to digestion, and the words the patients says are excreted and of very little use at best. Given the average modern human in contemporary society's strenuous over-reliance on words, and their average sense of the high importance of what they think and have to say, we were taught cognitive therapy as a concession. Cognitive therapy was used as a way of shaping cognition *as a behavior.*

But during the third decade of my clinical work, I had softened a bit in my holding of empiricism and EBP's. What caused me to initially soften? Challenges I encountered from some clinicians and researchers with advanced-length careers. Ironically, their challenges were in the form of objective scrutiny (my kind of thinking) about empiricism in our field. After considering and eventually internalizing these messages, I immensely enjoyed quoting four of their particular statements while providing formal, professional continuing education lectures (as if I was a *rebellious* empirical-insider). I would present them as follows:

1. **What about *practice-based evidence?***
    - Clinical research is so tight for inclusion/exclusion of participants and so tight in protocols tested, that it has no real-clinical-practice applicability. That is, clinicians are not able in real practice to filter their patients so extremely or conduct a protocol so tightly.
    - The field needs research trials in real-world clinical services with real-world inclusion criteria.
    - One criticism of the traditional residential program is that it is too cookie-cutter. But what's more cookie-cutter than a CBT manualized protocol?
2. **The plural of "anecdote" is "data".**
    - Researchers relegate anecdotal data to last-place in value. But the lives of people in recovery aggregate to a large data sample.

    - A surgeon who has done 10,000 of the same procedure has something valuable to say about the illness and course of care.
3. **"CBT is best" derives from, and is an artifact of, our limitations in measurement technology.**
    - CBT lends itself to being measured within our current abilities to measure, so it wins.
    - Future advancements in measurement technology might allow other therapies to compete equally and demonstrate higher efficacy.
4. **Why is addiction treatment held to a standard of symptom-free remission?**
    - Chronic diseases have patterns of remitting and returning symptoms.
    - If it were any other disease, a return to symptoms after stopping care would be interpreted as care being effective.
    - Corollary: why require someone to "fail" at a lower level of care first? Do no harm?

Some years later a colleague casually handed me a paper and strongly encouraged me to read it (Marquis, Douthit, & Elliot, 2011). The paper is **a critique** of the "evidence-based practice movement". And to me at the time I read it, the paper was **a splendid and contextualizing piece of logic** about the limitations of empiricism and the EBP movement. It propelled me ahead in my broader considerations. For example, that paper highlights, among other points, the following:

- Which proposed studies get funded and why? Why and when are null findings published or not published?
- Do we find **what is**, or **what we measure**?
- Criteria for what constitutes EBP with **concerns** on conceptual, cultural and methodological grounds. For instance, EBP promotes a narrow/medicalized approach to research methods and easily measured outcomes. And "Best" becomes what is institutionally dominant while other recovery-related and clinical practices are marginalized.
- An emphasis on treatment models **at the expense of** the person (the counselor; the patient), the counseling relationship, and non-diagnostic characteristics.
- **What suffers** under manualized approaches? Clinical judgment, intuition, creativity, flexibility; reduced appreciation of diversity considerations, developmental frameworks, person-centered considerations, wellness, strengths, and recovery-orientation.
- Research trial world: a single diagnosis, focus on the short-term, symptom reduction or acute treatment response. **Real-world:** multiple diagnoses, not a pre-fixed duration of care, is self-correcting, focus on overall improvement or recovery, a longer-term focus.
- CBT lends itself to EBP evaluation methodology (reductionistic, objectivism, structured, symptom focused, shorter term). And **less focus on** satisfaction, wellness, progress, insight, improved self-esteem, sense of personhood, and emotional self-awareness.

At essence, the paper asks if EBP's are an artifact of methodological logistics. And it asks what we can learn without excessive weighting of random controlled trials. To me, these topics open an important door of consideration. The authors outline 2 assumptions within the EBP movement and an assumptive context within which they sit. They note that: (1) Within the EBP movement it is assumed that diagnosis is the best indicator of appropriate treatment (versus

multiple dimensions, personality factors, developmental dynamics, sociocultural factors, environmental context, and other non-diagnostic characteristics and circumstances). (2) They note that within the EBP movement it is assumed that the treatment itself (the "ingredients") is the primary determinant of outcome (versus other factors by a higher percentage such as client factors, expectancies, and therapist variables). And they highlight that the EBP movement sits within **an assumptive world** characterized by a research culture of quantitative empiricism and a medicalized conception of counseling, emphasizing diagnosis and prescriptive technique.

The authors do preserve the value of research and EBP's. In doing so they note that if one's interest is limited to *observable and external symptoms and behaviors*, then narrow empiricism is justifiable. But if the interest is in *internal dynamics, self-concept, meaning and life narratives*, they state a qualitative approach should be added, and can still have rigor. They outline that the field should develop practices that rest on 3 pillars: best research, clinical expertise, and client non-diagnostic characteristics.

<u>And so, some considerations I was left with included:</u>

- What do we measure, and why?
- Are we able to identify or measure the supposedly most important variables?
- Would it even matter if we could?
- What is it like for someone to be them?
- Shall we meet and treat the total person?
- Or shall we rather apply a protocol to stop a problem we notice?

In the meanwhile, it seemed to me that society and our field were changing around me – at the level of zeitgeist. It seemed like <u>one shift</u> related to three aspects of our work: *being, purpose, and knowledge*. It seemed like a movement away from expert knowledge, clinical authority, and related practices.

I'll outline the shift by breaking down those three aspects in the form of first-person statements from the patient perspective.

"I don't need a person with letters, or recovery, or their own story, to…

A. "…tell me who I am." *(being; ontology)*
B. "…tell me what to do." *(purpose; teleology)*
C. "…understand me." *(knowledge; epistemology)*

Interestingly, those three points of emphasis seem to correspond with 3 aspects of our field. I've built a continuum from older (on the left) to newer (on the right) for each.

It seems we now have the following

The current zeitgeist seems to hold that a recovery orientation *is not* emancipatory or based in liberation, but is an oppressive and controlling construct. And thus, the notion is that "recovery" tells the person with the SUD who the person with the SUD *really is*. And "recovery" also tells the person with the SUD who they themselves, the recovery authority, *really are*. Further, in the current zeitgeist, these are then split off from the person with a SUD who is seeking a liberation framework. And the person with the SUD then seeks to gain or regain power and authority, and in turn tells the recovery authority who they themselves are, and who the authority is.

In that arrangement, the one seeking liberation splits recovery and liberation from each other, and artificially puts them in tension. Then asserts their perspective while adopting the role and position of power and authority. And thus, misses out on the recovery message content they could have otherwise gained. All of that is ironic to me.

**Recovery** ⟷ **Liberation**

Who I am (the person with SUD)

You tell me — I tell you

Who you are (the other person in the room)

You tell me — I tell you

Similarly, the current zeitgeist seems to put abstinence and harm reduction in tension, with a split in messages, sources, power, and authority also as described above.

**Abstinence** ⟷ **Harm Reduction**

What to do (person with SUD)

You tell me — I tell you

What to do (other person in the room)

You tell me — I tell you

And in this shift, we eliminate "knowing" and the attachment to knowing (e.g., the mutual sharing of knowing and what is known). For either or both persons (the person with the SUD and the so-called helper), "knowing" will not be stable and will flow. At times, knowing may seem to emerge, to disappear, or a void in knowing may manifest. Regardless, all knowing is viewed with skepticism and held lightly because "knowing" shifts. And in this way, treatment and peer support are split as well, and artificially put in tension.

**Treatment** ⟷ **Peer Support**

As a summary on my disillusionment with "empiricism-plus nothing" I'll say the narrowness of my world view, academic background, priorities of research, and clinical methods started to become apparent to me. Based on that I then also noticed a shift in the zeitgeist that to me was ironic and informative. So, I decided to undertake new learning, but to go about it my way – by giving myself "permission to think". I decided I was so unprepared that I needed to figure out *what* to look for, and *where* to begin to look. I began with *types and locations* of content.

**Part 2: Types & Locations of Latent Content**

Once I determined to pursue learning in the realm of depth psychology, my first major puzzle in determining *what* to study was *where* that content may be found. Where should I look? That is to say, if observable behavior and things people say are not the major focus of interest (and those are virtually all I have ever been familiar with), where would I even look for relevant content?

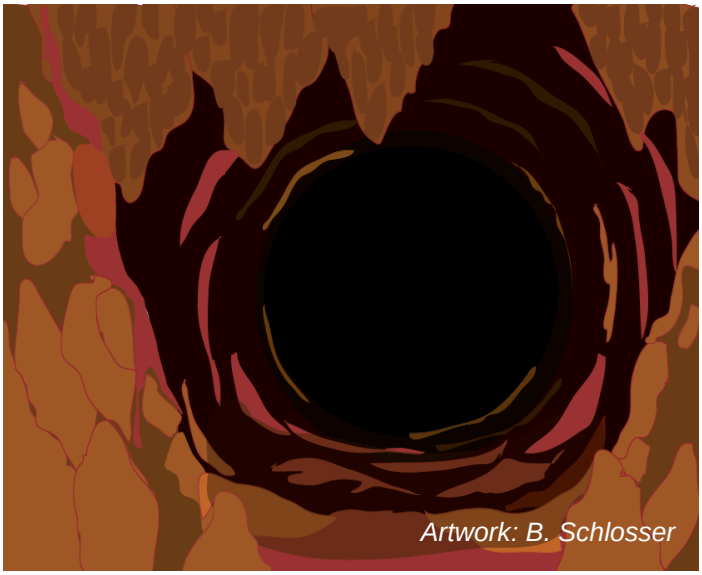
"Look" is an interesting repetition of my assumptions in this inquiry. In radical behaviorism, we are definitely trained to look, to record the sheer reality of what we notice, and to do all of that in the most objective and stark manner available for quantification – plus nothing. That kind of observing and recording is itself a competency and skill, and for most people undergoing academic and clinical training, or in clinical practice, does not come naturally.

So, my first question remains: "What is the *location* of the content of interest?"

Attempting to answer that question was unusually challenging for me, if only due to my stage of development within the (relatively long) length of my career. My development seemed to be in the way. And the strain quickly led to this notion: "If I knew *what* I was looking for, I would know *where to look."* Aside from the repetition of the assumption that the word "look" even applied to this or could be helpful (when it in fact might not), I determined that the "where" and the "what" were in some way separate, and in another way, linked.

So, my second question remains: "What is the *focus* of the content of interest?"

At this juncture I'll mention one of my favorite things to do, and to consider, is exploring the inside of a cave. Spelunkers are a metaphor for me.




I've spent years resisting the impulse to have the 2' x 3' map of the interior of Wind Cave framed and hung on the wall in my office. I'm not precisely sure why I've resisted.

At the time I toured it, we first took an elevator ride about 20 stories below the surface of the earth; the spelunkers backpacked 4 days in before they reached the edge of what they had mapped at that point in their work – then ventured into the unexplored.

*Not knowing* if I was right or wrong in a strict academic sense, I decided to do as the spelunkers do and allow myself to wander the caves of my thinking in order to develop loci and foci.

Unexpectedly, for reasons outside my awareness, the list came very quickly.

The list I made from the material I gathered seemed to be a mix of content and locations, and easily fell into two major groups.

**First Grouping:**

- **Non-observable**. Behaviorism limits itself to what can be observed, so I thought I would flip that and *exclude the observable*. What content cannot be observed? How refreshing! What would I find if I looked for things that can't be observed?
- **Non-discursive**. We learned behavior therapy, cognitive therapy, and various major schools of CBT as well as their particular methods. It was all very rigorous. I decided to flip "talking" as I had with "seeing" the observable. What would I find if I excluded words? What content could be found if discourse was not content, and if non-discursive material was? How refreshing!
- **Pre-symbolized.** I decided to really go for it and eliminated anything that could be represented by the patient. If they could put it into words, I already eliminated that by eliminating the discursive. But what if I went even further and looked for content that had not yet been symbolized in any way? For example, like an idea that was incomplete and hadn't even really formed, yet. I had heard of content being "symbolized" or "represented" in some new reading I had begun, so I decided to go for it and push for the pre-symbolized. What would I find? How refreshing! And I wasn't even really certainly sure what I even meant – which seemed like a good start!
- **Social system locus.** Grasping this was simple, but searching would not be easy. Don't look at the patient. Look at and listen to the social system the patient is within. Extract that material. Hooray! How refreshing!
- **Unconscious locus.** As a behaviorist, I decided I could accept the idea of "unconscious" by my natural starting point of "procedural learning". The classic example is learning to drive a car. The method becomes well established and can be done without conscious effort – and you can hold a conversation instead while you drive. What would I find if I excluded conscious content and extracted unconscious content? In truth, behaviorism is comfortable with this domain as it already eliminates the "mind" and "thought content" and "knowing" and so forth.
- **Multi-generational structures.** The last content area I added was from my own thinking about cultural assumptions within the family system – both the latent and the present or manifest – that are formed by those already departed. Let's become archeologists *of the present* and see what basket of assumptions have been preserved. How refreshing!

But there was a **Second Grouping** too. And it held two items: the 12 Steps, and the 12 Traditions.

I figured that given the primacy of these traditional domains of content across society, clinical awareness, community resources, and many recovering people, I should add the Steps and Traditions in, rather than try to avoid them.

Within the two groupings of foci and loci, I want to discuss two points in particular:

1. the notion of ***multi-generational structures***, and
2. ***the specific way*** that I decided to include the 12 Steps and the 12 Traditions.

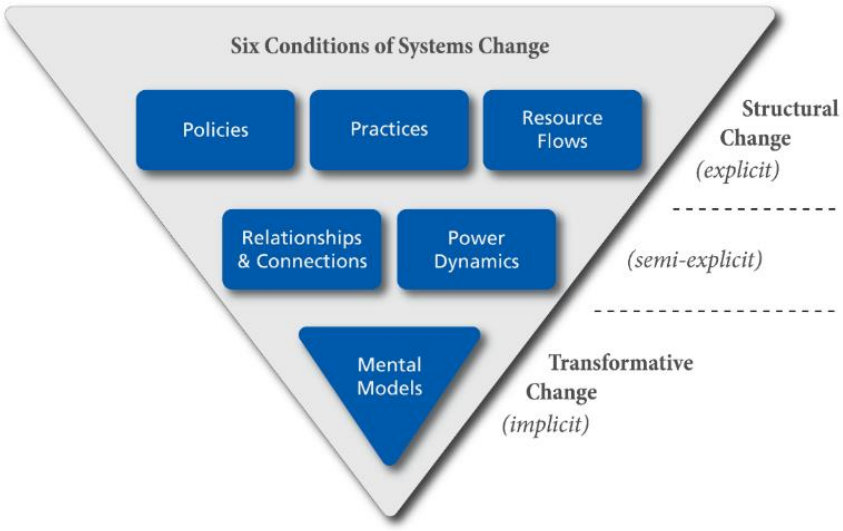
Why should one consider the **latent content** found in multi-generational structures?

Well, nuclear family systems, broader family systems, and local social systems hold:

- assumptions
- beliefs
- knowledge
- mores
- values
- etiquette and
- expectations

These are the implicit basket within which the newborn arrives and develops across the lifespan (eventually choosing some of their own). To me that is reason enough.

I had already been studying methods for guiding change projects being undertaken at the organizational and societal levels. The diagram below was developed to guide such projects (from FSG.org, "The Water of Systems Change").




In their discussion of this model of identification and management of explicit, semi-explicit, and implicit targets of change, the importance of addressing all components of all 3 layers is

emphasized. Structural authority, technical know-how, and resources might all be in place; likewise, power dynamics and the necessary relationships and connections might be available. But if underlying thought forms, assumptions, and related unconscious factors are not addressed, proposed changes at the level of societal structures or institutional structures will be less likely to happen most effectively, efficiently, and be sustained.

It occurred to me that this also applies to the family system within which people are born and raised.

In cognitive psychology, cognitive therapy, and cognitive-behavioral therapy, the phrase "mental models" would not be unwelcome. It could be loosely equated with "cognitive schema" which essentially means something like *thought structures*.

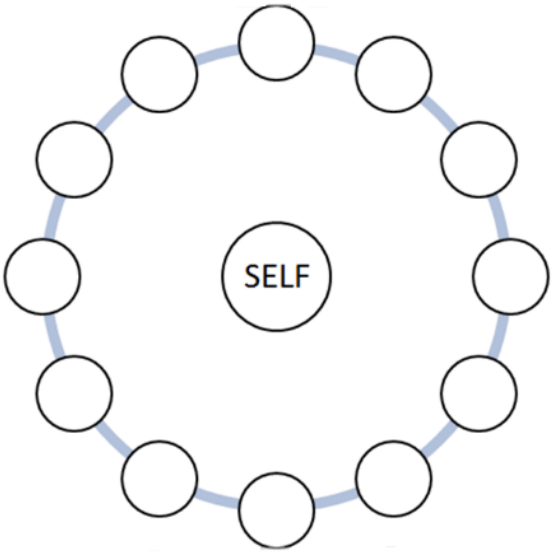
But my attraction to "mental models" had to do with those that are present in the form of unconscious multi-generational assumptions, cultural content below the level of awareness, and other areas of a-priori material too common to be commonly noticed. Unaddressed, or unappreciated, these areas of content might preclude certain opportunities for change or the otherwise beneficial effects of the routine and helpful clinical material one might encounter.

To me, an obvious example of that might be the 12 Steps and the 12 Traditions. They might be too familiar to be helpful. Or too common to be appreciated. Or too present to be recognized.

In the next portion of the work, I'll share a different take on the Steps and Traditions.

**Part 3: The Steps and Traditions Considered Wholistically**

Here, the (typical) ordinal, sequential manner of considering and working the Steps is not set aside. Rather, this represents an additional (added) perspective of the Steps – at the level of their intent – as ***encircling the person.***

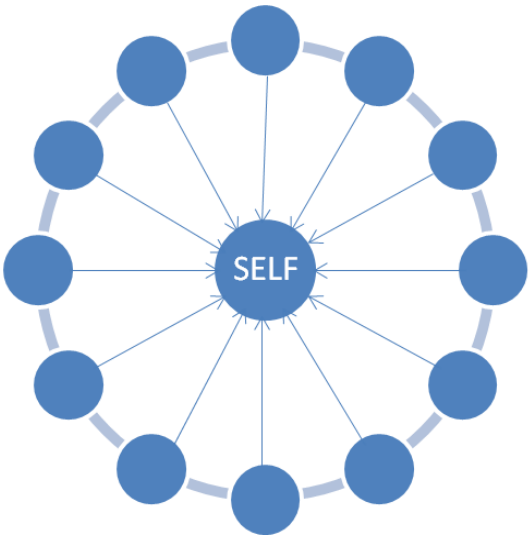



*Adapted from White Bison, Inc. (2002)*

This interesting notion sets up at least two immediate results.

First: that the individual relates to the entire circle of the intent of each Step, and of all Steps, *simultaneously, dynamically, as one supportive whole* from the Steps, *inward, toward the person.*

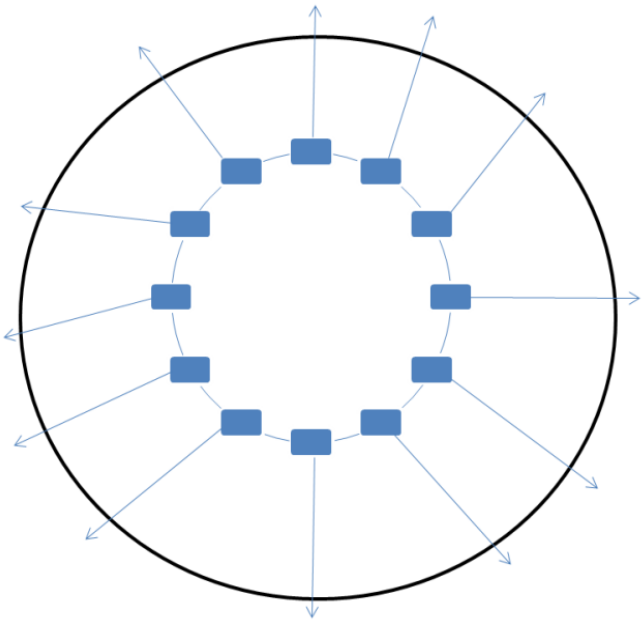
This is a supportive holding space not typically derived from merely considering the Steps in a linear fashion.




*Adapted from White Bison, Inc. (2002)*

Second: that the person may consider life, decisions, etc. *outward toward the world,* from the position and perspective of the traditions they hold *within self* (or at least from the supportive, holding environment of all the Steps), simultaneously. That is, the same circular framework is applied with the Traditions.

However, the Traditions are pictured *within the person* and inform the person's way of relating outwardly, to others and the world.



*Adapted from White Bison, Inc. (2002)*

It did not take long for me to land on the Steps and the Traditions as areas of multi-generational latent content in a family system focused on addiction illness and addiction recovery.

I decided to address the Steps as an entire whole, and the Traditions as an entire whole, rather than address each of the Steps and each of the Traditions separately. I took this approach as it seemed to reflect a whole multi-generational family system with an entire and specific culture.

Thus, considering and practicing the spiritual principles of the Steps and Traditions from *inside a circular framework* conveys a holistically informed:

- tension
- dynamic
- potential
- or resonance

that might be less evident if they were only considered linearly.

