Addiction and Alcoholism: The Form of the Disorder

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"It may be noticed that I am concerned with unconscious motivation, something that is not altogether a popular concept. The data I need are not to be culled from a form-filling questionnaire. A computer cannot be programmed to give motives that are unconscious in the individuals who are the guinea pigs of an investigation. This is where those who have spent their lives doing psychoanalysis must scream out for sanity against the insane belief in surface phenomena that characterizes computerized investigations of human beings."

Winnicott, D. (1971, 2005). Contemporary Concepts of Adolescent Development and Their Implications for Higher Education. In: Playing and Reality (pp 192-193). Routledge: NY.

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Introduction

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

It seems to me that an overly check-listed, manualized, and automated yes/no approach to determining the presence or absence of the DSM-5-TR criteria for SUDs is a poor way to establish the applicability of those criteria to any one particular case. And even more so for the presence or absence of addiction illness. Further, I think this is especially true when it's the patient being asked to make the determination. After all, when the diagnostic duty is relinquished to the patient, that transfer of control transforms the patient into both the clinician and the clinician's clinical supervisor.

For a full treatment of the screening and assessment of substance use disorders, one might be interested in reading my November 22, 2024 monograph on that exact topic.

But here, my main focus is not that level of granularity, breadth, or the associated and necessary logic. Rather, here, my main focus is *the syndrome* we all know as alcoholism (when present for alcohol) or addiction (when present for other drug classes). And what I address about addiction illness in this work is *the form* of the disorder.

Consider the following example.

When a patient who upon a first meeting in the initial hours or days of their stay in a residential addiction treatment program presents with all of the following:

- nicotine stains on their fingertips
- burn marks on their lips
- bronze-colored skin
- track marks on the back of their hands
- a wide gait
- yellowish eyes

and tells me they don't use drugs and don't have a drug or alcohol problem, I'm skeptical of that claim.

And so, I wonder, "What *form* does addiction illness take, beyond a simple DSM-5-TR SUD criteria count, and the well-known surface-level associated features?" My answer is as follows, with each or my proposed aspects of the form of the disorder in italics.

At this stage of my career, I'm of the opinion that Norman Hoffmann's mathematical modeling of *the weight* of each of the 11 DSM-5-TR SUD criteria, separately, is an intriguing look at the form of addiction illness. In essence, Norm wonders if the Big 5 SUD criteria are *the constellation* of criteria that constitute addiction illness. Inspired by that work, I ventured out on my own and developed a proposal. My proposal is that the disease identifiers established by Jellinek, which were later adopted by the DSM as its first two SUD criteria, could function as *first-rank symptoms* of alcoholism. That would be analogous to Schneider's two first-rank symptoms of Schizophrenia. Further, on the topic of the form of the disorder, I wonder what

could propel simple use into a disorder? Aside from the multivariate predisposing factors that are beyond the scope of this work, Susan Holman MD's quotation about consequences tending to *promote* addiction (rather than stopping or attenuating simple problematic use) is a central aspect of the illness. And is also a feature of its form. By contrast, simple problematic use (below the threshold of addiction), takes on a form that in the classical nomenclature of abnormal psychology would be characterized as a merely neurotic level of organization. But in this work, the reader will see the remainder of my proposal in that vein characterizes alcoholism and addiction as circumscribing the *borderline and psychotic kinds* of organization, form, and function. In doing so, I go on to describe both *psychological dependence* and *physical dependence,* as addiction's clinical form contains either or both. Similarly, *denial* tends to be present. But I will outline a *conscious* form and an *unconscious* form, as well as *the object* of each. This work also addresses the trajectory or *progression* of the illness, as well the positive trauma *in and at* what becomes a turning point into addiction recovery. Lastly, *mental relapse* will be described as part of the form of the disorder. Why? As Shepard Siegel's recent book explicates, and Gorski's life-long clinical work delineates, there's no such thing as "after" addiction. Once it has been brought to life it remains present, if only in a dormant form.