**Part 4: Developmental Layers, Compartments of Self**

Overall, concerning ***what*** to look for and ***where*** to look, it had occurred to me to look:

- for what **cannot be directly observed** (easy for me to label, as a mere reversal of what I knew)
- for what **is not bound in language** (another relatively easy mere reversal)
- for what **is pre-symbolized** (chosen after difficult learning I had undertaken)
- at the **location of the social system** (easy to choose, as a reversal from a career of focus on individuals)
- at the **location of the unconscious** (easy to choose, but vast learning would be required)
- at the **location of multi-generational structures** (easy to choose but only after career-long development)

And it had occurred to me to look at the Steps and Traditions (what was already in front of me) and what within a person they seem to point to – the notion that they serve as hints.

Allowing myself to go with my own thinking with regard to this specific content, at this level of freedom, was relatively new.

I realized the very process of allowing myself new, different, and personally innovated thinking, was in some way(s) a parallel to the very *thing* I was looking for (i.e. the "what") – and perhaps from some of the very same *places* (i.e. the "where").

At the time, I chose to simply keep moving along in my development of these ideas and conveniently ignore the "how" – so I wouldn't be bogged down while it escaped me.

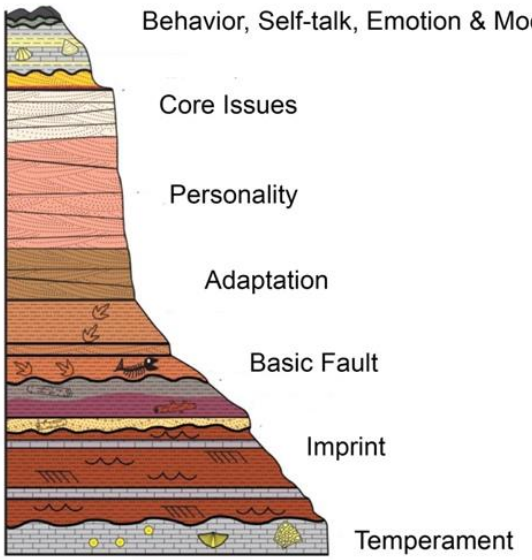
**Developmental layers**

Early on in my process of me allowing myself musing on these topics (at the level of thinking), I decided to look at macro (external) ***structures within*** **communities**, regions of a country, and whole people groups. My willingness probably emanated from my birth in one country, my raising from early childhood until my teenage years in another country, and then moving from that country to another – with that final move including a steep gradient from the very urban to the rural.

What kinds of structures? From life experiences, it seemed to me that assumptions, beliefs, frameworks of understanding the world, and so forth, differ by geographic region (as more obvious aspects of culture do). Further, it seemed to me these aspects of people groups, and the resulting differences, are not new. Rather, these ways of understanding and being in the world are themselves the result of a long lineage of thought content and thought forms – and that those lineages are necessarily specific to physical regions of the world.

I once described this thinking to a colleague in our field. I said it would be very interesting to look back in time at thoughts and beliefs and so forth that are held at the level of people groups, or regions, or communities, and see how they differ. And this would be analogous to how geological strata differ both horizontally (location) and vertically (time). That person summarized that set of notions by simply saying, "Cultural geology", (Budnick, 2018).

After years of meditation, I regressed to form and began with considering a single person. I decided that I could represent the *layers of essential development* of a person over their lifespan in the form of this diagram. I made a list of layers across the lifespan, from the bottom layer closest to DNA and birth, to the top, moving forward in time. Thus, the overt world of mere obvious behavior and speech content (i.e. behaviorism and CBT) stands atop a vast geologic formation and is tiny by comparison.



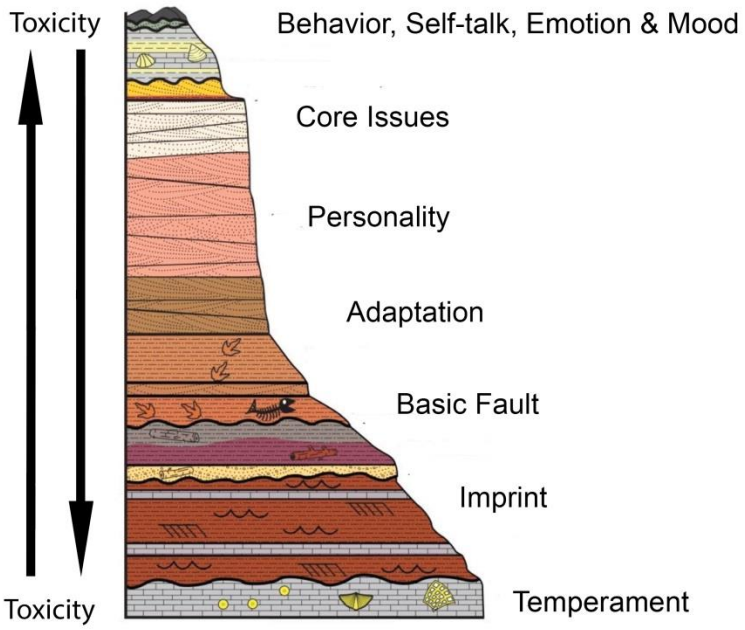

*Artwork: B. Schlosser*

- Temperament is the closest to genetics. For example, shyness is irrespective of introversion and extraversion, and can be reliably identified in neonates just minutes out of the womb.
- Imprint refers to life events from birth to around age 18.
- Adaptations are the more primitive reflex patterns we regularly rely on to avoid or manage pain or stressors – either external or internal. They start showing up early in life and personality formation rests on the preceding adaptations.

Alas, the image is simplified and cannot properly show how some of these layers or their effects are more continuous through time and across developmental stages. For example, our temperament never really leaves us.

Based on my personal and professional experience, I chose to begin with this notion applied to one individual person, and to do so with the notion of "toxicity" as a placeholder for problematic circumstances. Factors I decided loaded to toxicity included: genetic endowment, substance use, family member function, and historical family system dynamics, among others. And I realized poisons could trickle up, or down.

I added a caption of sorts to help hold and convey my thinking.




*Artwork: B. Schlosser*

**Compartments of Self**

My early clinical work in addiction treatment settings brought me initial awareness of common clinical concepts and tools – practical approaches that help clinicians and patients interface. Upon my arrival, clinicians already in the work shared their knowledge and tools with me. In this, my new undertaking of the exploration of less overt content, I recalled the "Johari Window" as it was shown to me early in my career. Given that my academic education in psychology included physiological psychology, sensation and perception, and psychophysics, I was able to readily absorb the notion of some awareness of self ***being beyond our own noticing***. And that this information would more expediently come as delivered to us by others (feedback). Likewise, it was easily acceptable to me that self-disclosure, as I understood it, seemed the primary method a person uses to make their interior information accessible to the clinician.

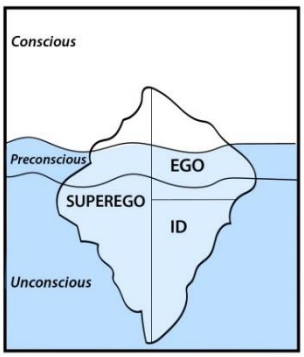
Overall, I found this basic tool helpful, relevant, and a good starting point to identify new loci and foci of material. Here's the Johari Window as it was taught to me early in my career.

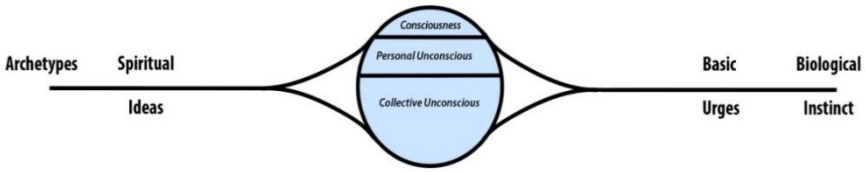
"Self" known to…

| | |
|---|---|
| **self and others** | **self and not others** |
| **others and not self** | neither others nor self |

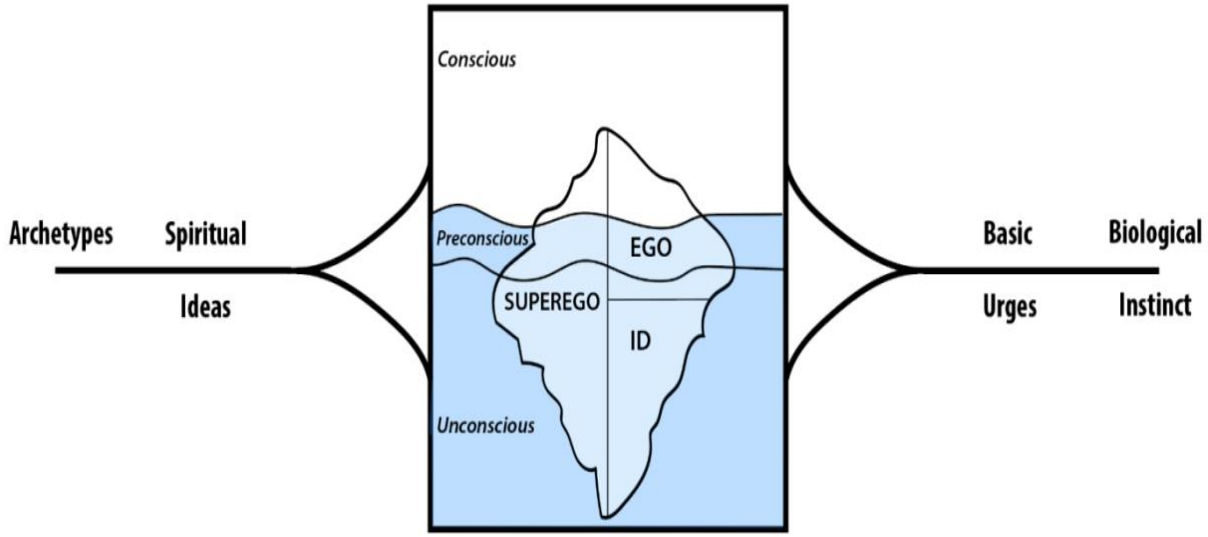
*Adapted from:* Luft, J. & Ingham, H. (1955)

Far less digestible were the classic formulations of the location and content of specific compartments of self in the work of Freud and Jung. I decided to "go with" Freud and Jung as they seemed on the one hand knowledgeable, and on the other hand primitive (not a pejorative in this usage). And more to the point, I decided to force myself to consider their content if only for its historical and foundational importance (lineage and temporal strata of thought content, etc.).
*Artwork: B. Schlosser*



Always a tinkerer, and a compatibilist, I combined them. I did not mean one picture to obliterate the content of the other. I only wanted to show them as simultaneous. I might think of a better way to show that later.




I really connected with Jung's phrase "collective unconscious" in my simple way of understanding it. I saw that as an alternative term for my idea about multi-generational assumptions. It was a nice way of putting it, as it seemed to me. I also really appreciated Jung's horizontal aspects – spiritual ideas extending beyond us and finally out to the archetypes. And similarly, basic urges on a line extending out toward biological instincts.

I didn't study Jung in these areas. Rather, I let myself meditate on these basic notions whenever it seemed fruitful to do so, and did so over months and years.

I ended up really liking the idea (accurate or not) that the outward edges of these horizontal domains extend outward into the fog of unawareness, on a gray-scaled continuum. That kind of considering also helped me let down some empirical armor and consider new things in new ways.

During my ongoing meditations, I would at times often return to the topic of the Steps and the Traditions in a general and basic way. What are they? Why do they fit? How do they fit? Why do they still exist in contemporary society? What use are they – and why?

I had an interesting notion about the Steps and Traditions come to me during those meditations. I'll present it in the next portion of the work. But be ready for something quite different. And I of course have no clue or concern if what I will say about them has any validity or relevance at all. It's just me showing the reader my thinking, that resulted from me giving myself permission to think about these things.

**Part 5: Internalizing and Externalizing Dimensions**

I figured our field needed a *unified field theory*. That is, a theory that would be central, and unify us.

While attempting the basic chore of considering and attempting to identify material that is non-observable, non-discursive, pre-symbolized, within a social system locus, within an unconscious locus, and nested in multi-generational structures, it occurred to me that the 12 Steps and the 12 Traditions of Alcoholics Anonymous might be a fit and worth exploring.

"Why is that?" one might ask. My answer may be unexpected.

Some explanation of my background is necessary at this juncture. After my graduate internship, my next 19 years I spent serving within a residential Therapeutic Community program (9-12 month stay) that had a methadone maintenance program essentially in the front foyer and first few offices of that residential building. Neither of those treatment models derive from a 12 Step recovery tradition or 12 Step facilitation therapeutic model. Although both programs in some small ways evidenced a familiarity and rough congruence with recovery and methods as defined and practiced through those models, patient involvement in 12 Step recovery communities was optional – and most patients chose other recovery communities and pathways.

Upon arrival in my current workplace, however, the third decade of my career took place within a program strongly rooted in 12 Step recovery. Only in that third decade of my career did I begin to deeply study and meditate on the targets, methods, and mechanisms of change present in 12 Step recovery processes and 12 Step facilitation as a clinical practice*. And more recently, ***turning my attention to considerations of the non-overt***, the following realization struck me quite clearly:

> *"The Steps and Traditions can apply to any person with addiction illness. Thus, if they are helpful to any such person, it is not because they are specifically built for people with severe substance problems particularly or exclusively, but rather that they must apply at least in part to the interior of <u>any person</u>, as any person is eligible to one day need them."*

Or, as I stated it to workplace colleagues:

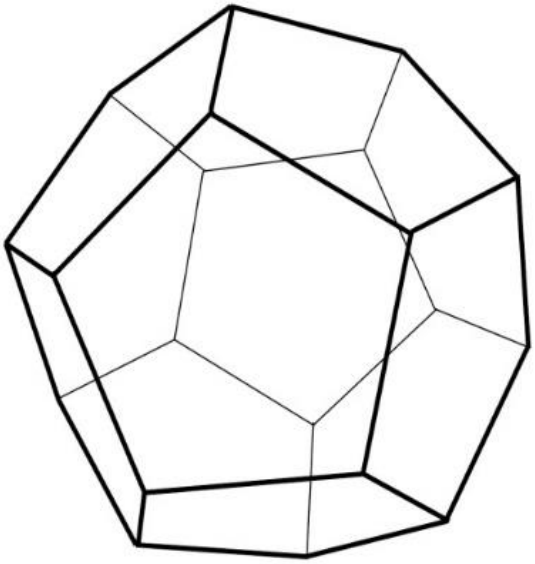
> *"Bill and Bob must have figured out a personality theory. Or they reverse engineered one, by developing the Steps and Traditions. Given that the Steps and Traditions are potentially helpful to anyone with addiction illness, they must point to universal aspects of the interior of all people."*

Next, I decided that the ***Steps pertain to internalizing dimensions*** of a person, and the ***Traditions apply to externalizing dimensions***.

I decided to use the commonly held spiritual principles of the Steps under the assumption that if the Steps of AA are helpful, it is because they have (perhaps inadvertently) identified ***12 aspects of what comprises a person.*** That is, the Steps can be considered the entrance to an *a-posteriori* personality theory. It should be noted at this point that colloquial wisdom of long-time AA

attendees includes that the Steps "help a person not commit suicide" – that is, self-destruct. Thus, this list of the 12 factors found in **the Steps illuminate *one's relation to self.***

The image that came to mind was a 12-sided gem, with each facet representing one of the 12 interior aspects of a person.



*Artwork: B. Schlosser*

I took the liberty of:

- re-working the **related principles**, separately
- by **giving them new identifiers**
- and also **developed a range for each** separately, using various approaches – including unipolar or bipolar spectra.

Even if an empiricist argued this has no "validity", I found the execution very freeing and affirming.

Next is a display of those results.

It's a table of the **internalizing dimensions.** Each dimension is listed separately. And each dimension has a few accompanying words that outline its own descriptive range.

| Internalizing Dimensions of Personality | | | |
|---|---|---|---|
| **PERSONALITY FACET** | **RANGE** | **PERSONALITY FACET** | **RANGE** |
| **Reality** | Denial; Reality with blind spots; Conscious malingering | **Asking for help** | La Belle indiffe'rence; Accessing resources; Hypochondriasis/ the sick role/ secondary gain |
| **Hope** | Despair; Self-efficacy; Grandiosity | **Empathy** | Others as objects; Others as subjects; Diffusion of selfobject |
| **Trust** | Self as solution; Partnership; Other as solution | **Amends** | Developmentally dependent; Restoration; Existential guilt |
| **Pain** | Conversion reaction; Self-examination; Conscious or unconscious thanatos | **Self-monitoring** | Desymbolization; Incipient symbolization; Insight |
| **Internal Inconsistency** | "Self" vis-à-vis: "Self"; "Others"; "The world" | **Mindful connection** | Distracted; Grounded; Conscious connection; Obsessive |
| **Willingness** | Self-will; Surrender; Impulsivity | **Altruism** | Self as The Entity; Transactional mutuality; Principled service |

Externalizing Dimensions

I repeated the procedure with the Traditions and the idea of externalizing dimensions within each person.

Those I listed are the spiritual principles of the Traditions as identified by Overeaters Anonymous.

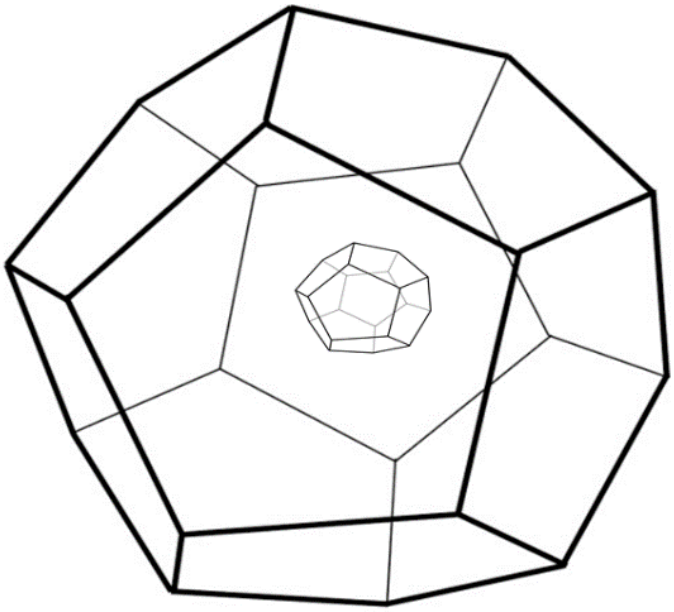
One should note that the colloquial wisdom of AA attendees is that the Traditions "help a person not commit homicide" – that is, to not destroy others. Thus, the 12 externalizing factors ***illuminate one's relation to others and the world.***

**Externalizing Dimensions of Personality**

| PERSONALITY FACET | RANGE | PERSONALITY FACET | RANGE |
|---|---|---|---|
| **Unity** | Aloof;<br>Martyr;<br>Hero;<br>Helper | **Responsibility** | Self-supporting;<br>Parasitic;<br>Parasitic host |
| **Control** | Authoritarian;<br>Transactional – toward goal;<br>Transactional – releases goal;<br>Dereliction | **Fellowship** | Professionalized;<br>Indigenous |
| **Identity** | Exclusivity;<br>Inclusivity;<br>Common factor(s) | **Structure** | Synthetic context;<br>Organic context |
| **Autonomy** | Immature indecisiveness;<br>Mature autonomy;<br>Disregard of system | **Neutrality** | Open;<br>Agnostic/skeptical;<br>Opinionated;<br>Closed;<br>Seeks controversy |
| **Purpose** | Constancy;<br>Variability;<br>Escape as status | **Anonymity** | Seeks renown;<br>Seeks public notice |
| **Solidarity** | For sale;<br>For auction;<br>For barter;<br>Not entangled | **Spirituality** | Driven by principle;<br>Driven by person(s) |

The 12 Traditions (the principles of relating to others and the world) complete the picture of what factors comprise a person: *24 factors in all.*

Here is the resulting completed image: 12 internalizing dimensions nested within 12 externalizing dimensions.



What I wanted to picture I ultimately chose not to, because it would be too visually messy. What I really had in mind were directional arrows emanating from each side of each object.

The arrows from the outermost set of facets would point outward to the open space beyond the diagram, going out from each facet. That would symbolize the externalizing of those dimensions, and the arrows themselves would begin to connote the respective range of presentation for each (quality, amplitude, distance, etc.).

However, the arrows beginning at the facets of the inner-most gem would be pointed inward toward the center of the innermost gem. That would visually represent those internalizing dimensions of self. These aspects would express themselves inwardly toward the person (and thus be far less observable, or not directly observable at all). Those features would be expressed inwardly for the most part, rather than outwardly.

It was quite different for me to allow myself such freedom of expression in formulating a theory of my own and representing it in a way that was natural to me (and yet without much regard for how it might seem to others).

I let myself be relatively less concerned about it being "true" from a factor-analysis standpoint, confined by psychometrics, etc., and simply aimed at reflecting my thinking as it is.

I wish our field was unified. One way to bring that about is to **give our regard *to the person*, rather than ourselves.** Our disparate theories can unify us; forced agreement can divide.

And it is to the topic of the person we serve that I now turn with a specific look at the change process.

**Part 6: The Change Process**

**During several years of self-study*** concerning abstinence-oriented recovery from addiction illness, 12 step facilitation as a clinical practice, the mechanisms of change in 12 step recovery (both the treated population, and the untreated population), and the history and development of the concept of addiction recovery as it applies to clinical therapy and related research, I came across some very interesting notions about how people change. These notions were not of the kind I was accustomed to considering, given my academic preparation in radical behaviorism, learning models of addiction (e.g. based on Pavlovian conditioning), behavior modification methods (e.g. controlled drinking), and my clinical experience in evidence-based modalities.

How did this material differ?

Overall, this academic and clinical research literature I studied more recently focused on **themes** and **patterns** of change, **dynamic change** processes, **synergistic** processes, **tension-release** within a person and in their interactions with society over the course of change, and **critical thresholds** evoking change processes and movement.

Literature of such an academic nature pointed at ***phenomenological*** and ***experiential content*** was well outside any familiarity to me.

One factor identified as critical in the change process was **extrication from** addiction illness and the related lifestyle. This was natural for me based on my clinical experience and fit my emerging notions of personal and cultural geology; to be extricated from the rubble of the past made sense to me. Similarly, **accommodation of the new** was central in the change literature, and this was natural for me to consider given my familiarity with cognitive schema. **I took the liberty of adding "shedding"** to this model, hinting at the work of releasing and renouncing, especially over life seasons and layers.

Further, I was introduced to some articles related to the general idea of the therapeutic ***environment*** later in my career, and they hit me particularly hard – in a good way. So, I developed an idea of *a very particular kind* of clinical environment. That sub-portion of my journey now follows. And the content might surprise you as you continue to follow along.

One article (Bion, 1967) discussed specific aspects of **clinician memory and desire**. The article described how a clinician could endeavor to have no memory of the patient or past sessions with the patient, *intrude* into the current moment. And it also described how the clinician could endeavor to have no clinically-imposed desire for the patient's future *over-ride* the current moment.

"No memory" of the patient was hard for me to accept. But the idea in the article was for the clinician to ask themselves if they are meeting <u>with the person</u>, or merely with their <u>memory</u> of the person? The point of the challenge was to direct one's attention wholly to the person that is with the counselor *in the now*, rather than the remembered version of the same person as they were in previous meetings. That kind of push for deep empathic attunement held a lot of appeal for me.

I quickly added one more feature of the clinical space I was building: **"no time".** That might sound strange. I'll put it like this: since starting clinical work in 1988 I have never had a clock in my office. Why is that? When the patient sits down, I endeavor for time and the keeping track of time to go away. (Admittedly, working in residential settings my whole career and long-term residential for 19 of those years fed that freedom).

I also wanted **"no question asking"** to be included. During the Behavioral Health Recovery Management (BHRM) project our leadership team decided that the Achilles' Heel of addiction counseling is the over-reliance on asking questions. Across our entire agency at that time, we endeavored to mindfully eliminate as much question asking as possible, even while conducting assessments and assessment interviews. Thus, in my thinking about clinical environment, **"no question answering"** would also be a natural stretch-goal, in keeping with basic person-centered and motivational-enhancement methods (removal of authority, etc.).

Lastly, given my other recent reading in philosophy, I decided **demands in science, philosophical assumptions, and forced applications of clinical art** were all subject to "go away".

While considering these things, I decided that the base of the change process, in terms of function within clinical settings, was the **"analytic stance."** Both the term itself and the concept has intrigued me since I first heard it a few years ago.

I was challenged to replace "analytic stance" as the base with the therapeutic "common factors" as they are called in clinical parlance. I purposefully declined. I declined because when I was asked to do so, I realized that I had *already decided* that the clinical common factors are not the base – and had unconsciously made this intentional. That decision had been made before I realized I had made it.

But why? Warmth, attunement, pacing and other behaviors that can be reliably observed and scored by trained 3rd party (rating) clinicians can be *feigned while fidelity is met.* From my years of a relatively rigid fidelity-based past, I knew that all too well.

Thus, the phrase "analytic stance" is preferred, at least for me, as it holds the interior (less observable) and exterior (more observable) aspects of the whole person of the therapist – with more teleological validity. **I built my own model of the analytic stance by adding 6 further items** to Bion's injunctions of "no memory" and "no desire" in the clinician.

I found Bion's article so unprecedented and refreshing I wanted to share some of my raw notes here, to perhaps refresh and inspire the reader.

<u>General notes while reading Bion (1967):</u>

- Memory is misleading – it is distorted by unconscious forces.
- Desires interfere when *observation* is essential, including upon the operation of *judgment,* through *selection* and *suppression* of material.
- If you are enacting recall of the patient, you are not meeting with the *current* person.

- In a session evolution happens; "out of the darkness and formlessness something evolves".
- As memory and desire are abandoned, anxiety will rise in the therapist.
- Progress is measured by number and variety of moods in a session; less clogging and the tempo within sessions will quicken.
- Sessions must have no history and no future.
- Move away from memory (of the patient e.g. from past session). Shall we meet with the person as they are now, or with our memory of them?
- Move away from desire (for the patient's future). Shall we meet with the person as they are now, or with our projected hopes for them?
- What is known by *both* patient and therapist is obsolete. What is known by only one - a defense is operating.
- Move away from the notion that one has seen the patient before.
- Move away from interpretations from generalized theories, and toward the power of one's developing intuition.
- Focus on the present.
- Remember that sensuous aspects of presenting symptoms are a hindrance to counselor intuition.
- In any given session, only the unknown is important.
- *Resist* memory in proportion of the impulse *to* remember.
- Desires for results, cure, or understanding must not proliferate.
- Interior of the clinician takes on the nature of the analytic stance.
- Clinician empties self as both a precondition and procedural process during a session.

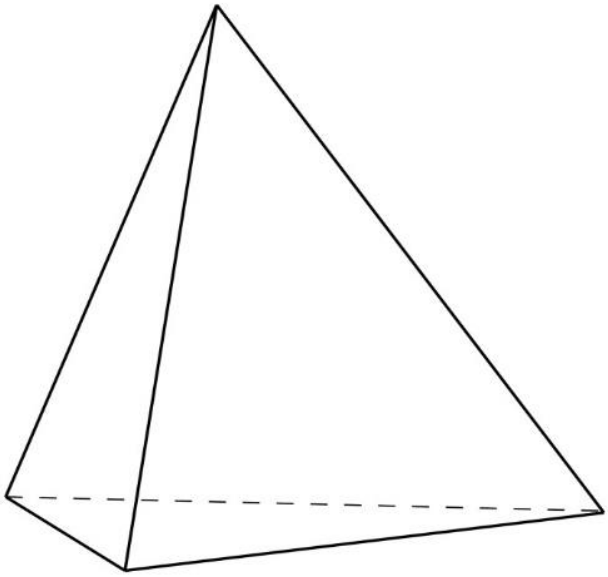
I decided that the person in their change process could be represented by a four-sided gem (a pyramid). The three sides of the pyramid would represent the change process (moving as one, or dynamically enacted in the moment, and non-linear; Resnicow & Page, 2008). And the bottom of the pyramid represents all the elements of my version of the analytic stance.

**3 sides** (*Adapted from:* Jorquez, 1983)

- Extrication (from)
- Shedding (the old)
- Accommodation (the new)

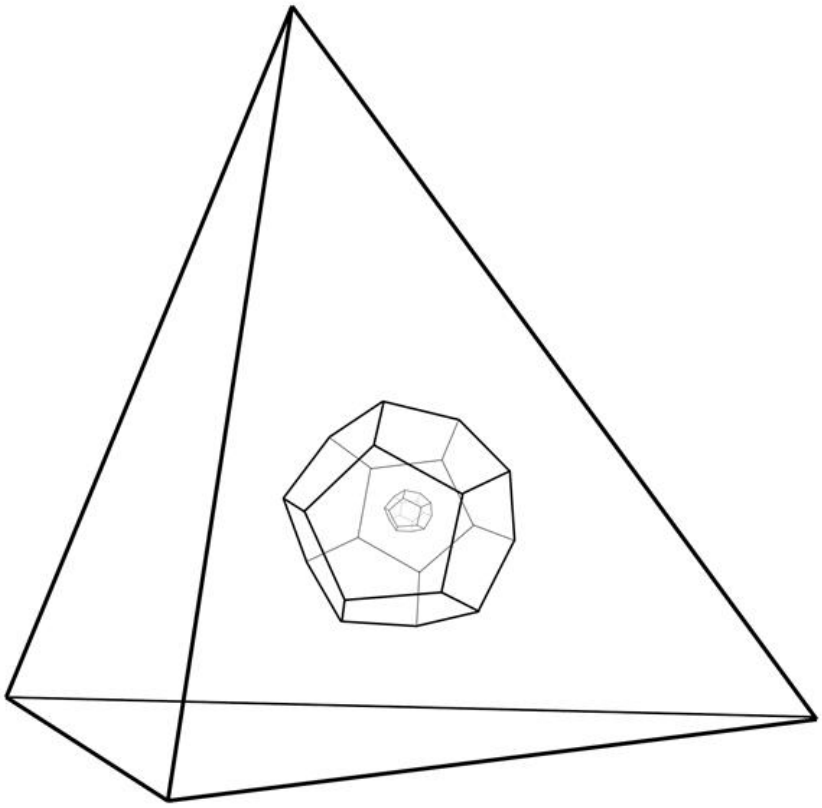
**with the analytic stance as the base** (*Adapted from:* Bion, 1967)

- No time
- No art
- No science
- No philosophy
- No question asking
- No question answering
- No memory
- No desire



*Artwork: B. Schlosser*

It was natural for me, then, to place the completed image of the 12 internalizing dimensions nested within the 12 externalizing dimensions, ***inside*** the 4-sided figure that pictures the change process and its base.



As for the change process itself, I considered the following:
Clinical addiction professionals are trained in sequential change (Stages of Change, 12 Steps, etc.) rather than continuously wholistic, organic, and dynamic change processes.

- ***Should we always assume and work within a staged approach?***

Clinical addiction professionals are trained in symptom reduction (drug use, craving management, managing triggers, drug refusal, harm reduction, etc.) and personal goal attainment (obtaining housing, gaining employment, entering school, addiction hospice, etc.).

- ***Should we only work in logical steps toward attainment of concrete goals?***

Clinical addiction professionals are trained in interviewing strategies that are targeted to bring about clinically-derived outcomes, goals, and changes.

- ***Should we overly-rely on questions, reflections, and paraphrasing meant to bring about changes chosen by the counselor?***

From over three decades of my clinical observations here are two resulting conclusions:

1. People often do not change in a linear or predictably-ordered fashion.
2. People often do the work of multiple sub-processes of change like extrication, accommodation, and shedding *simultaneously*, over long periods of time.

***Could it be helpful to adopt a holistically-centered method with some individuals***, rather than a method centered within fixed stages, concrete steps, and questions moving toward the counselor's goals? I envisioned an analog of such a method and wrote about how it could apply to our work (Coon, 2022).

From that point I started to read in the clinical-applied literature about the content, nature and process of analytic therapy. I was surprised to find some content that seemed generally congruent with my background in cognitive-behavioral therapy.

In the next portion of this work, I'll begin by introducing some content from a psychoanalyst trained in the Jungian tradition: James Hollis. I had the opportunity to hear Dr. Hollis present a lecture in-person several years ago. It was one of the most breathtaking, most memorable, and helpful continuing education presentations I've ever heard.

What follows are some content areas from one of his books I've read. His handling of clinical content in that material leapt off the page at me, and I incorporated it into my learning and meditation process related to depth psychology. Eventually, I harvested a much larger amount of his material for a variety of purposes.

**Part 7: Errors in Cognition and Meta-Cognition**

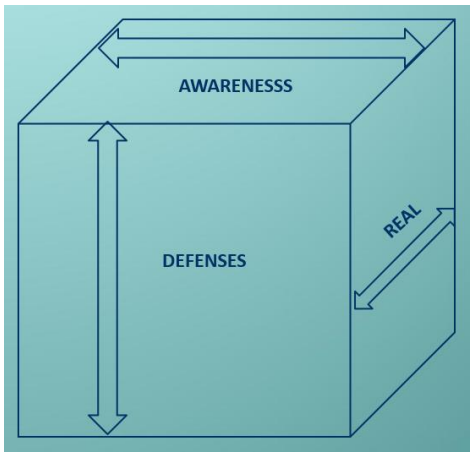
The Primitive

"When the primitive thinks he literally has visions, whose reality is so great that he constantly mistakes the psychic for the real." (Hollis, 2013, pg. xiii).

To help me grasp this in a clear-cut way, I regressed to form from my education and built the following 2x2 matrix.

| | **Stimulus** | **Response** |
|---|---|---|
| **The Primitive** | Thinks | Visions |
| | Psychic Material | Is Real |

Another part of my response to reading that sentence was to draw the image it evoked (I tend to be a visual thinker, rather than a semantic one).




The Modern

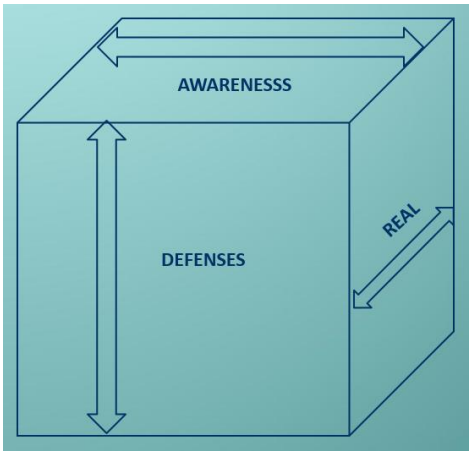
Next, I applied the principle of the above grammatical construction, for the purpose of a thought experiment examining the *modern person*. I used the language arts device called "copy and compose", replaced key words with ideas of my own, and produced the following:

"When the modern perceives, he has thoughts, whose reality is so great that he constantly mistakes the thoughts for the real."

| | **Stimulus** | **Response** |
|---|---|---|
| **The Modern** | Perceives | Thoughts |
| | Thought Content | Is Real |

*Adapted from:* Hollis, J. (2013).

Sticking to form, I considered that sentence in the context of this formation.




It occurred to me that the person sits within this 3-dimensional space relative to: their defense function; life history, fund of information and mental status (awareness); and the real.

**Defense** function is pictured on the vertical axis as that axis connotes maturity of defense, historical layers of collective and personal material, and related degree of difficulty in extrication from the past. **Awareness** is pictured on the horizontal axis to connote breadth of life experience and range of operation of the sensorium. Reality testing and related capacities are pictured as distance toward or from the **Real.**

Among other devices I'm employing in this portion of my writing is the fact that I'm leaving it ambiguous if "primitive" and "modern" are referring to the patient or the therapist. And if either primitive or modern are preferred, and when, and why. A stretch consideration would be to apply "primitive" and "modern" in his formulation to "the third" of the relationship, rather than either or both of the two people present.

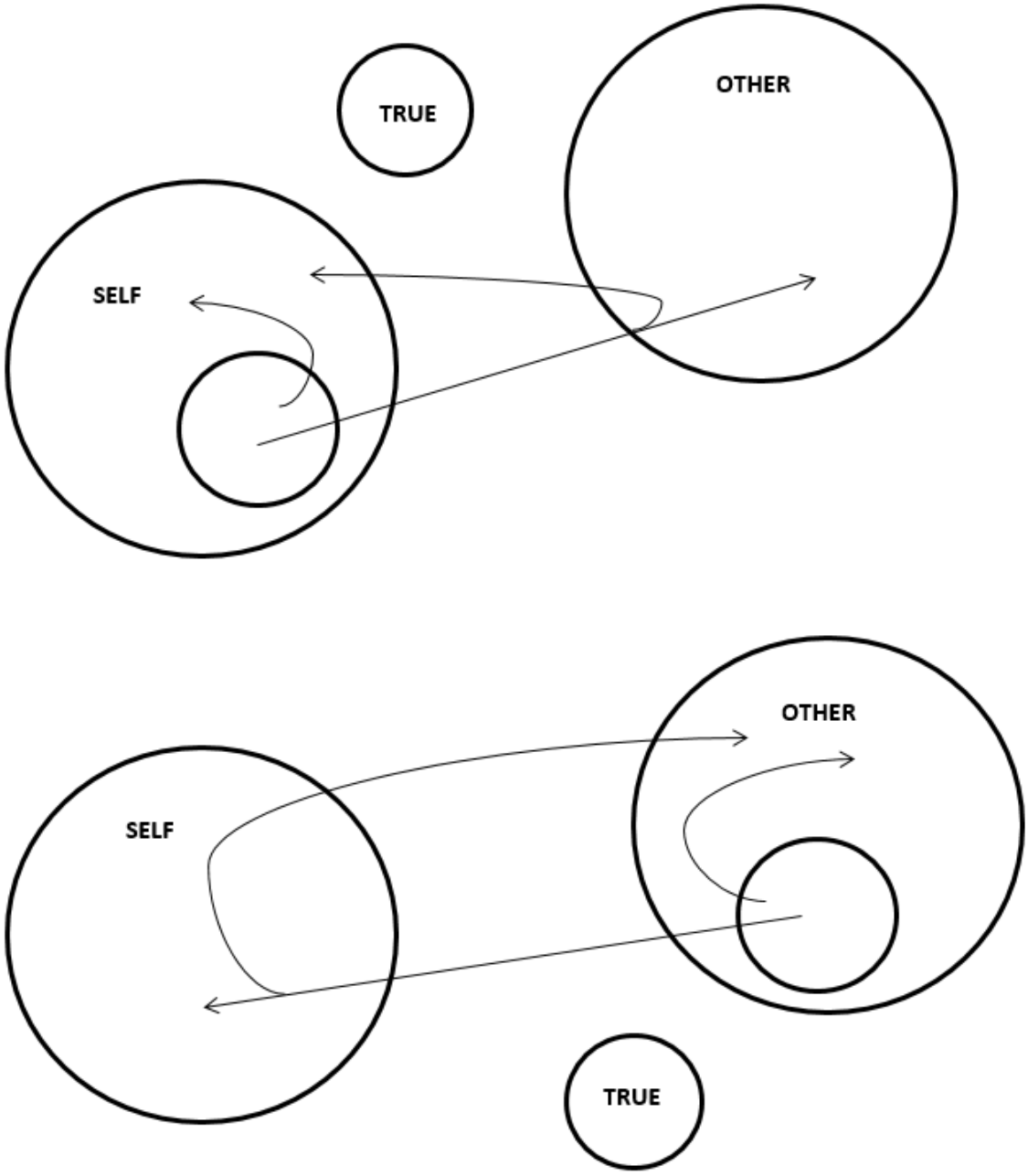
Additional reading in the psychoanalytic literature and the literature of philosophy led me to find these key notions.

> According to the patient, what in the counselor is skewing the view of the patient (Kohut)? According to the counselor, what in the counselor is skewing the view of the patient (Kohut)? What "selfobjects" of the counselor are in the session (Kohut)? If you want to understand someone examine what they are saying about their identity, personality, world view, and values through the signs they choose (Baudrillard). If you want to understand someone see their life as alone on a freeway while the world passes them by on a screen (Baudrillard).

So, it struck me while reading Hollis that a person communicates with another, and in so doing notices their own communication, while holding the truth that they know. And that the other person with whom they are communicating does the same.