The reader should keep in mind that the aim of this work is simple. I am merely proposing that alcoholism/addiction has a form. And I list and describe what I believe to be elements of that form. In doing so, I am not claiming to be correct. And I am not claiming that "addiction" can only be present if each of the elements of its form that I list are present. I am not replacing the checklist of the DSM-5-TR criteria with a checklist of proposed elements of a form. Rather, in this work I am offering a total framework from which one can consider clinical data. The framework could also be used as the origin of a research agenda related to the identification of addiction illness and its differentiation from other substance use disorders – both in kind, and in course.

And so, to begin my examination of the overall topic of *the form* of the disorder (addiction illness or alcoholism), first I'll propose two first-rank symptoms of alcoholism.

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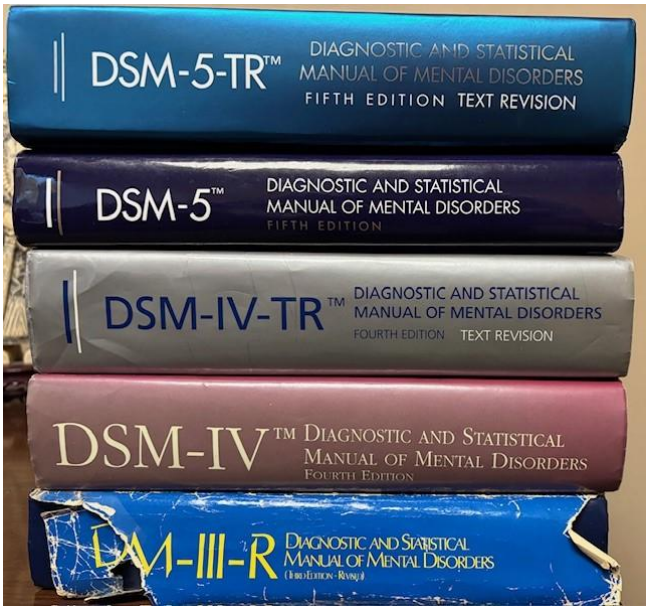
Part 1: Two First-Rank Symptoms

Proposing Two First-Rank Symptoms of Alcoholism

Jason Schwartz recently wrote at *Recovery Review* about the 11 DSM-5 criteria for SUD (APA, 2013). In doing so he discussed the:

- category of Substance Use Disorder in the DSM-5 as being too broad to be useful;
- ballooning of epidemiological data concerning the incidence and prevalence of addiction based on category errors in the context of the DSM-5 SUD cutoffs for "mild", "moderate" and "severe";
- commensurate and inordinate swelling of numbers for those in "recovery" – based on that kind of inflated data.



Over the years, when Jason has written on this and related topics, he has many times referenced Norm Hoffmann's "Big 5 SUD Criteria". For those that don't know this area of Norm's work, he has determined, in general, that each of the SUD criteria numbers 2, 4, 5, 7, and 11 co-vary with each of the other 11 criteria in such a way that to have *any one* of The Big 5 is to be more likely than not to have 6 or more total criteria. That is to say, each of The Big 5 "weigh heavy" separately. And that further, Norm wonders if the pattern of The Big 5 *as a constellation* are the disease of addiction.

While reading Jason's work on the problem of SUD as a category being too broad to be helpful, and his concerns about its implications, the *first-rank symptoms of schizophrenia* crossed my mind.

Read on and think about alcoholism as you do.

In clinical psychology, we learn about the "Schneiderian First-Rank Symptoms" of schizophrenia (1959/1946). In that system of thinking *hallucinations* and *delusions* are the entrance requirements, so to speak, for a diagnosis of schizophrenia. If someone does not

present with at least one of those two symptoms, the diagnostician is not permitted to find a diagnosis of schizophrenia regardless of what other symptoms or criteria might be present. Hallucinations on their own, and delusions on their own, are well established as fundamental to the disorder of schizophrenia. And students of clinical psychology learn about their use as "First Rank Symptoms" of schizophrenia in the work of Kurt Schneider.