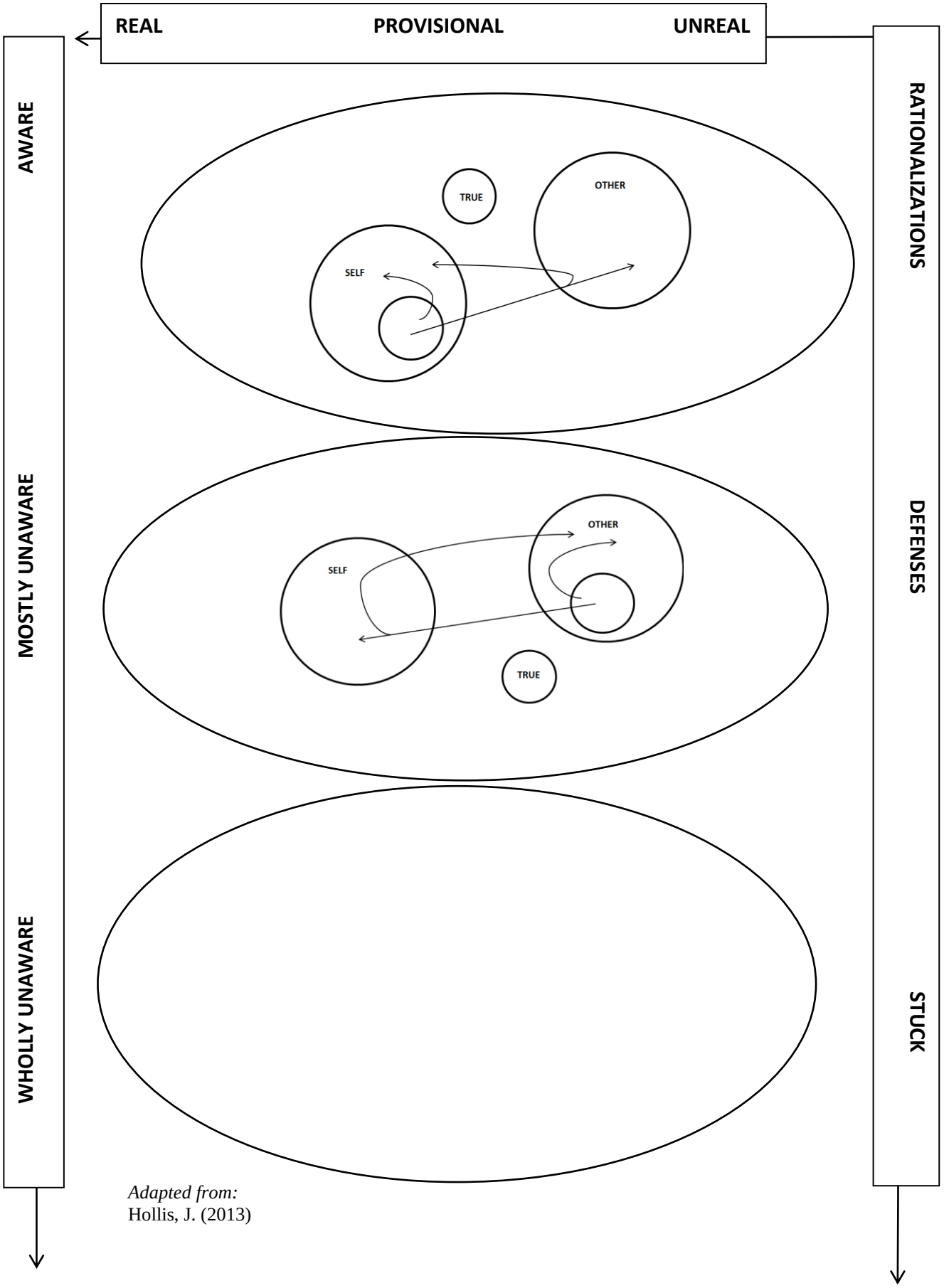
It further struck me that very process happens in a rather lightning fast way as humans interact, and does so within a shifting location of/for each person in that 3-D space of awareness, defense,

and reality. And of course, to help myself learn, I turned my thoughts about this into an image. This time the thoughts arrived as mere notions and were not in words, or in an image. Here are the two people during the therapeutic moment.




*Adapted from:* Hollis, J. (2013)

And true to form, in my typical way, I then nested that diagram within the 3-D context I had built to represent awareness, defenses, and the real. The diagram that resulted is pictured next.




*Adapted from:*
Hollis, J. (2013)

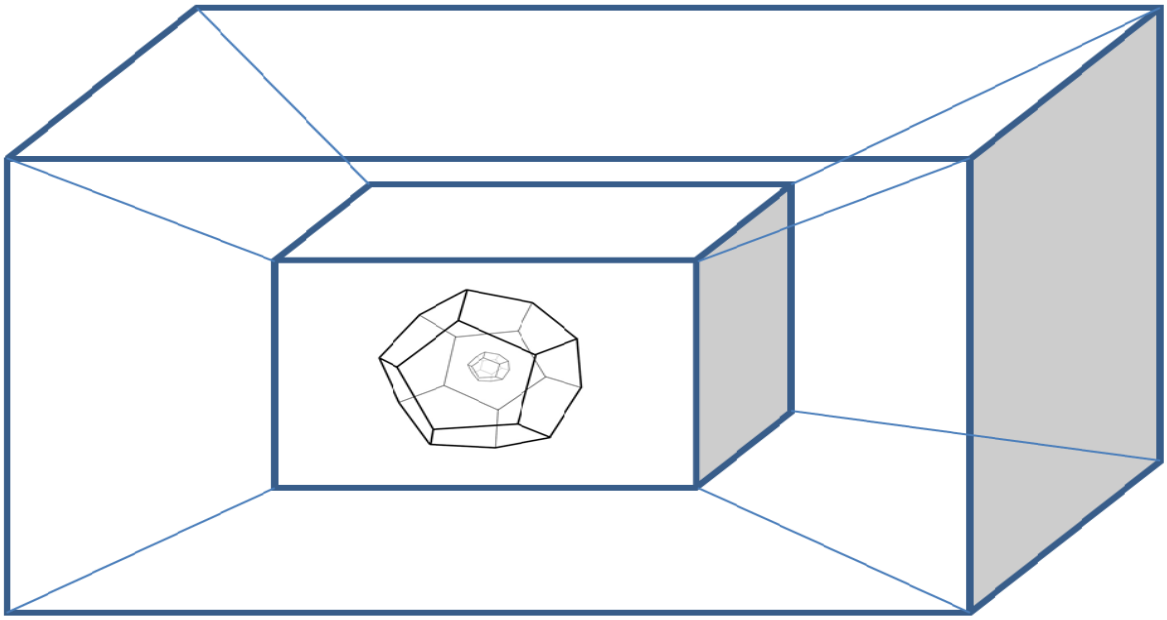
Notice my adaptation of the 3 functions of “awareness” and “defenses” and the “real”. They are the contextual frame within which these relations are defined and occur.

Next, I then aggregated the (1) internalizing dimensions, (2) externalizing dimensions, and (3) those 3 functions related to self and to others/the world – toward building a personality theory that could pertain to addiction illness.

**Part 8: Personality & Addiction Illness**

The *person* is represented by the *entirety of:*

1. The **interior-most** 12-sided object (facets of personality function pertaining to one's relation to self), within…
2. The **outer-most** 12 sided object (facets of personality function pertaining to one's relationship to others), within…
3. The **interior-most cube**, representing the location in 3 coordinates of one's relationship to *awareness, defense function and reality* (as it pertains to one's relation to self, or internalizing characteristics), within…
4. The **exterior-most cube**, representing the resulting location in the same 3 coordinates of one's relationship to others and the world (externalizing characteristics).



It occurred to me that abnormal psychology has lacked "substance-induced personality disorder" as a nosological entity. And that this entity is present in some persons presenting for addiction treatment. And that when present, it is in some patients the center of their case conceptualization. That is to say, it functions centrally toward understanding and addressing long-standing alternating patterns of progress and regress, or remission and return to active symptoms.

*Adapted from Hollis (2013)* I now present some topics and questions that survey non-diagnostic characteristics of the person, as a person. I found reading his material and assembling this list rather refreshing (qualitative and subjective aspects, vs only objectively measurable ones).

- What emotion schemas are present in the person as screens, lenses, and containers of emotion?
- What powerlessness is important?

- What does "mother" mean?
- What does "father" mean?
- How was the father fathered?

- How was the mother mothered?

- Gaining permission to be oneself is the implicit task (vs enacting the impulses of those that imprinted us).

- What is the *"detritus of actual experience"?*

What *weltbild* is the person from (structure, moral order, normative choices for rules and their consequences) – what spiritual and psychological latitude and longitude?

How does the person find true north? Know you have an inner compass and know its access. Learn to trust and converse with it. Know it goes with you as you travel. How do you plan to consult it more often in the future?

<u>Cosmology, ecology, sociology, and psychology</u>

- Why are we here, in service to what, toward what end? (cosmology)

- How are we as animals with spirit to live in harmony with natural environment? (ecology)

- Who are my people, what is my duty to others, and what are the rights, duties, expectations, and privileges of my tribe? (sociology)

- Who am I, how am I different, and what is my life about, and how am I to find way through life? (psychology)

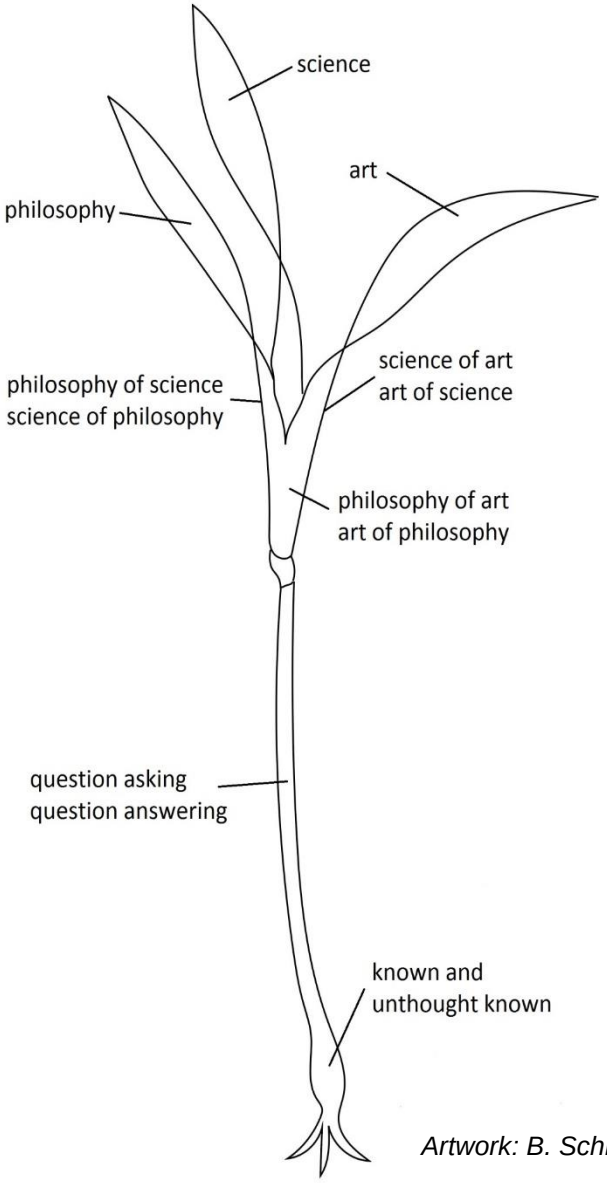
What "god" has been neglected or offended, as identified by the neurotic symptom?

What does your psyche know that shows up as symptoms or support?

**Part 9: A Model of Personhood**

I asked myself how these internalizing and externalizing aspects of self could be coalesced into a simple and coherent model of personhood at a fundamental level – one that focuses on the components, compartments, functions, and expressions of self that are common to human experience?

To begin to move toward a resolution of that challenge, consider the following diagram that is meant to show what a person is.




*Artwork: B. Schlosser*

Overall, it seems as if people can't help thinking, can't help but to think, and can barely help their thinking. And yet, *thinking, while being so prevalent and well known, seemingly escapes our grasp* – even with regard to its purpose at the fundamental level.

One resolution of the purpose of thinking is the assertion that it is an expedient toward *question asking and question answering*.

The same could be said for the purpose of *the endeavor of science* (the scientific method). If it's not going too far, one could certainly argue that the same is *the purpose of philosophy* (asking and answering questions). Though not unprecedented or new, *art* (in virtually all its forms) can be thought of as either asking questions, or answering them, or at least evoking either or both indirectly (if not directly).

Of course, this raises the basic notion that these three disciplines can be combined or separated; one informing the other, framing the other, contextualizing the other – or true blends (meta-disciplines, etc.).

The term "un-thought known" (Bollas) is not a new notion as the placeholder name label for the unconscious. In my particular thinking I mean that term to at least include:

- assumptions (ideas ***before*** the idea)
- *a-priori* conclusions (ideas ***after*** the idea)
- and the collective unconscious (ideas ***informing and surrounding*** the idea)

I also mean for the "un-thought known" to be the container of more usual content domains such as:

- ***procedural learning*** that has been relatively mastered and relegated to outside conscious thought
- ***somatic memory stores*** and their ***attached semantic network***
- ***Pavlovian linkages*** and their ***attached semantic network***
- ***sensory inputs below the limen*** *(the limit or threshold)* of noticing

Sometimes the thinking of others seems to have been worked out – and we seem to notice their worked-out thoughts within their efforts (as we experience them) in philosophy, science, or art. If so, that thought content enters our awareness and trickles down into us to partially inform our own question asking and question answering. And ultimately, our own thoughts, and un-thought-known.

This much I was relatively familiar with on some level, given my background in academic study of human cognition. However, a workplace colleague later in my travels one day made a simple statement that affected me profoundly. That person, while describing a clinical instance, calmly and freely stated, concerning some person's experiencing of a life event, that, *"…it hit their unconscious."*

What? Excuse me? What did you say? Did you say that something struck the person directly at the level of their unconscious?

"Yes," was the simple reply.

For me this was unprecedented. Sensation first? Yes. Perception second? Yes. But a direct input or port of entry at the level of the unconscious – or something like that? To clarify I asked

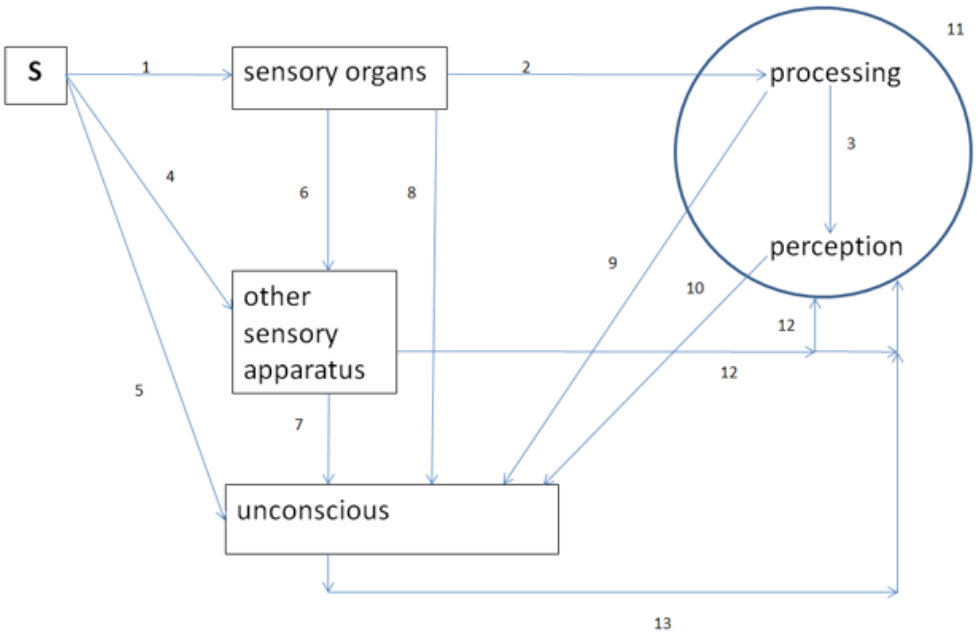
if they meant to describe the by-passing of sensation and perception at a strict structural and functional level, and replace that with the notion of stimuli simply “hitting the unconscious.” The “Yes” answer was simple and clear. Wow.

I immediately began to image the implications of that claim. And for a challenge that weighty, I regressed to form and built a logic model. To give that logic model a look, turn the page.

**Part 10: Material hitting the unconscious**

I attempted to build a logic model that was rational concerning the notion that raw experiential data could "hit the unconscious". This was a freeing yet difficult exercise for me. It helped me gain access to additional unprecedented areas of my considering. It seemed as if those areas were there, but given the narrowness of my education I just hadn't accessed them. I'm content to be uncertain about the "validity" of this model, and that I'm perhaps going to modify it, abandon it, or build a total replacement version in the future. See what you think.

**Material Hitting the Unconscious**




1. External sensory stimuli hit the sensory organs (eyes, ears, etc.).
2. Sensory organs send signals to sensory processing centers.
3. Sensory processing centers yield perception(s).
4. Meanwhile external sensory stimuli also directly hit other sensory apparatus (structures) that are not commonly considered. Likewise, other sensory stimuli also exist, such as internal stimuli related to inner ear mechanisms of the experience of physical position and balance.
5. And meanwhile external sensory stimuli also directly hit the unconscious.
6. Sensory organs may send signals to other (not commonly considered) sensory structures.
7. And that signal may also hit the unconscious.
8. Sensory organs themselves also have outputs that hit the unconscious directly.
9. The process and content of processing raw sensory data also hits the unconscious.
10. Once formed, the perception itself hits the unconscious.
11. This clarifies the "conscious mind" at number 11 at least consists of the combination of certain rudiments: the activities of processing, and resulting perception(s) – that are both above the limen of conscious awareness.
12. Meanwhile the outputs of other sensory apparatus form perceptions directly.
13. The unconscious informs conscious perceptions (including as the antecedent content blend(s) in from sensory organs and other sensory apparatus) prior to the finalizing of their development, if and as applicable.

**But what material is *in* the unconscious?**

I had undertaken planned and structured learning within a study group focusing on the psychoanalytic literature and also the area of philosophy. Over a series of years, we covered a

large amount of content across a relatively wide range of sources. Two in particular helped me glean some content areas that I have phrased here in the form of questions – that seemed suitable to our work.

Adapted from: Daoism (Philosophize This)

- What is the patient *strongly for?*
- What does the patient *strongly resist?*
- What dialectics would the patient *gladly resolve* (remove the tension) rather than retain, or rather than find an axis (a third position or pole upon which to carry them)?
- If the patient looked *for nothing* and followed it, where would that lead?
- What knowledge and traditions *have been obstacles?*
- How has the patient *been governed?*

Adapted from: Negation (Freud)

- Neutral-probe the *elaborate semantic network.*
- Notice words that either:
    - Are used to explain other words, but that *the speaker disavows a-priori*;
    - And notice if they are also relatively emotionally charged (location of complexes) at the semantic level.
- Recognition that the unconscious is expressed in a negative formula.
- *Notice projection*: "You'll think".
- *Notice rejection*: "I've no such intention."
- Palpate the *unknowable.*
- What would you consider the *most unlikely imaginable* thing in that situation?
- What was *furthest from your mind* at that time?

This entire adventure of meditating toward determining the foci and loci that I would turn my attention toward, as opposed to the observable and semantic and manifest etc. that is the sole focus of behaviorism, eventually led me to ask, "Where is addiction located?" That might seem like an odd question to the reader, but I think it's a very elementary and important question. And I encourage the reader to continue forward and consider the next portion of this work, that attempts to present my answer to that question.

**Part 11: Where Is Addiction Located?**
*If you were asked to physically point to the location of a person's addiction illness, where would you point?*

My answer might surprise you.
- Where would <u>you</u> point if <u>you</u> were asked?
- Have you ever thought of that question?

But first, try to think of some ways someone could go about answering that question.
- One way to find or build an answer to that question would be to *look at the addiction definition* from the American Society of Addiction Medicine (ASAM). The current language from ASAM includes the idea ASAM has used elsewhere that "the public understanding and acceptance of addiction as a chronic brain disease and the possibility of remission and recovery have increased." Based on that, one might naturally conclude that addiction is located *inside the skull.*
- Another way to build an answer would be to *look at research* from the National Institute on Drug Abuse (NIDA). NIDA prioritized brain research in the 1990's and called the 90's the "Decade of the Brain". The results of that research and the resulting information campaign might leave one to think that addiction is located *inside the skull.*

<u>A different way of knowing would be look, see, and say what you see</u>
- Here's an example of "look, see, say what you see". In the history of scientific inquiries some things have been named *how they simply looked.*
  - In the history of the study of human anatomy and physiology we learn that a portion of the brain, when it was found and seen, looked blue.
  - In Latin, "locus" means "place" or "location". And "coeruleus" is a word that contains the root for the word blue (like "cerulean blue").
  - You might have heard of the brain structure we call the "locus coeruleus"; they named that portion of the brain the Latin for "blue place".
- Where would *you* look to see addiction illness? And if you looked, what would you say you saw?
- After you looked and told us what you saw, what you said would have been based on *where you looked.*

This is a puzzle or a paradox. How so? You will *already lead yourself* to a certain answer simply *by deciding where* to look. Looking in a certain place or in a certain way naturally results in certain conclusions. ASAM and NIDA decided where they were going to look. And they found brain function.

After 3 decades of looking *at clinical work,* if I was asked to point at where addiction illness is physically located, I would point to the nexus of the individual person's social network (family, friend, neighbor, etc.).

That is to say, the seat of addiction illness is not merely inside the physical person of the one using substances. It is located in *the centrality of their relevant relational web.*

When I presented that idea in a recent conversation, I was challenged to locate the seat of addiction illness in the person. Admittedly, I must say that the seat of addiction illness being inside the individual person is a real possibility. And thus, I need not unnecessarily complicate the matter with an irrelevancy. However, in my thinking, the example of such a phenomenon would be something like a castaway on a deserted island, out of human contact for decades, initiating substance use and developing addiction illness under those conditions.

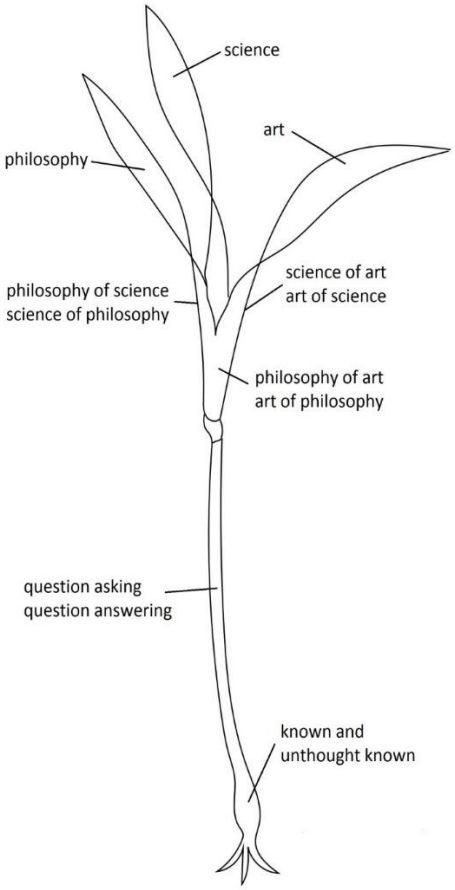
Possible? Yes. Commonly the case? No. To be thorough and cover that contingency, I will add my perspective of what a person is. And overall that perspective includes **two basic ideas:**

- Bio-psycho-social-spiritual
- Developmental layers across the lifespan

What follows is my treatment of each.

One of my favorite ways of thinking about a person as a total person is to use the phrase "bio, psycho, social, spiritual" as a reminder and starting place. And then, I often use either or both of two images to provide some details.

**Here is the first image.** After years of meditation on "bio-psycho-social-spiritual", I decided that I could represent the *essence of the phenomenological function* of a person in this diagram.



For clarity and thoroughness, I'll say that I mean the words shown in that diagram in their simplest sense.

For example:

- **"science"** could include any rational information gathering (e.g. a child turning over rocks in a tidal pool, or someone tracking the movement of stars), and
- **"art"** could include any craft on any level (e.g. a child using paint, or an adult practicing advanced metal work).

On the one hand, philosophy, science and art ***are products*** of considering; so in that way they could be thought of as petals produced by a flower.

And on the other hand, philosophy, science and art ***are ways we take-in*** from the world around us; so in that way they could be thought of as the green leaves of the plant.

Generating questions, hypotheses, and answers to questions in life all seem central to the human experience. Thus, that is represented as central in the diagram.

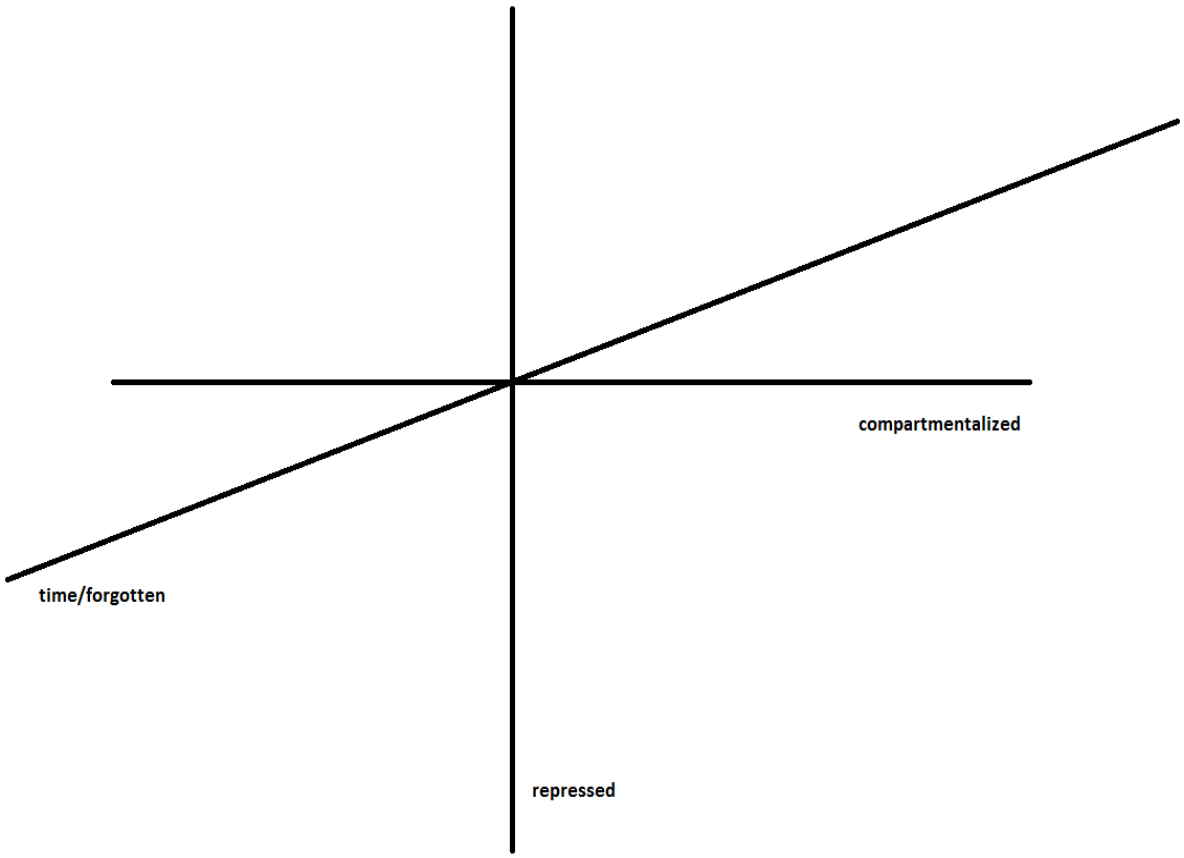
Meanwhile, much of what we know (that is either immediately accessible or even relatively out of access) seems to be stored below our level of conscious considering. And it seems that we take-in from the environment around us (e.g. soil, or other or deeper material, etc.) at that level too.

In my further formulation of the relative locations of function for these factors, I pictured a plot on 3 axes. The **X axis** = the degree of lateral compartmentalization; the **Y axis** = the degree of conscious availability; and the **Z axis** = the degree of proximity in time and resulting availability of recall.

The location of the "split" is determined separately for each factor. The coordinate location of a life fact or topic is not necessarily fixed, is subject to change, and does not represent a global or enduring characteristic of the person. Some topics for some individuals might be indexed beyond the vanishing point (recall Jung's lateral factors) *by two factors* and not the third.

What follows is a picture diagram that represents coordinates within "the unthought known".

**Part 12: Coordinates Within the Unthought Known**




*Adapted from: The Self as Object (Christopher Bollas)*

For example, on a certain topic, a particular person may experience a changing 2-factor coordinate location (level of *repression* on Y changes across *time* on Z), while their *compartmentalization* status on X remains zero (no compartmentalization) over time.

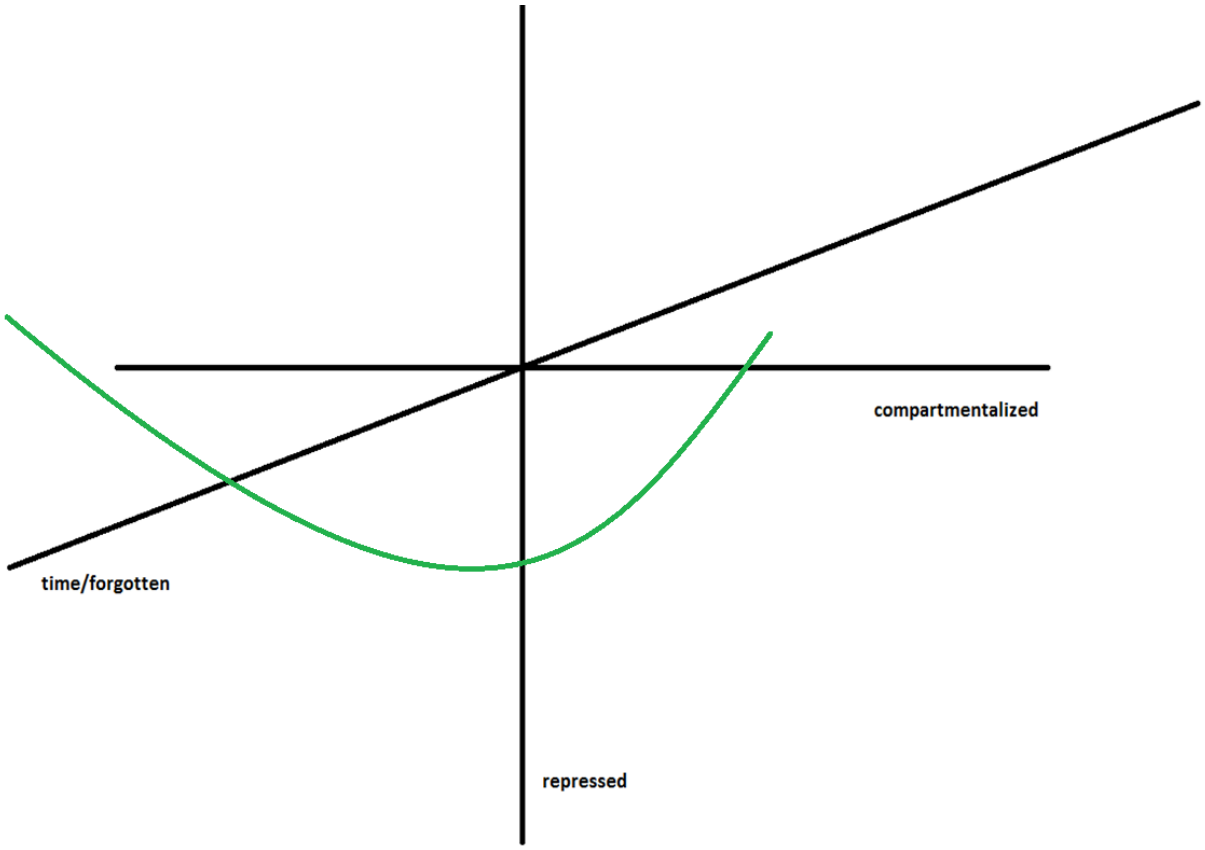



**Figure:** example of movement of content through time during therapeutic process, from the more remote, in repression, and then up through the limen of noticeability and less compartmentalization.

*Adapted from: The Self as Object (Christopher Bollas)*

This framework was concrete enough, and rooted in empiricism just enough, that it felt natural for me to explore it. Around that time, our learning group had tackled a philosophical piece about illusion and reality. And that content contributed to my further explorations of the potential content within the unthought-known.

<u>Illusion and Reality</u>

*Adapted from: A Look at Suffering – Dostoyevsky (Philosophize This).*

How can the clinician-patient dyad begin to move about in the domain of the unknown – to them both, or to one or the other? Perhaps one method would be to attempt to identify and remove illusions.

Illusions to Remove

- "What if…" at the level of the idea of improving one's life.
- The removal of suffering.
- Attachment to progress and progressing.
- Technology as the answer to anything.
- Fear of failure through removal of the avoidance of insecurities.
- Constant unbridled success and the notion of it as pleasurable.
- The perfect life as different from our current life.

- What we think we are like (brave, law-abiding, dangerous).
- Fury and self-hatred as reactions to our own unreasonableness, greed, short sightedness, folly, selfishness – as impossible to eradicate in our natures.
- Science and technology can save us from our nature.

Realities Often Avoided

- That we seek hedonism and constant bliss through technology.
- We hold "hedonistic imperative vs suffering" as a frame of reference or imperative.
- Boredom as instructive.
- What we are *actually* like (tender, deluded, anxious, violent, panicky) and want vs our own view.
- Compassion for people much more terrible than ourselves. But what about ourselves?
- Reconciliation with the reality that we cannot live a life of purity or be truly good and there is a tender person inside the monster

I wrote a caution against the over-use of questions that contained nothing but questions. And I did so, ironically, on the topic of empathy. But I designed the questions to be uplifting and encouraging, rather than interrogative and experienced as an assault. At this point I felt like the word "empathy" is so common we might not know what it even is. And I wanted to probe the topic anew.

**Part 13: What Is Empathy?**

Is the person that is speaking relatively known or relatively unknown to us?

- Do we hear their words, or do we hear *them* (their person)?
- As we listen, how do we determine if we hear or neglect their words?
- As we listen, how do we determine if we hear or neglect their person?

As we listen, do we apprehend the transcendent?

- Do their words obscure their person from us? Or do we hear their person?
- To the extent we know them, are either their words or person obscured by our knowledge of them?
- To the extent we know them, do we hear our projections instead of them and their words?

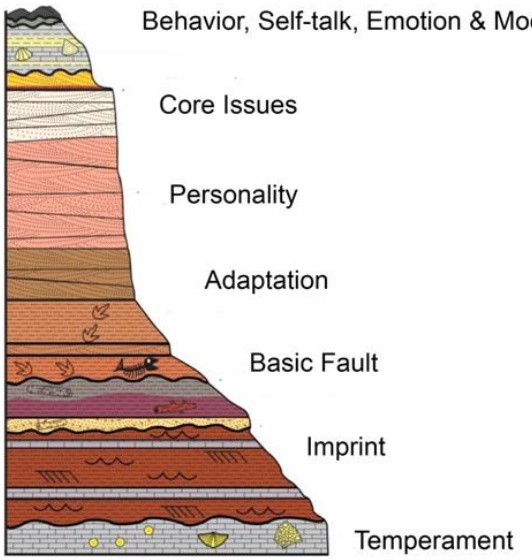
Is our history (personal or professional) in the way of hearing?

- Do we hear with quality?
- Do we hear with coherence?
- Are we hearing the person's desired outcome instead of hearing their person?
- Does our desired outcome for them obscure us from hearing their words? Or from hearing their person?
- What theory, tradition, or discipline of theirs is in their way?
- What theory, tradition, or discipline of ours is in our way?
- Are we employing an objective arrangement instead of listening?
- Are we hearing, or only following a narrative of words?

What is being said?

What is the person saying?

**Part 14: Revisiting the question, "Where is addiction located?"**
The diagram of the plant, meant to picture the phenomenological essence (bio-psycho-social-spiritual model), was the first of 3 attempts to answer the question, "Where is addiction located?" Here is the second: a developmental perspective of what a person is.

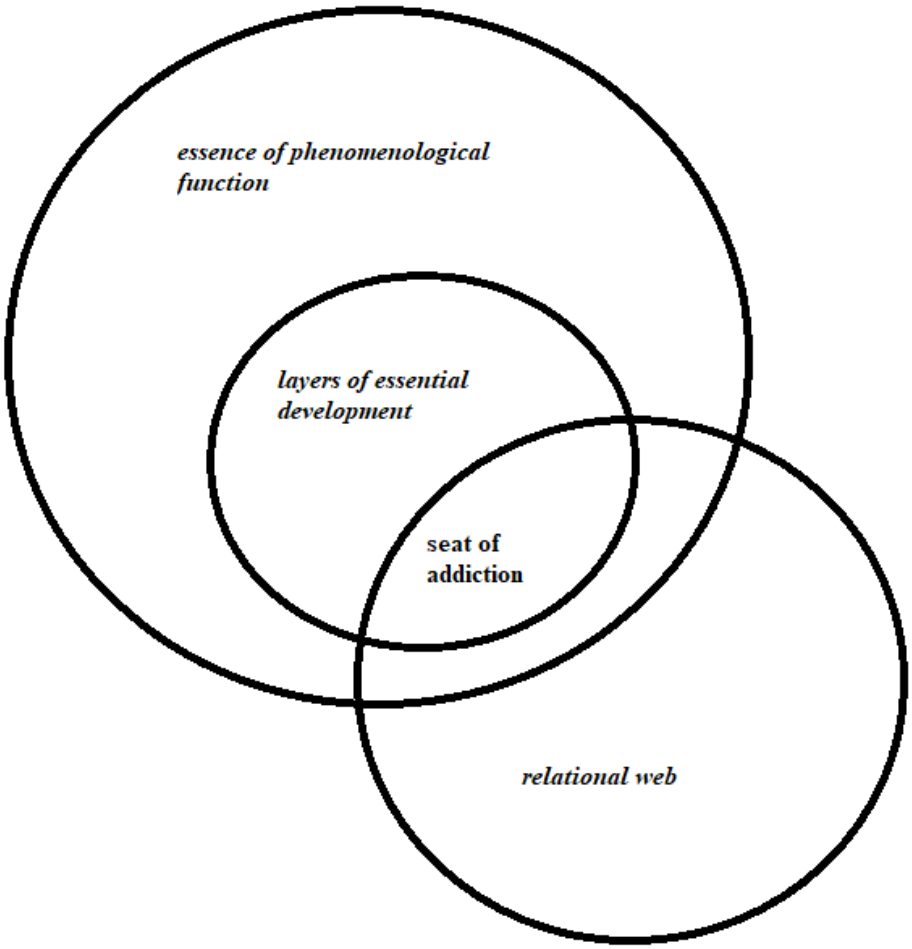



Around that time our learning group read the relatively famous paper from the analytic literature titled "Ghosts in the Nursery" by Selma Freiberg. It led me to adapt an entire set of considerations for clinical practice.

- Anxiety as information, not problematized.
- The patient is half in the past, and half in the present.
- The therapist as an auxiliary ego
- Markers: emotional starvation, developmental impairment.
- Wanting something different from one's own life, vs preventing a/the downward spiral over time.

As propelled by those considerations, I continue considering the question, "Where is addiction?" Is addiction seated merely in the person's phenomenological essence? I don't think so. Is it seated only in the ***layers of essential development*** of a person? I don't think so.

Regardless of the bio-psycho-social-spiritual model, and of developmental layers and stages, when I look back out the rear windshield of my addiction career, I see that addiction illness is ***located in the nexus of interpersonal relations, differently, for each person***.




Examples include the:

- seat of the family system
- relational web of street associates
- network of colleagues and work partners

It seems to me that addiction illness has its nexus or epicenter **in the space of relationships**, nested inside our developmental heritage, and the essence of what it is like to be ourselves.

Related to that theme, our study group interacted with some introductory materials concerning political philosophy and outlined a set of considerations for an entrance point to better understand the person's socio-political fabric.

**Considerations for Clinical Practice**

The first portion was adapted from Philosophize This and their handling of Confucianism. The next two are from the psychoanalysis and political philosophy. The domain to explore is summarized as follows:

Encouraged to work for a transcendent purpose – in that way *on their own* they put behavior in alignment with what is virtuous at the societal level, and sustain themselves in that effort (vs force or control by a government). These could be the kind of domains within which we have

the patient describe or compare and contrast their family of origin, current family, or way of understanding their society.

*Sincerity* in all relationships:

1. Sincerity becomes a parent;
2. from being a parent, it becomes manifest;
3. from being manifest, it becomes brilliant.
4. Brilliant, it affects others;
5. affecting others, they are changed by it;
6. changed by it, they are transformed.

Only the sincere *transform.*

- benevolent, lead by example vs loyal, serve the ruler
- loving vs obedient
- good, fair vs understanding
- gentle vs respectful
- considerate vs reverence

Adapted from: Loving Hate (Bollas)

- What negative intimacy do you state or evoke?
- What means established you as a person, and fully exhibited?
- What view of the world, and others, do you participate in, re-create, maintain over time, and hate?
- What would be destroyed if you found harmony?
- In what way do you merge into what you hate?

Adapted from: Dewey and Lippman (Philosophize This)

- What complexity, subtlety, and nuance did your family miss, and does your current family miss?
- What were the Public opinions of your family of origin? What were those they held publicly and those they had concerning public life? What are those of your current family? What are your own?
- Describe your pseudo community and how you built it (inclusion and exclusion of members, concepts held) at the level of stereotyped ideas.

To me, the natural extension that leapt forward from my question "Where is addiction?", my attempts at moving toward answering that, and these kinds of considerations about the values and priorities inside family systems and related political philosophy was the question, "Where is recovery?" But that question and my handling of it are outside the scope of this work.

Thus, I'll stay on topic and share some thoughts that resulted from the next portion of my study: the area called Object Relations.

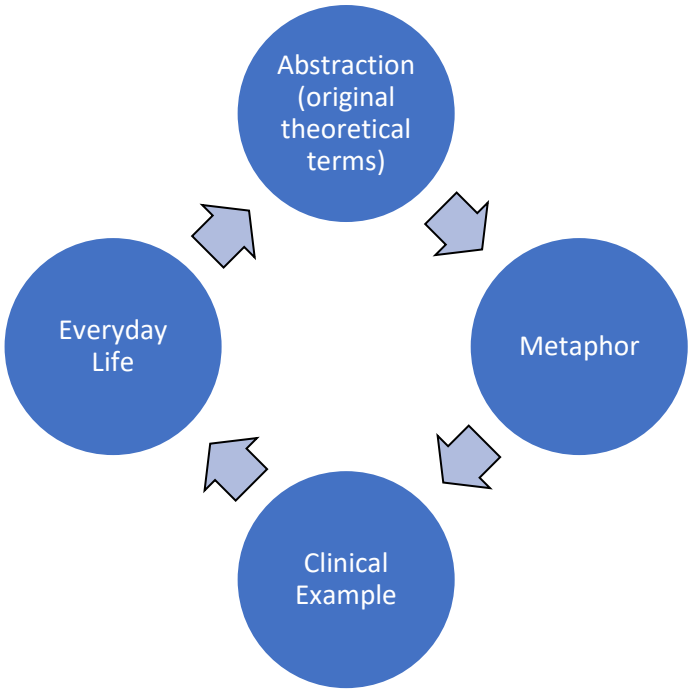
**Part 15: Object Relations**

Before the start of 2021 a book club professional associate of mine developed a plan to identify content for the two of us to study across all of 2021. He finalized the outline of content for us to study and developed the reading schedule for 2021.