As an empirical matter, the sensitivity and specificity of the first-rank symptoms of schizophrenia have been the subject of a 2015 Cochrane Review (one of the most rigorous empirical methods in existence).

The intrepid reader might have a look at the Review, or at least scan its Discussion section. One take-away from that Cochrane Review is that the first-rank symptoms showed utility in *ruling out* rather than *ruling in* schizophrenia. Another is that the authors could *not* recommend the first-rank symptoms as a diagnostic test for the schizophrenia diagnosis.

That Cochrane Review was discussed in a later paper (Mitchell, 2015) suggesting that the utility of the classic first-rank symptoms might be best in initial screening questions in community surveys or waiting room screenings. The author concluded by stating, "Clearly, more work is required to clarify whether individual first-rank symptoms have particular diagnostic value and whether a combination of symptoms might be more useful."

For me personally, that "combination of symptoms" reminds me in turn of Norm's Big 5 SUD criteria.

I'll quickly mention two other areas of work on Schneider's first-rank symptoms of schizophrenia.

One area of work examines them as *predictors of remission* (Malinowski, et al, 2020). Those authors stress the importance of clear definitions of individual diagnostic criteria in doing that work. They also mention how the DSM-5 had departed from first-rank symptoms (compared to previous DSMs), and their study indicated the value of returning to the first-rank symptoms for their usefulness if developed empirically.

The other area of work examines the first-rank symptoms as a window into *the structure of the disorder* (Heering, et al, 2013). Think about the 11 SUD criteria, the Big 5, and the nature of alcoholism as you consider the authors stating, concerning schizophrenia,

> "In conclusion, we showed that first rank symptoms represent separate clusters within the group of positive symptoms, and consist of two underlying clusters of symptoms, which is in line with the original proposal by Kurt Schneider. Both symptom clusters are relatively stable over time within individuals. We believe that evaluating the development of symptom patterns is more fruitful then using diagnostic categories alone, since psychosis can be perceived as a syndrome with heterogenic symptomatology. Knowledge on the development of symptom patterns may contribute to our understanding of how clinical phenomena link with underlying cognitive mechanisms irrespective of diagnostic category."

All of this, then, reminds me of the seminal work of Jellinek done with alcoholism. Jellinek's papers titled, "Phases in the Drinking History of Alcoholics" (1946) and "Alcoholism, a genus and some of its species" (1960) point to the notion that two forms of the disease of alcoholism exist.

1. One characterized by drinking more than planned once drinking begins;
2. And the other by those that cannot stay stopped once drinking has ceased.

Jellinek held that each of these two differing forms of alcoholism constituted a disease, while his other proposed forms of alcoholism did not.

The reader might recognize those two identifying features as being borrowed by and appearing in the first two criteria for SUD/Alcohol Use Disorder in the DSM-5: drinking more than planned (criteria # 1), and a persistent desire or inability to cut down or abstain (criteria # 2).

And so, I wonder:

- Could those two classic identifiers of Jellinek's (criteria 1 and 2 from the DSM-5) be First-Rank Symptoms of alcoholism?
- Should loss of control and staying stopped be empirically evaluated for their diagnostic sensitivity and specificity (via Cochrane Review methodology), aside from their weight in the Big 5?
- What is the utility of these two factors identified by Jellinek as a diagnostic test?
- As a simple two-factor probe, do these factors have potential use in initial screening questions in community surveys, or waiting room screenings?
- How are these two factors (loss of control, staying stopped) predictors of remission?
- And what do they include, if properly probed and developed, that could teach us about the structure of the disorder?

For now, I'll propose that drinking more than planned after drinking has commenced per occasion, and the inability to stay stopped once cessation has commenced, are the First-Rank Symptoms of Alcoholism. And perhaps failing to meet them means screening addiction out.

Next in this work I'll examine a central feature of addiction illness that pertains to progression of the illness.