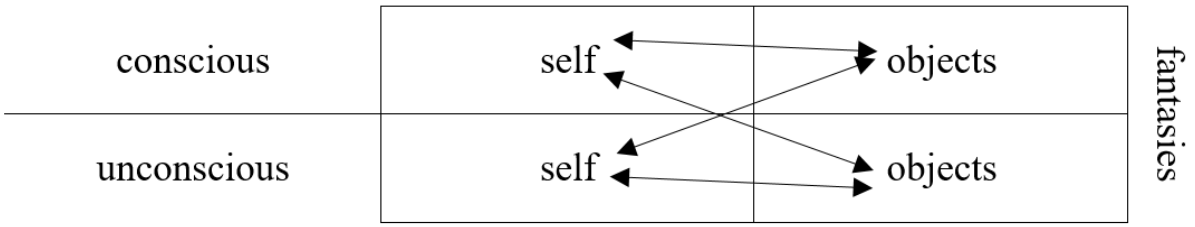
The first book we chewed through was extremely beneficial for me. Why? How so? It was empirically sound, interdisciplinary (in that it was derived from a synthesis of physiological psychology, clinical-applied work, empirical research and so on), and was aimed solely at **character issues and personality formation** (a relative weakness in my understanding). That text brought me along very far in my development, and was quite appealing to both my empirical leanings and broad wonderings. The book was Stephen Johnson's text titled "Character Styles." If I read it annually for the rest of my career I would benefit at every turn.

We then started reading the next book in our year-long schedule. It's Hamilton's (1990) text titled **"Self and Others: Object Relations Theory in Practice"**. I couldn't even get out of the Preface without being dramatically struck by some of the content. For example, the author stated that the book is meant to serve as an aggregation of all of the historical major thematic content, and changed emphases over time, in the broad area of Object Relations, and be accessible to the average reader. And in doing so, the author would endeavor to use a four-part framework for informational/instructive content delivery: first the abstract as terms with definitions, then expounding that with a relevant metaphor, followed by a clinical example, and lastly one from everyday life – which would lead back to the abstract.

I was so struck by that framework, I devised the image below, adapted from Hamilton, to help me concretize the framework. I will attempt to incorporate this framework in my daily verbiage (talking, writing, training, consulting, etc.).



The other major piece that struck me most profoundly (also from the earliest parts of the text), was the portion stating that Object Relations includes the study of the relations between **self** and one's **objects** – and that these both include the **conscious** and **unconscious** components of *each.* Challenged, I concretized that for myself by building the following image:




*Adapted from* Hamilton, N. G. (1990)

I found Hamilton's assertion fascinating that each and all of the conscious and unconscious content concerning self and objects are considered *fantasies* in the Object Relations way of understanding persons. When I encountered that claim, I was initially confused as it was entirely new to me. I had to slow down and consider that idea on its own terms, at face value. One's notion of one's self, and one's notions of things, *are fantasies*? When I did slow down and really consider it, my reflex was to compare and contrast **"fantasy"** with **"reality"** – in terms of the first word/concept in my clinical language that arose in reaction to that idea.

Even if I'm wrong that these quadrants of content are not specifically outside of "reality" in clinical terms, it's still an interesting thing to consider: that one's notions of self and of objects are of one's own construction, and thus – not "real" or "reality".

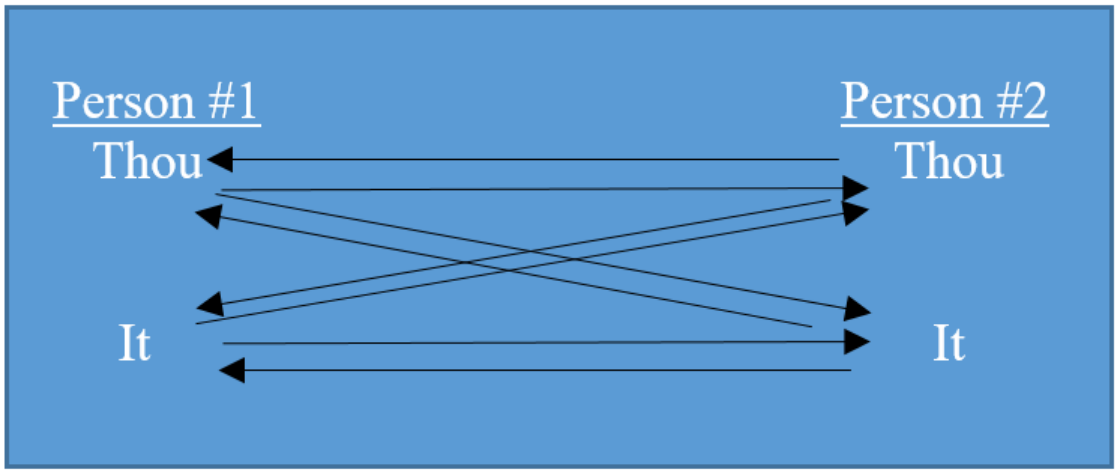
One principle strongly present within the deep cultural assumptions of Therapeutic Community (the kind of residential clinical programming within which I worked for my first 19 years after my initial clinical training) is that *one cannot see one's self.* And by extension, one comes to know one's self *as one is* (not as we *wish* we would be known) – by being in and relating in community. In therapeutic community this awareness of the real self is achieved by revelations that arise as one encounters the social norms, concepts, and rules of the program. And also by one's daily social interactions that include verbal sharing, dialogue, feedback, and most of all – listening.

Regardless, these notions from Hamilton reminded me of Martin Buber's notion of It/Thou. Buber's formulation of It/Thou is one of relating to others as things (objectively) which he calls "It", or as people (subjectively) which he calls "Thou".

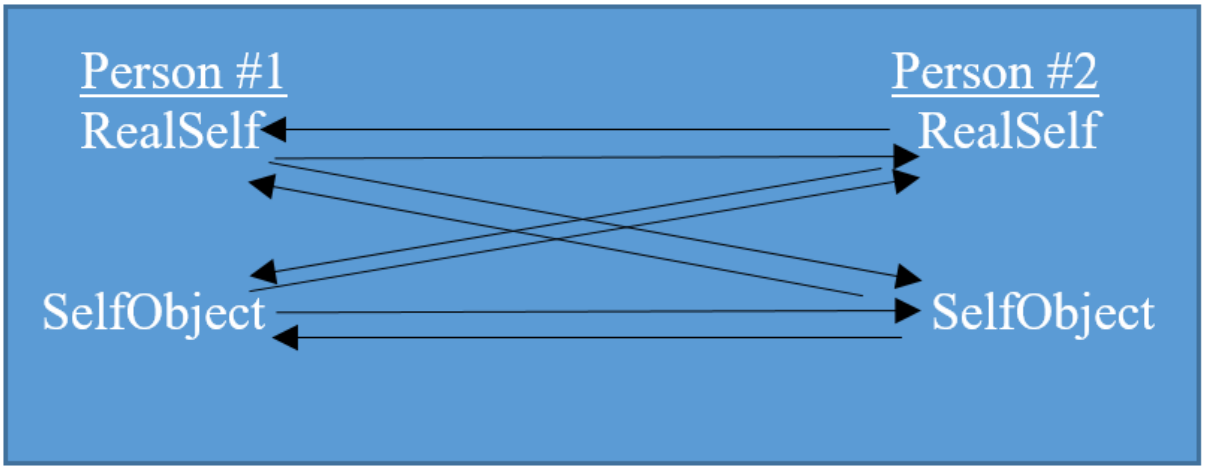
Earlier in 2021 when studying Buber's work, I formulated a grid of relational potentials from his basic notion of It/Thou. I took the liberty of differentiating the source and the receiver, and diagrammed two people relating in that level of detail, as: It/It, It/Thou, Thou/It, and Thou/Thou. I also took the liberty of including the conscious and unconscious of each of both the **It** and the **Thou.**

After I made the grid based on Hamilton's work I noticed that the Hamilton grid was almost identical in form to that I made in response to Buber.

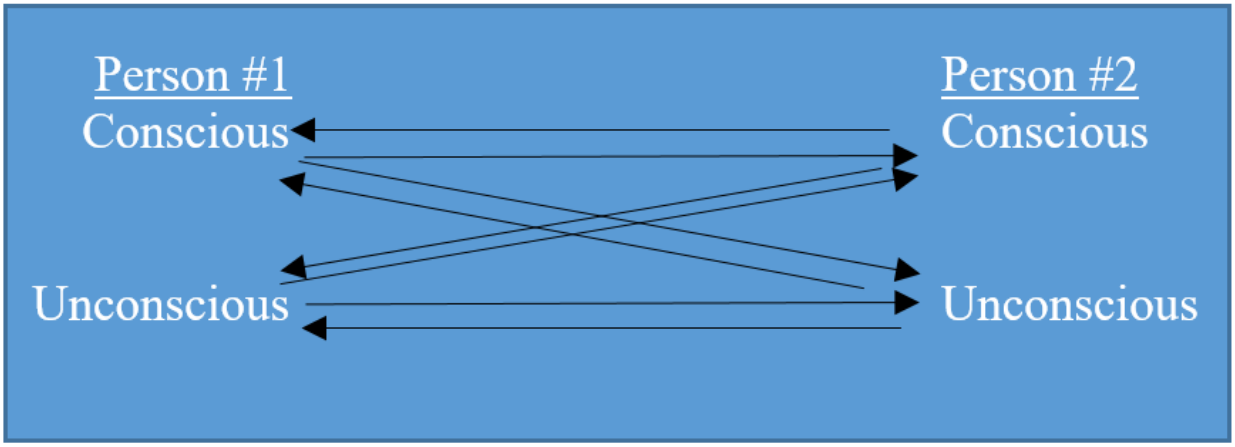
Next are the grids I drew based on my thinking about Buber's **It/Thou** formulation.




I took the liberty of making another, as a thought experiment, using notions from Kohut (1984).
Example 2: Possibilities in Real Self/SelfObject relating between 2 people

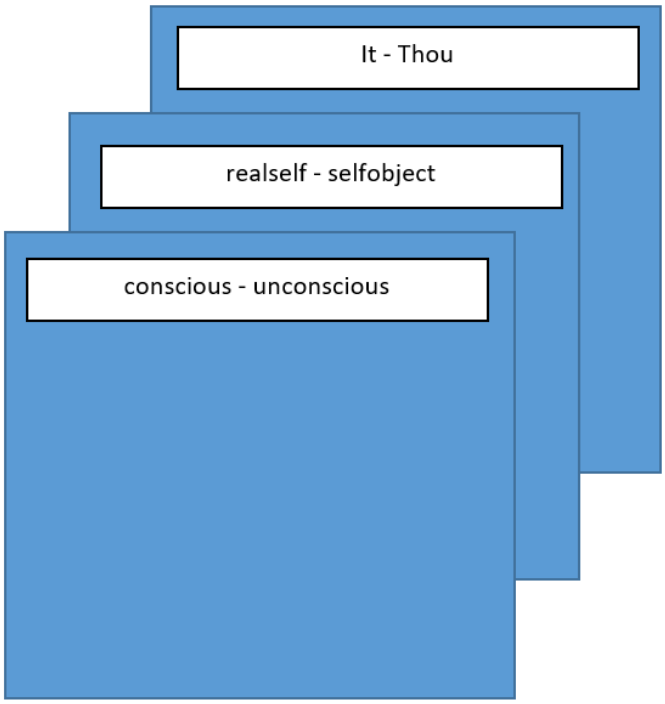


Example 3: Possibilities in Conscious/Unconscious relating between 2 people



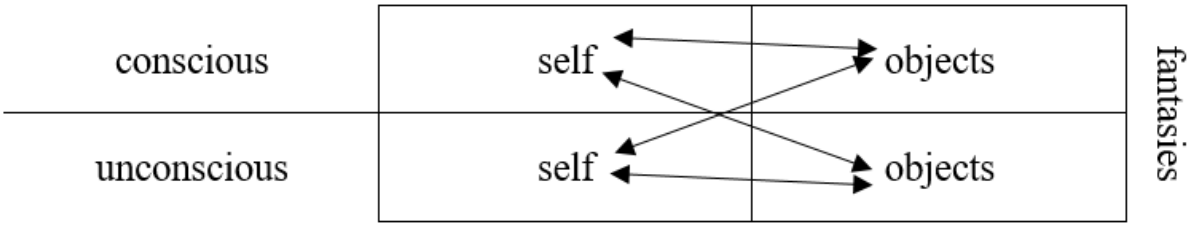

In this fourth and final image for this section, what I mean to represent are 3 simultaneous macro functions. The person would be in the foreground in front of the first square.

- When relating to another, what **conscious** and **unconscious** content is operative?
- Are we speaking *from* our **real self,** or **a selfobject**? And *to*?
- And are we speaking *from* the **It** or from the **Thou**? And *to*?




In my formulation, our communication emanates from, and is altered by, all three (like light refracting through a prism or set of prisms).

**And now, back to Hamilton.**




*Adapted from* Hamilton, N. G. (1990)

***Probing,*** I noticed thus far in his book there was no mention of relations between the *conscious self* and *unconscious self*. I also noticed there was no relation noted between *conscious objects* and *unconscious objects*. That is to say, I noticed I only saw relations between *Self and Objects* (as shown in my diagram above).

For me, this material naturally led me to start to consider what we call our "will" or perhaps our experience of seeming to have a "will". And I enjoyed my struggle with that topic, as it naturally ensued.

**Part 16: Object Relations and the Will**

**Wonderings**

And so, I wondered about the beginnings and full development of *character:*

1. Are character and personality problems associated with identity disturbance, such as borderline presentations, a kind of problem arising from self-self relations?
2. Are character and personality problems associated with compulsivity, such as found in OCPD, a kind of problem arising from object-object relations?

And for some reason, around that time, I also thought of a person's *will*, and wondered:

1. "What is the will?"
    - Is it an *organ* of the mind, or a *function*?
    - If it is a function, of what organ?
2. "What part of the mind is being accessed to mobilize my will, to be willing to do something when I don't want to - but know I need to? A meta-will?"
    - That is to say, does one exert one's will to overcome one's will?
    - If so, what part of the mind is doing that function?

Compelled, I had a conversation with a workplace colleague (Kagan, D., 2021) about that list of wonderings. That conversation helped me conclude my thinking up to this point. In short, I determined that *the will* is not an organ of the mind, or a function, but rather a compartment. And that it is a compartment for and of potential energy (and its lack).

- This compartment, as I construe it, can be filled with objects that load to provide energy (like wood in a stove). Of course, objects could also be removed or lost, and that would result in the diminishment of potential energy.
- I also decided that the compartment (like any other mass in physical science) can be raised or lowered (thereby increasing or reducing available potential energy) on a scale of values or valuing. A ranked position would raise or lower the potential energy of the objects in the container.

Thus, the compartment seems to be <u>fillable</u> and can be <u>raised and lowered</u>. One can toss into the container what one *wishes*, and can place the container at the height one *wishes*.

Further, I decided in that conversation that the resulting activity within the compartment:

- can have *vessels out* to other organs and functions of the mind,
- can be accessible directly for various impacts, influences and controls by *levers* accessible from other organs or functions of the mind
- would contain a nexus of "hedonic calculus"
- nests within:
    - the larger intra-sensorium of the complete mind,
    - a complex set of factors and resulting internalizing and externalizing vectors of influence, similar to a Kurt Lewin-type life space, but of the person's *interior*.

Understood properly, my notion could result in something like a physics study of mass, altitude, velocity, trajectory, attitude, and distance in and of our day-to-day actions – resulting from our "will". (Maybe I thought of "will" as a relevant topic due to my career in addiction treatment).

It was explained to me that one set of vectors that could function as a factor and impact the "will" are those that result from the thought experiment of holding an idea neutrally, construing the opposite polar extremes of the option (e.g. full implementation and full lack) and then examining the resulting impacts of those extremes (Kagan, 2021).

**Applications to Addiction Illness**

At this very early juncture in my development concerning object relations theory, I have started to ponder some applications to alcoholism and drug addictions.

*Uniqueness and projection of understanding*

One example of orality is the infant in the first two months of life. They exhibit a kind of natural and (in that stage of life) inescapable primary narcissism - they are all about self, completely dependent, self-referential, and blissfully unaware of the rest of the world, others, and life.

*Some* people with moderate to severe substance use disorders maintain there are two things that *only they* understand: addiction, and people with addiction illness. And yet, *some* are not closed in that way, would not be led to make that kind of claim, and would disagree with that claim if they heard it.

I wonder if some of what we see in our field from some helpers generally, regardless of their status qualifiers, is nothing more than universal infantile primary narcissism. That is to say, *"I understand this patient. This patient is like me. I have a special understanding of this patient. I defend and advocate for those who are like me. Compared to others, I alone understand. This is what I do."*

In Object Relations theory as I understand it so far:

- It is said that "self" is only knowable to each individual concerning themselves, from the position of *their own interior*. In that way, it is understood that no one has access to the inner life of another, and therefore the word "self" designates the aspects of personhood only each has concerning one's self.
- By contrast, the same body of literature differentiates use of the word "person" as referring to what is known of someone else from the position of others – that is, *from the outside*.
- The term "object" is used to refer to an experience (an aspect of self, or others, or events in the outside world) that is roughly *retained in one's interior*.
- These take on detailed designations by kind, including the term "self-object".

***What the Steps, then, seem to help bring about (reveal, engage, and mobilize)***

Archeological surfacing of material from unawareness into relatively more awareness (both in the moment and accumulatively over time) of at least:

- self
- person
- objects, and
- selfobjects

as they pertain to the intrapsychic apparatus relevant to:

- addiction illness in its active-use phase

- in its episodes of non-use
- pre-recovery content and process
- recovery itself, and
- the process of personal transformation from early recovery onward.

Seeing self, including (or) and:

- seeing one's person as others do,
- seeing interior features as problems or assets,
- and differentiating them from self.

Seeing potential in principles, relational community, and reciprocity.

And thus, it seems as if my struggle to learn and grow in this journey at that juncture took me full circle to the loci and foci in the two domains I identified:

1. First grouping:
    - Non-observable
    - Non-discursive
    - Pre-symbolized
    - Social system locus
    - Unconscious locus
    - Multi-generational structures
2. Second grouping:
    - Internalizing characteristics (represented by the Steps)
    - Externalizing characteristics (represented by the Traditions)

I'll now conclude the formal content of this writing at this location. Doing so is an embedded enactment. That is to say, I'll leave the topic open. And the journey as well. My reading, discussions, struggling to learn and grow have continued well beyond what I've written in this work.

Toward something tangible for the reader, what follows is an Epilogue providing each major content area of this work, handled separately in the light of each addiction counselor Core Function from a relevant and widely known clinical credentialing body (the IC&RC). Perhaps the reader could use the following pages as a launch pad for some practical considerations, discussions with colleagues, or a place for notes or journaling related to these topics.

The first page of that section is an entire matrix of all of the content. I included that so the reader could see the vastness of the entire domain of all of these considerations at a glance.

## Epilogue: Relevance to the 12 Core Functions

| | Disillusionment & limits of empiricism | Types & locations latent content | Steps & Traditions Wholistically | Internalizing and Externalizing factors | Non-linear change process | Model of personhood | Personality & Addiction Illness | Object Relations |
|---|---|---|---|---|---|---|---|---|
| Screening | | | | | | | | |
| Intake | | | | | | | | |
| Orientation | | | | | | | | |
| Assessment | | | | | | | | |
| Treatment Planning | | | | | | | | |
| Counseling | | | | | | | | |
| Case Management | | | | | | | | |
| Crisis Intervention | | | | | | | | |
| Client Education | | | | | | | | |
| Referral | | | | | | | | |
| Report & Record keeping | | | | | | | | |
| Consultation | | | | | | | | |

**Screening**

| | |
|---|---|
| Disillusionment with, and some limits of, empiricism | |
| Types & locations of latent content | |
| The Steps & Traditions considered wholistically | |
| Internalizing & externalizing factors | |
| Non-linear change process | |
| A model of personhood | |
| Personality and addiction illness | |
| Considering object relations | |

**Intake**

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|---|---|
| Disillusionment with, and some limits of, empiricism | |
| Types & locations of latent content | |
| The Steps & Traditions considered wholistically | |
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| Non-linear change process | |
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**Orientation**

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|---|---|
| Disillusionment with, and some limits of, empiricism | |
| Types & locations of latent content | |
| The Steps & Traditions considered wholistically | |
| Internalizing & externalizing factors | |
| Non-linear change process | |
| A model of personhood | |
| Personality and addiction illness | |
| Considering object relations | |

**Assessment**

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|---|---|
| Disillusionment with, and some limits of, empiricism | |
| Types & locations of latent content | |
| The Steps & Traditions considered wholistically | |
| Internalizing & externalizing factors | |
| Non-linear change process | |
| A model of personhood | |
| Personality and addiction illness | |
| Considering object relations | |

**Treatment Planning**

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|---|---|
| Disillusionment with, and some limits of, empiricism | |
| Types & locations of latent content | |
| The Steps & Traditions considered wholistically | |
| Internalizing & externalizing factors | |
| Non-linear change process | |
| A model of personhood | |
| Personality and addiction illness | |
| Considering object relations | |

**Counseling**

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| Disillusionment with, and some limits of, empiricism | |
| Types & locations of latent content | |
| The Steps & Traditions considered wholistically | |
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| A model of personhood | |
| Personality and addiction illness | |
| Considering object relations | |

**Case Management**

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|---|---|
| Disillusionment with, and some limits of, empiricism | |
| Types & locations of latent content | |
| The Steps & Traditions considered wholistically | |
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| Personality and addiction illness | |
| Considering object relations | |

**Crisis Intervention**

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|---|---|
| Disillusionment with, and some limits of, empiricism | |
| Types & locations of latent content | |
| The Steps & Traditions considered wholistically | |
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| Non-linear change process | |
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| Considering object relations | |

**Client Education**

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|---|---|
| Disillusionment with, and some limits of, empiricism | |
| Types & locations of latent content | |
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**Referral**

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|---|---|
| Disillusionment with, and some limits of, empiricism | |
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**Report and Record Keeping**

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|---|---|
| Disillusionment with, and some limits of, empiricism | |
| Types & locations of latent content | |
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**Consultation**

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|---|---|
| Disillusionment with, and some limits of, empiricism | |
| Types & locations of latent content | |
| The Steps & Traditions considered wholistically | |
| Internalizing & externalizing factors | |
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| Personality and addiction illness | |
| Considering object relations | |

## References

Balint, M. (1969/1979). The Basic Fault: Therapeutic aspects of regression. Brunner/Mazel, New York.