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Part 2: Susan Holman, MD Quotation

Sentences to Ponder (Susan Holman, MD)
"Consequences don't stop our using. They promote it."

When I first heard Dr. Holman say this around 2009, it really struck me.

Why?

It had an entire feel about it. Not how she said it, but the words themselves. And the message was pretty specific, too.

For decades I had of course heard and read the phrase, "…using in spite of consequences." But this was different.

This had a whole thing inside it related to course of illness and progression. How so? This phrase shows us the relief found in the using that happens during the disorder, *for the problems caused by the disorder.*

To me this shines a light on one of the hallmark features of addiction illness that can help separate it from mere problematic use, especially as evidenced over time.

We know that "unpleasure" as it may be called, or an aversive state as it may also be called, is anesthetized or relieved by using. And that this is a second benefit that some gain from their initial use, other than the routine first benefit of euphoria. Research has shown that at the population-sized level, those with initial discomfort such as mood disorders or clinically significant anxiety, are at increased risk for developing a SUD, due to this second benefit.

This combination of positive reinforcement (the pleasure of euphoria) and negative reinforcement (the relief from unpleasure or discomfort) propels continued use. This double benefit can propel the course of illness forward at a rate and trajectory that is sooner, faster, and further, then would otherwise be the case and attributable only to the pleasure of the drug itself.

How so?

As simple using continues, during the "course of illness", the consequences of using that might otherwise arrest or attenuate the using are relieved – by using.

Next, I'll describe Norman Hoffmann's work on the weight contributed by each DSM-5 SUD criteria, separately, and his proposal of the resulting "Big 5 SUD Criteria" as the possible constellation of criteria that is addiction illness.

Part 3: The Big 5 – Norman Hoffmann, PhD

"The Big 5" SUD Criteria

Norman Hoffmann has both published, and presented at national conferences, his work concerning what he calls "The Big 5" substance use disorder (SUD) criteria from the DSM-5.

In short, Norm has examined *the relative weight* of each of the 11 DSM-5 SUD criteria separately, as applied to the probability of having any one or more additional positive criteria for SUD (from data collected on thousands of consecutively incarcerated individuals).

The empirical questions and answers on The Big 5, as Norm has presented them, are summarized here:

1. Question: Which of the 11 DSM-5 criteria for SUD are commonly found among individuals with *no SUD diagnosis*?
   - Answer: Tolerance, and Use in dangerous situations.
   - That is to say, in his sample, the presence of tolerance as a single factor did *not* make it more likely than not that any additional criteria were present – and the same was true of use in dangerous situations as a single factor.
2. Question: Which of the 11 DSM-5 criteria for SUD are commonly found among those with *mild to moderate* SUD?
   - Answer: Unplanned use, Time spent, Interpersonal conflicts, and Use in spite of medical/psychological conditions.
3. Question: Which DSM-5 criteria for SUD are found *primarily in severe* SUD's?
   - Answer: Efforts to control/cut down but unable (rule setting), Craving with compulsion to use, Failure to fulfill role obligations, Activities given up or reduced, Withdrawal.
   - That is to say, in his sample, the presence of any one of these 5 criteria, separately, *was* more likely than not to be present among 6 or more total positive SUD criteria for any one individual.

In presenting these results from his research, Norm has asked if perhaps the total constellation of The Big 5 is what is commonly called the disease of addiction. Interestingly, Norm has also noted the individual may fit mild or severe characteristics (aside from DSM-5-TR scaling), based on The Big 5, and as a result he has expressed the following questions:

- Are those with mild to moderate DSM-5 ratings without any of The Big 5 able to moderate use with less intense and briefer services?
- What are the implications of The Big 5 for etiology and course of illness of the individual?
- Specifically, do those that are positive on 2 or more of The Big 5 in fact require initial residential placement and/or more intense and longer care, and require abstinence – even when not numerically "Severe" according to DSM-5?