Barlow, D. H., Hayes, S. C. & Nelson, R. O. The Scientist Practitioner: Research and accountability in clinical and educational settings. Pergamon: New York.

Bion, W. (1967). Notes on Memory and Desire. The Psychoanalytic Forum. 2:272-273, 279-280.

Bollas, C. (1987). The Shadow of the Object: Psychoanalysis of the Unthought Known. Columbia University Press: New York.

Buber, M. (1923/1937/2010). I and Thou. Martino Publishing.

Budnick, C. (2018). Personal communication.

Campbell, D. T. & Stanley, J. C. (1963). Experimental and Quasi-Experimental Designs for Research. Houghton Mifflin, Boston.

Carmines, E. G. & Zeller, R. A. (1979). Reliability and Validity Assessment. Sage Publications, Beverly Hills.

Coon, B. (2022). Coast Guard Search and Rescue: Lessons and Inspiration. *Recovery Review.*

Crowe, K. (2017). Personal communication.

Feldman, L. (2015). Personal communication.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts In The Nursery: A psychoanalytic approach to the problems of infant-mother relationships. Journal of the American Academy of Child Psychiatry. 14(3):387-421.

Hamilton, N. G. (1990). Self and Others: Object Relations Theory in Practice. Jason Aronson Inc., Northvale, New Jersey.

Hollis, J. (2013). Hauntings: Dispelling the Ghosts Who Run Our Lives. Chiron Publications, Asheville, NC.

Johnson, S. M. (1994). Character Styles. W. W. Norton & Company: NY.

Jorquez, J. (1983). The Retirement Phase of Heroin Using Careers. Journal of Drug Issues. 13:343-365.

Kagan, D. (2019; 2020). Personal communication.

Kania, J., Kramer, M. & Senge, P. (2018). The Water of System Change. FSG.

Kohut, H. (1984). How Does Analysis Cure? University of Chicago Press.

Luft, J. & Ingham, H. (1955). "The Johari Window, a Graphic Model of Interpersonal Awareness". Proceedings of the Western Training Laboratory in Group Development. Los Angeles: UCLA.

Marquis, A., Douthit, K. Z. & Elliot, A. J. (2011). Best Practices: A critical yet inclusive vision for the counseling profession. Journal of Counseling & Development. 89: 397-405.

Resnicow, K. & Page, S. E. (2008). Embracing Chaos and Complexity: A Quantum Change for Public Health. American Journal of Public Health. 98(8):1382-1389.

White Bison, Inc. (2002). The Red Road to Wellbriety In The Native American Way. White Bison: Colorado Springs.

***Some of the recovery research I studied**

Andresen, R., Caputi, P. & Oades, L.G. (2010). Do clinical outcome measures assess consumer–defined recovery? *Psychiatry Research*, 177, 309-317.

Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228.

Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review*, *50*, 443-456.

Dennis, M.L., Foss, M.A., & Scott, C.K. (2007). An eight-year perspective on the relationship between the duration of abstinence and other aspects of recovery. *Evaluation Review*, *31*(6), 585-612.

Dennis, M.L., Scott, C.K., Funk, R., & Foss, M.A. (2005). The duration and correlates of addiction and treatment careers. *Journal of Substance Abuse Treatment*, *28*, S51-S62.

DuPont, R., Compton, W.M. & McLellan, A.T. (2015). Five-Year Recovery: A new standard for assessing effectiveness of substance use disorder treatment. *Journal of Substance Abuse Treatment.* 58:1-5.

DuPont, R. L., Keith Humphreys, K. (2011): A New Paradigm for Long-Term Recovery. *Substance Abuse*, 32(1):1-6.

Fiorentine, R., & Hillhouse, M. P. (2000). Drug treatment and 12-step program participation: The additive effects of integrated recovery activities. *Journal of Substance Abuse Treatment*, *18*(1), 65-74.

Galanter, M. (2014). Alcoholics Anonymous and Twelve-Step Recovery: A model based on social and cognitive neuroscience. *The American Journal on Addictions, 23*, 300-307.

Hser, Y-I; Hoffman, V; Grella, C. E. & Anglin, D. (2001). A 33-Year Follow-up of Narcotics Addicts. *Archives of General Psychiatry. 58:* 503-508.

Jorquez, J. (1983). The retirement phase of heroin using careers. *Journal of Drug Issues, 13*, 343-365.

Kaskutas, L. A., Ammon, L., Delucchi, K., Room, R., Bond, J & Weisner, C. (2005) Alcoholics Anonymous careers: Patterns of AA involvement five years after treatment entry. *Alcoholism: Clinical and Experimental Research*, *29* (11), 1983-1990.

Kaskutas, L. A., Bond, J., & Ammon Avalos, L. (2009) 7-year trajectories of Alcoholics Anonymous attendance and associations with treatment. *Addictive Behaviors*, *34*(12), 1029-1035.

Kaskutas, L.A., Borkman, T.J, Laudet, A., Ritter, L.A., Witbrodt, J., Subbaraman, M.S., Stunz, A. & Bond, J. (2014). Elements That Define Recovery: The Experiential Perspective. *Journal of Studies on Alcohol and Drugs*. 75: 999-1010.

Kelly, J.F., Greene, M.C., Bergman, B.G., White, W.L., & Hoeppner, B.B. (2019). How Many Recovery Attempts Does It Take to Successfully Resolve an Alcohol or Drug Problem? Estimates and Correlates From a National Study of Recovering U.S. Adults. Alcoholism: Clinical and Experimental Research.

Kelly, J.F., Hoeppner, B., Sout, R.L. & Pagaon, M. (2011). Determining the relative importance of the mechanism of behavior change within Alcoholics Anonymous: A multiple mediator analysis. *Addiction*, 107, 289-299.

Kelly, J. F., Macgill, M., & Stout, R. L. (2009). How do people recover from alcohol dependence? A systematic review of the research on mechanisms of behavior change in Alcoholics Anonymous. *Addiction Research and Theory*, 17(3), 236-259.

Kelly, J. F., Stout, R., Magill, M. J., Tonigan, J., & Pagano, M. (2010). Mechanisms of behavior change in Alcoholics Anonymous: Does AA lead to better alcohol use outcomes by reducing depression symptoms? *Addiction, 105(4),* 626-636.

Kelly, J.F., Stout, R.L., Magill, M.J., Tonigan, S., & Pagano, M.E. (2011). Spirituality in Recovery: A lagged mediational analysis of Alcoholics Anonymous' principles theoretical mechanism of behavioral change. *Alcoholism: Clinical and Experimental Research, 35(3),* 454-463.

Kelly, J. F. & White, W., Eds (2010). Addiction Recovery Management: Theory, Research and Practice. Humana Press.

Kleinig, J. (2008). Recovery as an ethical ideal. *Substance Use and Misuse*, 43, 1685-703.

Klingemann, J.I. (2012). Mapping the maintenance stage of recovery: A qualitative study among treated and non-treated former alcohol dependents in Poland. *Alcohol and Alcoholism*, 47(3), 296-303.

McLellan, T. (2012). What is recovery? Revisiting the Betty Ford Institute Consensus Panel definition. *Journal of Substance Abuse Treatment*, *38*, 200-201.

McLellan, Lewis, O'Brien, and Kleber. (2000). Drug dependence, a chronic medical Illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association*, 284(13):1689-1695.

Moos, R. H., & Moos, B.S. (2004). Long-term influence of duration and frequency of participation in Alcoholics Anonymous on individuals with alcohol use disorders. *Journal of Consulting and Clinical Psychology. 72(1),* 81-90.

Moos, R. H., & Moos, B. S. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcoholism: Clinical & Experimental Research, 29*(10), 1858-1868.

Morgenstern, J., Bux, D. A., Jr., Labouvie, E., Morgan, T., Blanchard, K. A., & Muench, F. (2003). Examining mechanisms of action in 12-Step community outpatient treatment. *Drug and Alcohol Dependence, 72*(3), 237-247.

Subbaraman, M.S. & Kaskutas, L.A. (2012). Social support and comfort in AA as mediators of "Making AA Easier" (MAAEZ), a 12-step facilitation intervention. *Psychology of Addictive Behaviors. 26*(4), 759-765.

Toumbourou, J., Hamilton, M., U'Ren, A., Stevens-Jones, P., & Storey, G. (2002). Narcotics Anonymous participation and changes in substance use and social support. *Journal of Substance Abuse Treatment, 23*(1), 61-66.

White, W. L. (2007). Addiction Recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment. 33*: 229-241.

White, W. L. (2009). Peer-Based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation. Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services. Chicago, IL.

White, W. L. (2014). The History of Addiction Counseling in the United States: Promoting Personal, Family, and Community Recovery. NAADAC.

Witbrodt. J., Kaskutas, L., Bond, J. & Deluchi, K. (2012). Does sponsorship improve outcomes above Alcoholics Anonymous attendance? A latent class growth curve analysis. *Addiction*, 107, 301-311.

Witbrodt, J., Mertens, J., Kaskutas, L. A., Bond, J., Chi, F. & Weisner, C. (2012). Do 12-step meeting trajectories over 9 years predict abstinence? *Journal of Substance Abuse Treatment*. *43,* 30-43.

Zemore, S. E., Kaskutas, L. A., & Ammon, L. N. (2004). In 12-step groups, helping helps the helper. *Addiction*, *99*(8), 1015-1023.

## Suggested Reading

Allsopp, K., Read, J., Corcoran, R. & Kinderman, P. (2019). Heterogeneity in Psychiatric Diagnostic Classification. Psychiatry Research. 279:15-22.

Blatner, A. & Blatner, A. (1988). Foundations of Psychodrama: History, Theory, & Practice, 3rd Edition. Springer: New York.

Brady, M. (1995). Culture in Treatment, Culture as Treatment: A critical appraisal of developments in addictions programs for indigenous North Americans and Australians. Social Science & Medicine. 41(11): 1487-1498.

Bucci, W. (1997). Psychoanalysis and Cognitive Science: A Multiple Code Theory. The Guilford Press: New York.

Dunkel, C., Kelts, D. & Coon, B. (2006). Possible Selves as Mechanisms of Change in Therapy, in C. Dunkel & J. Kerpelman (Eds.). Possible Selves: Theory, Research and Application. (pp. 186-204). Nova Publishers.

Foucault, M. (1969). "What is an Author?" Collège de France. Retrieved from the world wide web 08/21/19 at: https://www.open.edu/openlearn/ocw/pluginfile.php/624849/mod_resource/content/1/a840_1_michel_foucault.pdf

Freedman, N., Ward, R. & Webster, J. (2011). Towards a Psychoanalytic Definition of Symbolization and Desymbolization. In Another Kind of Evidence: Studies on internalization, annihilation anxiety, and progressive symbolization in the psychoanalytic process. Karnac Books, Ltd., London.

Freud, S. (1915). General Psychological Theory: Papers on Metapsychology. The Unconscious.

Freud, S. (1937). Analysis Terminable and Interminable.

Galanter, M. (2014). Alcoholics Anonymous and Twelve-Step Recovery: A model based on social and cognitive neuroscience. The American Journal on Addictions, *23*, 300-307.

Hang Hai, A., Franklin, C., Park, S., DiNitto, D. M. & Norielle, Aurelio, N. (2019). The efficacy of Spiritual/Religious Interventions for Substance Use Problems: A systematic review and meta-analysis of randomized controlled trials. Drug and Alcohol Dependence. 202: 134-148.

Hofmann, S. G. & Hayes, S. C. (2018). The Future of Intervention Science: Process-Based Therapy. Clinical Psychological Science. 7(1): 37-50. doi.org/10.1177/2167702618772296

Humphries, K., Blodgett, J. C. & Wagner, T. H. (2014). Estimating the efficacy of Alcoholics Anonymous without self-selection bias: An instrumental variables re-analysis of randomized clinical trials. Alcoholism: Clinical and Experimental Research. 38(11): 2688-2694.

James, L. (2016). Carl Jung and Alcoholics Anonymous: Is a Theistic Psychopathology Feasible? Acta Psychopathologica. 2(1): 7. DOI: 10.4172/2469-6676.100033.

Jellinek, E.M. (1952). Phases of Alcohol Addiction. Quarterly Journal of Studies on Alcohol. 13(4): 673–684.

Oldham, J.M. & Morris, L.B. (1995). The New Personality Self-Portrait: Why you think, work, love, and act the way you do. Bantam: New York.

Rubianes, M., Muñoz, F, Casado, P., Hernández-Gutiérrez, D., Jiménez-Ortega, L, Fondevila, S., Sánchez, J., Martínez-de-Quel, O. & Martín-Loeches, M. (2020). Am I the Same Person Across My Life Span? An event-related brain potentials study of the temporal perspective in self-identity. Psychophysiology. e13692. doi.org/10.1111/psyp.13692

Sänger, J., Müller, V. & Lindenberger, U. (2012). Intra-and Inter Brain Synchronization and Network Properties When Playing Guitar In Duets. Frontiers in Human Neuroscience. 6(312):1-19. doi:10.3389/fnhum.2012.00312

Schuch, F. B. & Stubbs, B. (2019). The Role of Exercise in Preventing and Treating Depression. Current Sports Medicine Reports. 18(8): 299-304.

Westen, D. (1998). The Scientific Legacy of Sigmund Freud: Toward a Psychodynamically Informed Psychological Science. Psychological Bulletin. *124*(3): 333–371.

http://www.williamwhitepapers.com/blog/2016/02/disengaged-styles-of-recovery-bill-white-and-dr-john-kelly.html

White, W., & Kurtz, E. (2006). The Varieties of Recovery Experience. International Journal of Self Help and Self Care. 3(1-2), 21-61.

## Supplemental Material

Throughout this journey of mine, wherein I gave myself permission to think, and to start and stay outside of rigid and rigorous academic content and hardline empirical methods, I did some writing along the way. Most of that writing has been placed online, freely available.

Here are those sources in chronological order, listed by their topics/description of the work:

1. **Denial.** August 22, 2020. I got to hear an in-person lecture by a neuroscientist named Anil Seth. His topic was how the brain assembles our perception of what it outside our physical body. And how that perceptual experience is in fact hallucinated, and unchangeable despite any and all perceptual challenges or proofs. His talk made me consider that what we call "denial" may be a phenomenon of various differing kinds – some physical, some mental, some as blends. https://recoveryreview.blog/2020/08/22/one-kind-fits-all-denial-all-the-time/
2. **The clinical relationship's empty space.** January 15, 2021. Qualitative aspects of the transactional space when that space is objectively and manifestly empty started to preoccupy my thinking. We can seem to sense the quality of the space. What is that human capacity? How can we tune in to that material? And intentionally improve it? https://recoveryreview.blog/2021/01/15/negative-space/
3. **Latent presence and quality of recovery function.** February 27, 2021. I extended the topic of the empty space in the clinical relationship to the question of latent recovery presence and quality related to a group of people. Sensing the agenda in the room. https://recoveryreview.blog/2021/02/27/throw-flour-on-the-invisible-man-toward-locating-recovery-function-and-assessing-recovery-quality/
4. **The unconscious.** March 11, 2022. The entire notion of the unconscious was one I eventually totally reconsidered. Rather than reject it without examination or evidence, due to it coming from Freud and how we were poisoned in behaviorism against any and all depth psychology content, I did my own learning and thinking for myself as well. Having been involved in the conversion of our program in 2013 to a tobacco-free model of addiction treatment, and subsequently realizing the SUD arena is asleep on this topic of the leading preventable cause of death in the USA, and that the number of deaths each year in the USA from tobacco are more than all overdoses in the first 3 waves of the opioid epidemic combined, I chose "tobacco" as the content for this work. https://recoveryreview.blog/2022/03/11/our-unconscious-relationship-with-tobacco/
5. **Parallels between Freud and Pavlov via cultural linguistics.** May 12, 2022. Some rather challenging learning in the areas of structural linguistics and semiotics caused me to regress to form and consider that material through the lens of more recent developments in Pavlovian conditioning theory. A number of striking parallels between Freud's formulation of the unconscious and Pavlov's work are shared, as are newer developments in each area – as revealed by the areas of structural linguistics and structural anthropology. https://recoveryreview.blog/2022/05/12/rescorla-is-to-pavlov-as-semiotics-is-to-freud/
6. **Grief vs. Depression.** May 21, 2022. Here I present Freud's differentiation of these two topics, amplify the object relations as differently involved in each, and apply them specifically to addiction counseling. https://recoveryreview.blog/2022/05/21/grief-and-depression-as-factors-in-addiction-counseling/

7. **Clinical technique vs. empathy.** June 22, 2023. Here I present the puzzle of whether technique or empathy should predominate. I also address the puzzle of 3 different approaches within that challenge: (A) "My technique is correct. The patient must adapt to it. And the patient needs to learn how to adopt it and be improved by it." (B) "We must adapt our technique to the patient. Don't change the patient, change your technique." (C) "Empathize. Neither lead nor follow the patient." I do so by preserving each of those separately, blend each possible 2-part combination, identifying the total topic common to all 3, and the responsibility for oscillation between choices in the moment. https://recoveryreview.blog/2023/06/22/technique-vs-empathy/
8. **The question of identity.** June 24, 2023. Struggling with one's identity is an associated feature of addiction illness. Who am I? Who was I? Who am I turning into? Recent research has identified a brain region associated with the function of one's sense of self. And specific problems arise when substance use damages this area of the brain. In this work I describe those research findings. To me, then, here we have the bio-psycho-social-spiritual model right before us. And the linkages between neurophysiology and some elements of depth psychology are right before us as well. (This area of inquiry reminds me of a research project I was involved in years ago in the area called "Possible Selves". I added the reference for that project in the Suggested Readings list of this document). https://recoveryreview.blog/2023/06/24/the-question-of-identity/
9. **Resistance.** October 10, 2023. I got to the point where no matter what I did, I couldn't seem to shake the topic of "resistance". This is odd and funny to me, give that as a behaviorist we were taught resistance does not exist, since everything is goal directed and all behavior is like that. I eventually did a selected set of readings starting from Freud and moving all the way through to contemporary neuroscience – on the topic of "resistance" – and how the information in each source can contribute to our work. https://recoveryreview.blog/2023/10/10/notes-on-resistance-in-addiction-counseling/
10. **The patient's unknown goal.** April 29, 2024. During some later reading in the psychoanalytic literature, I came across the idea of the "unknown goal" of the patient. Yes, that would be content in the unconscious, but I was so supremely delighted by this phrase, and improved by it, I can't attempt to convey that at this point. All I can say is that as a behaviorist, a hardline CBT'er, and someone rigorously raised for 20 years in clinical fidelity models, the entire world of Motivational Interviewing (MI) as well as Motivational Enhancement Therapy (MET), and nearly religious adherence to the principles and practices of "person-centered planning", this topic of the "unknown goal" was supremely liberating. https://recoveryreview.blog/2024/04/29/the-patients-unknown-goal/

Here, I'll provide two resources I built that have to do with the topic of "understanding".

1. **Biases among medical and scientific experts.** December 7, 2021. In this work I respond to the question about what such biases I notice in our field. I list various kinds of bias, describe how they present themselves in a practical way, and outline methods that can limit or prevent various biases. I can't get away from the idea that I can perhaps detect or generate some awareness of these biases due to the severity of the empirical background I came from in academic and clinical scientist-practitioner psychology and behaviorism. https://recoveryreview.blog/2021/12/07/what-biases-do-you-observe-among-many-of-the-scientific-and-medical-experts-in-the-field/

2. **Comments on the task of interpreting.** November 14, 2022. This is not about building and delivering a therapeutic interpretation. Rather, this work is a close look at interdisciplinary methodology, and how the addiction counselor is charged with, and can go about, making unitary coherent meaning from disparate clinically-relevant sources. The source material from which this was derived is mainly social, humanistic, spiritual, and rooted in social sciences. https://recoveryreview.blog/2022/11/14/comments-on-the-task-of-interpreting/

Much earlier, however, I wrote two packets for workshop trainings. These are quite dense and technical. I thought seriously about adding them as an appendix to this monograph, but their content seemed to deserve its own attention. Perhaps I'll turn the two of these into a monograph of their own. They were built to go together.

- The first was based on **brain science** and developing clinical methods from **"top-down"** approaches, **and** also from **"bottom-up" approaches**. The content was centered in interdisciplinary methods, which is not controversial, but did open a large door for me on other clinical methods than those grounded in behaviorism (spiritual care, psychodynamic psychotherapy, etc.)
- The second was based on cognitive preferences (summarized as **left/right hemisphere dominance)** and how to understand and use either or both methods intentionally. But the impetus for my learning and development of the training packet was exposure to a real-life art therapist. So, the training packet contains my empirical/academic reading and considering about totally other methods and how we can responsibly incorporate patient cognitive preferences into our work, regardless of our clinical tribe.

I also decided that the all-too-common overly-reductive, quantified, objective, check-listed, maximally efficient, close-ended interviewing template for a typical psychosocial interview defeats my desire to grow in the Depth Psychology area of knowledge and practice. And that it would be a beneficial exercise to build a list of questions/topics for a bio-psycho-social-spiritual patient interview – that is derived from the resources in philosophy, the psychoanalytic literature, and related resources I had encountered during my still on-going multi-year study. That document is immediately below. It is not intended for use with a patient. Making this was an exercise at giving myself permission to think and of stretching beyond the limits of radical behaviorism as applied to the development and use of a qualitative interview.

# What's it like to be you?

***What follows is a list of questions and topics. They present an opportunity to reflect. Feel free to comment on any of them, in any way you wish.***

1. Who were you, as a person, prior to age 4?

2. Who are you, *at essence,* at the level of your *essential features?*

3. What are the thought structures that you rely on to reach your conclusions?

4. In what way have you arrived at your version of reality?

5. What contextual frame have you adopted to form conclusions?

6. What possible selves you are interested in?

7. What identity did you previously have, have you previously avoided, would you like to try?

8. What top/bottom dualism and hierarchy is in the way?

9. Define what concepts are important to you, or that you struggle with, by describing things that contrast with them.

10. If you reached into the unknown, what would you find?

11. Describe your family system as a machine.

12. Describe your addiction as a machine.

13. Describe each member of the family system as a new machine.

14. Describe recovery, and the recovery community, as a machine - or as a rhizome.

15. What are you becoming?

16. What is in action?

17. In any given counseling session, only the unknown is important. What is it?

18. What words have meanings as they relate to the meaning of other words, at a point in time and structural context, that are still important now?

19. What words have a historical list of meanings that are still important now?

20. What words are generative and give rise to words?

21. Why are words helpful to you in counseling?

22. What is helpful about a word that is helpful? And how?

23. Discuss “proof”.

24. Discuss “certainty”.

25. Discuss the importance of mythology, religion, unverifiable speculation, aesthetic claims, nonsense of the past, and “metaphysics”.

26. Discuss the importance of mythology, religion, unverifiable speculation, aesthetic claims, nonsense of the past, and “metaphysics” as pejorative terms for *unverifiability*.

27. Philosophy has run its course and is out. Science is in. Philosophy now is only good for explaining how science and mathematics (which are superior) work. How do you respond to that?

28. According to you, what in the counselor is skewing their view of you?

29. According to the counselor, what in the counselor is skewing their view of you ?

30. What selfobjects of the counselor are in the session?

31. Consider “field theory” – such as electromagnetic fields. Discuss your *theoretical* field and the counselor’s *clinical* field.

32. Discuss the small clinical failures that must be recognized and processed in the therapeutic work as central to the process.

33. Describe parts of self from the contextual reference point of childhood protections, resources, and of a group.

34. Discuss empathy with your own childhood experiences as superior to realizing the undetected lie of the omniscient clinician or parent.

35. Discuss your dishonest dealings as tests of the counselor’s clinical willingness to see and value your *self*.

36. What do you have to say about your identity, personality, world view, and values – through the signs you choose?

37. Describe your life as alone on a freeway while the world passes you by on a screen.

38. Describe the framework of your emotions. Also describe that framework as a blended whole, and as a place with emotional stores.

39. Describe the parts of your emotional framework that serve as screens, lenses, and containers of emotion.

40. How is the model inside your life repeated?

41. How is the model inside your life and its explicit and implicit messages reacted against by you? And, in what way is there an attempt to "treat" the message of the model (distract, drug, treat others)?

42. What powerlessness is important?

43. What does "mother" mean?

44. What does "father" mean?

45. How was the mother mothered?

46. How was the father fathered?

47. Comment how gaining permission to be oneself is the implicit task (vs enacting the impulses of those that imprinted us).

48. Describe the products of waste or the debris from your life's experiences.

49. What structure, moral order, normative choices for rules, and their consequences - are you from? What is your spiritual and psychological latitude and longitude?

50. How do you find true north? Know that you have an inner compass and its access. Learn to trust and converse with it. Know that it goes with you as you travel. How do you plan to consult it more often in the future?

51. Why are we here, in service to what, toward what end?

52. How are we as animals with spirit to live in harmony with the natural environment?

53. Who are my people, what is my duty to others, and what are the rights, duties, expectations, and privileges of my tribe?

54. Who am I, how am I different, what is my life about, and how am I to find my way through life?

55. What "god" has been neglected or offended, as identified by the neurotic symptom?

56. What does your psyche know that shows up as symptoms or as support?

57. What are you strongly for?

58. What do you strongly resist?

59. What dialectics would you gladly resolve (remove the tension of) rather than retain, or rather than find an axis upon which they could exist?

60. If you looked *for nothing* and followed it, where would that lead?

61. What knowledge and traditions have been obstacles?

62. How have you been governed?

63. As you dig for words that are used to explain other words, which ones do you disavow before you even say them?

64. As you dig for words that are used to explain other words, which ones do you notice are also relatively emotionally charged?

65. Express the knowledge you have but don't think about, in the form of a negative formula.

66. Describe what is unknowable.

67. What would you consider the most unlikely imaginable thing in your current situation?

68. What was furthest from your mind at your most recent more important time?

69. Suppose a utopia collapsed, and then answer: "*Why?"*

70. What suffering and redemption can you hold simultaneously, as a dialectic?

71. Discuss suffering as inescapable, necessary, and instinctively pursued.

72. Discuss unnecessary suffering (ruminative thoughts, being overly attached, etc.) vs repeating life patterns over and over.

73. Discuss free will and determinism from the perspective of choosing to suffer, and of being forced against your will to hurt others for a purpose.

74. Discuss the harms you *choose* to inflict upon others vs the harms you *must* inflict upon others. And discuss which ones *do* or *do not* seem good, and right, and easy - and why.

75. Is there a fundamental problem common to humans that is evident with regard to the nexus of suffering and the pursuit of survival?

76. Upon reprieve from one's fate, one might finally become spiritually beneficial to others. What basic fault is common to all people? Is there also then a basic correction?

77. External solutions that bring solutions are arbitrary unless they have a 2-way transactional nature; is this so?

78. Describe a helpful and effective *facilitating environment* in the home. And in counseling.

79. Discuss "maintain order" as a value.

80. Discuss the discipline of the mind as an exercise of authority and power.

81. What are your internalized values, behaviors, and thoughts?

82. Who wants you to be a docile subject, and why is that their focus?

83. Whose goal is to remove costs from the system and to complete reformation to support the system?

84. Is power in knowledge, such as dominant cultural discourses like science? What power do you have?

85. What surveillance, normalization, examination, and re-examination has been in your life?

86. Discuss the all-seeing system and the power of that mind over a single person's mind.

87. Those that will not reform and conform are fascinating to us; in what way is it that we love criminals because they show us we are in a social prison?

88. Discuss your view of science from the angle of an individual's subjectivity and society-level subjectivity.

89. Replace archeology with genealogy. How did the evolution take place?

90. Pick and discuss a subject in your life or family system where there is a lot of agreement about what things are, and how things are.

91. What types of power affect you in your daily life?

92. A capillary can represent an unstable network flowing in and from every direction all at once. What examples come to mind?

93. We all exert our power every day: suggestion, persuasion, surveillance, cultural norms, encourage, discourage, who to hear, and to silence. What examples come to mind?

94. Scientific discourse and cultural norms hijack us through thought-leader knowledge. Like what?

95. Is the one speaking absent from their words? Do they disappear? Discuss how words can be a shield of invisibility – of transcendental anonymity.

96. Blurting out is authorship, even if not consistent in quality, coherence, style, or convergence with previous work. Like what?

97. We can become a "second-self" as subject matter, when we are an author or in authorship.

98. The unspoken generational claims of rights are above the baby's rights.

99. Discuss what people holding a baby too tight – because the baby will protest – says about us as people.

100. Discuss undoing the effects of childhood vs having helpful access to our childhood.

101. Sometimes we "identify with the aggressor" while ignoring the emotional experience that was not remembered. But this is different from moving toward what will undo us. How so?

102. Describe your inflicting of your own childhood pain upon your family or coworkers.

103. Discuss the psychological requirements for your identification with your betrayers and aggressors.

104. Describe your emotional starvation.

105. Describe your developmental impairment.

106. Do you want something different from your own life? And does that really prevent your downward spiral over time?

107. What are some topics or occasions where you speak of trivial concerns at length or in an inarticulate way – especially as an indicator of phobic dread?

108. What are some topics that cause you to engage in oblique communication? What terrible secret is hidden behind that hint?

109. What do you resist in the form of napping?

110. Describe your family in the framework of the 5 constant relationships:
    a. Ruler (benevolent, lead by example) vs Subject (loyal, serve the ruler)
    b. Parent (loving) vs Child (obedient)
    c. Spouse (good, fair) vs Spouse (understanding)
    d. Elder sibling (gentle) vs Younger sibling (respectful)
    e. Older friend (considerate) vs Younger friend (reverence)

111. Comment on this line of cause and effect: Sincerity becomes a parent, from being a parent it becomes manifest, from being manifest it becomes brilliant, brilliant it affects others, affecting others they are changed by it, changed by it they are transformed. Only the sincere, transform.

112. Discuss the notion that people should be encouraged to work for a transcendent purpose. And in that way *on their own* they put behavior in alignment with what is virtuous at the societal level, and thus sustain themselves in that effort (vs are forced or controlled by a government).

113. Have you experienced:
    a. A moment of conversion?
    b. An aesthetic moment?
    c. A suspended moment when self and object feel reciprocally enhancing and mutually informative?

114. Have you seemingly been held by the spirit of an object – by the hand of fate? If so, what generative illusion resulted?

115. How do you handle yourself as an internal object within intra-subjective space?

116. Describe your: reception of wishes; mediation of conflict between wishes; practicalities and inhibitions; and facilitation and management of partial fulfillment of wishes.

117. Describe your daydreams, imaginary characters, and domains of self-expression.

118. What objects in your life are converted into emotional reassurances?

119. How were you managed?

120. What do you avoid? Make compromise with? What fragmented objects do you expel?

121. What negative intimacy do you state or evoke?

122. What means establishes you as a person, and fully exhibited?

123. What view of the world (and others) do you participate in, re-create, maintain over time, and hate? What would be destroyed if you found harmony?

124. In what way do you merge into what you hate?

125. In what way are you informed rather than educated?

126. What is seen but not known, heard but not understood? What mental representation and thinking is substituted by the language of the body?

127. What unforgettable vision or image of self are you attempting to implant?

128. What are you repressing? What unseen material did you lack in your mirroring?

129. Discuss how the illness of two or more people represent your primary objects.

130. What complexity, subtlety, and nuance did your family miss, and does your current family miss?

131. What were the public opinions of your family of origin? What were those they held publicly and those they had concerning public life? What are those of your current family? What are your own?

132. Describe your pseudo community and how you built it (inclusion and exclusion of members, concepts held - at the level of stereotyped ideas).

133. In what way do you think, feel, reflect, fantasize, desire, and dream?

134. How do you evidence ego weaknesses: impulsivity, tendency to action, low tolerance of limits and delayed gratification, concreteness, grandiosity, magical thinking, and incapacity to mourn?

135. Of the unknown past suggest what is plausibly true rather than actually true.

136. Why is it so hard to bear guilt and uncertainty? And what does this have to do with your trauma, relationships, and non-trauma conflicts? And what does it have to do with repeating in the counseling relationship?

137. Describe what if you take the artistic way of looking at the world vs the literal or scientific way.

138. What do we learn from art? What kind of truth do we gain from art that is not available from any other human activity?

139. In what way is substance use an indigenous anesthesia, like acetaminophen?

140. Describe the pleasure of desiring vs the pleasure of obtaining.

141. What did art teach you in advance of an event?

142. What sensory pleasure (animal) vs thinking pleasure (reading, argument) vs intentional pleasure - do you take from art?

143. What mistaken pleasures can you identify? What scenes or events pleased you, but later you discovered the truth?

144. Pleasure says, “come again” about the visitor. Knowledge says, “thanks” about the information. Expound this.

145. Describe how putting aesthetic values first is a kind of immoralizing activity.

146. Expound this logic: form leads to repetition; it puts you back in relation to the thing. Truths are to be rehearsed in order to be owned. This and meditation lead to revealed truth.

147. Art is not “useful” but interesting for its own sake; every illusion matters.

148. What garbled versions of moral relativism have had large influences on you?

149. To defend objective aesthetics is much more difficult than to defend objective morality. Architecture is the only art within which people are inclined to agree.

150. International human rights organizations have an agenda that has grown out of control. Do you have a human right to health care, a home, and basic income? And what would settle the question? Isn't it true that no one knows?

151. Should elites impose their judgments on the masses via special transnational commissions and national courts?

152. Customs are a reflection of objective moral truth. What are your customs that are reflections of moral truths?

153. Parallel legal systems within a nation ultimately reject the notion of and identity of the nation state (national laws vs international laws). Describe your laws as they conflict with those of others or other groups.

154. Comment on the notion that families can be differently constituted and can live side by side – even if the other family does not live in the right way – and toleration is not required to do so.

155. Is the program or clinical method reflective of: Reality (credible, plus quale); Alternate worlds (mere myth); Simulation (mere replica); Simulacra (signs where there is no original or object)?

**Resources from which those items were developed**

***Gilles Deleuze*** "What Is Philosophy?" (Philosophize This ep. 125); "Immanence" (Philosophize This ep. 126); "Anti-Oedipus" (Philosophize This ep. 127); "Difference" (Philosophize This ep. 129)

***Wilfred Bion*** "Notes on Memory and Desire"

***Jacques Derrida*** "Derrida and Words" (Philosophize This ep. 119)

***Logical Positivism*** "What is logical positivism?" (Philosophize This ep. 120)

***Heinz Kohut*** "The Problem of Scientific Objectivity and the Theory of the Psychoanalytic Cure"; "The Curative Effect of Analysis: A Preliminary Statement Based on the Findings of Self Psychology"

***Jean Baudrillard*** "Simulacra and Simulation" (Philosophize This ep. 124)

***James Hollis*** "The Ghosts of Our Parents"; "The Sailor Cannot See the North: The Haunted Soul of Modernism"

***Daoism*** "What is Daoism?" (Philosophize This ep. 007)

***Sigmund Freud*** "Negation"

***Fyodor Dostoyevsky*** "A Look at Suffering" (Philosophize This ep. 94); "Literature – Fyodor Dostoyevsky" (The School of Life, YouTube)

***Donald Winnicott*** "Fear of Breakdown"

***Michel Foucault*** "Discipline and Punish" (Philosophize This ep. 121); "The Order of Things" (Philosophize This ep. 122); "Power" (Philosophize This ep. 123); "What Is An Author?"

***Selma Fraiberg*** "Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships"

***Confucianism*** "What is Confucianism?" (Philosophize This ep. 008)

***Christopher Bollas*** "The Spirit of The Object as The Hand of Fate"; "The Self as Object"; "Loving Hate"; "The Psychoanalyst and the Hysteric"

***John Dewey and Walter Lippman*** "On Democracy" (Philosophize This ep. 130)

***Howard Levine*** "Difficulties in Maintaining an Analytic Stance in the Treatment of Adults Who Were Sexually Abused as Children"

***Roger Scruton*** "The True, The Good & The Beautiful." (The Wheatley Institution, YouTube) "On Moral Relativism." (Common Sense Society, YouTube)

***Michael Balint*** "How Doctors Learn In a Balint Group"; "Preventing Burnout: Increasing Professional Self-Efficacy in Primary Care Nurses in a Balint Group"

***Gideon Rosen*** "Questioning Materialism." (Meaning of LifeTV, YouTube)

## Favorite Quotes

"….so I learned something from him without entirely knowing what it was. Which is kind of the story of the life of most psychoanalysts and clinicians who have a sort of monastic, contemplative life. You sit behind somebody or you work with somebody for hours a week. Months, years pass and you're learning something, although you don't quite know what you're learning." *Christopher Bollas. "Mental Pain". Lecture presented November 10, 2016.*

"…not so much the empirical, deductive, observation. But really the intuition of the analyst – the analyst's use of reverie, spontaneity, of creativity and intuition – as opposed to simply empirical observation. Because after all what we're talking about here is something which has psychological significance but without psychological representation. In the treatment of neurotics, the analyst's position is one of waiting and responding. In the treatment of these other conditions, the analyst's position is one of waiting and then leading. So, it requires something very different and a kind of oscillation and balance between the two. And a willingness to entertain wild thoughts, to allow spontaneity to arise from within one's self, and to trust in an analytic process that will be catalytic and creative with and for the patient…The capacity to wait, the capacity to bear ignorance and uncertainty, and the capacity to trust one's spontaneous analytic reflexes…We want to teach our students to wait, to be patient, to be cautious, but also to be free enough to be spontaneous. And it's the oscillation and balance between the two that's so complicated...Sometimes it's better to make an enlivening countertransference mistake, than to be technically correct but dead with the patient."
*Howard Levine.*

## About the Author

**Brian Coon** has been working full time in residential addiction treatment programs from his graduate internship in 1988 to the present. Following his internship, his first 19 years were spent serving in a 9-12 month residential Therapeutic Community (TC) program that shared a staff and physical plant with an outpatient methadone maintenance program. The TC had a nursery component for children up to 12 months of age to live with their mothers during treatment.

In the early 1990's that residential program was improved when the organization won a 5-year CSAT demonstration grant for pregnant, post-partum, and parenting women including a physical plant and staff expansion in the TC to include a nursery component and capacity for 14 children from newborn to age 4, training and standards for gender-specific and culturally-relevant care, nurturing parenting programming, developmental assessments (cognitive, social, motor) and corresponding manualized therapeutic interventions for the children, and addition of a women's health focus. That grant included various additional improvements across the organization. Brian sat on the steering committee of that effort after funding was concluded. During all of his last 12 years in that organization, he had full clinical and managerial responsibility for the TC and outpatient methadone maintenance program. Later in those 12 years he had additional responsibility to guide a criminal justice halfway house under contract with the Federal Bureau of Prisons (FBOP), an intensive outpatient program provided inside a 300-bed city/county work release detention facility, and a one-year outpatient SUD aftercare program for FBOP, among other duties.

Notably, that organizational workplace was the community agency within which the Behavioral Health Recovery Management (BHRM) project was begun and operated. Brian served on the BHRM implementation steering committee for the entire 10-year lifespan of the BHRM project starting in 1998. The BHRM project was the living clinical laboratory where the principles and practices of recovery orientation for clinical services, recovery coaching, and approaches that later came to be known as "Recovery Management" and "Recovery-Oriented Systems of Care" were innovated and developed. The BHRM steering committee expanded and sharpened its focus when that workplace was chosen to participate in the Network for the Improvement of Addiction Treatment (NIATx) at the start of Round 2 in the Robert Wood Johnson Foundation-funded portion of NIATx's history.

Throughout its 10-year lifespan the BHRM steering committee also led change in the area of co-occurring SUD and MH disorders by identification of national experts in best practices and promising practices and contracting those experts in: authorship of clinical practice guidelines for the organization, provision of training within the organization, and on-going consultation in implementation of their protocols in a multi-year state-funded effort within that organization. The steering committee led by taking responsibility for initial clinical fidelity at the clinician, program and organizational levels based on those protocols, ongoing clinical supervision and sustainability of fidelity in those practices, continuous quality improvement of service delivery, and a focus on change management integrating those clinical practices with BHRM principles and NIATx change methods in the dozens of programs across the organization.

Since 2008 he has worked in a freestanding interdisciplinary program that includes specialized services for public safety-sensitive professionals and young adults. He assisted that organization's senior leadership with transformation in 2013 to a smoke-free approach to addiction treatment, and the successful sustaining of that approach to the present time. In that workplace, his routine duties include the clinical supervision of clinical supervision, and of counseling.

Brian holds a BS in psychology and MA in community-clinical psychology. He is a licensed clinical addiction specialist (LCAS), certified clinical supervisor (CCS), and nationally credentialed as a master addiction counselor (MAC). His academic and clinical background is in the scientist-practitioner model, cognitive-behavioral psychology, and evidence-based treatment of co-occurring substance use and mental health disorders in adult populations. He has given continuing education presentations at state, regional and national conferences as well as various clinical organizations. He has authored or coauthored a variety of publications including peer-reviewed literature. He has a strong life-long interest in biology and philosophy. His recent years have been marked by an interest in the analytic tradition/depth psychology, the mentoring of clinical supervision, and the impacts of each upon systems of care, individual clinicians, and clinical teams. In his spare time, he serves as an Affiliate at *addictionandbehavioralhealthalliance.com* and has written additional articles as a Contributor at *recoveryreview.blog.*