Overall, Norm encourages the clinician to consider *the pattern* of positive criteria, in addition to the mere total number of criteria present.

Concerning patterns, next I'll explore 3 distinct patterns of disorganization that may be present in the context of any mental health disorder. And I'll propose the pattern specific to addiction.

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Part 4: Neurotic, Borderline, Psychotic

SUD Typologies: considering reality testing, defense mechanisms, and identity integration

Three Levels of Organization

Traditional psychodynamic approaches to abnormal psychology examine three levels of general organization/disorganization of any person with any mental disorder. These three levels are not of the *disorder* only, or of the *person* independent of their disorder. Rather, they are with regard to the totality of *the whole person*.[1]

Originally, Freud thought there were two levels: "neurotic" and "psychotic". After many years the clinical community came to a general consensus that a third level seemed to exist. That third level was between the more severe "psychotic" level and the far less disturbed "neurotic" level. The proposed in-between level was named the "borderline" level, because it was on the border between the two levels first proposed.[1,2] Consider the following descriptive range of the three levels.

Psychotic	**Borderline**	**Neurotic**
broken reality testing	inconsistent reality testing	intact reality testing
very primitive defenses (e.g. delusional projection)	primitive defenses (e.g. splitting)	mature defenses (e.g. intellectualization)
no integrated self or self-other differentiation	fragmented self; unstable self and others	stable identity

Examples for SUDs

Below are SUD examples that could serve as indicators across the three levels.

Level of Organization	**SUD Example**
Neurotic	
Intact reality testing	Presents the consequences of using behavior as the chief complaint
Mature defenses	Consistently intellectualizes to support moderation goal
Stable identity	Seeks to preserve self and life situation as goal of therapy
Borderline	
Inconsistent reality testing	Assigns cause for some consequences of using to other people while unable to acknowledge other consequences

Primitive defenses	Intermittently hostile and volatile
Fragmented self	Divides others to friend or enemy status
Psychotic	
Broken reality testing	Drinking while jaundiced and voicing contentment with sleep hygiene and pattern of eating
Very primitive defenses	Blames facts and circumstances for problems drinking causes
No integrated self or differentiation	Boundaryless relationships at level of identity and autonomy

Application to SUDs

How can the determination of a recommended level and kind of SUD care be made that includes such information? And done so in a way that adds to what is found in the DSM-5-TR diagnosis of the individual?[3] A proposed pathway is outlined below.

First, listen to their life story. Then determine which level of organization their disorder takes.

- "Neurotic" is the "hard-drinker" (AA)[4] or the "non-disease form" (Jellinek).[5,6]
- "Borderline" and/or "Psychotic" is the "true alcoholic" (AA)[4] or the "disease form" (Jellinek).[5,6]

Next, consider both the DSM-5-TR SUD severity and level of organization determination. This provides a more wholistic view of the person than the DSM alone.

Finally, what level of challenge does the person present?

- Generally, the "neurotic" range would indicate appropriate options could include one, some, or all of the following:
    - Moderation management.
    - Stopping use, plus nothing – and that strategy actually works.
    - SUD education. CBT, MI, or a combination.
- Generally, the "borderline/psychotic" range would indicate appropriate options include all of the following:
    - Primary addiction treatment such as in a residential program or IOP.
    - Finding, choosing and joining a mutual-aid fellowship.
    - "Identifying" relative to the diagnosis and the fellowship.
    - Abstinence and a personal program to sustain full-person recovery

Next in this work I'll describe two presenting pictures specific to alcoholism and addiction that in a former era constituted clear evidence of addiction illness.

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Part 5: Physical Dependence, Psychological Dependence

The Concepts of Psychological Dependence and Physical Dependence Are Being Lost
I have been thinking about "psychological dependence" and "physical dependence" a lot lately. It seems to me our field is losing these concepts.

Psychological Dependence
Back in the late 1980s counselors and patients alike would bring up "psychological dependence" from time to time. But over the last 20 years this concept seems to have slowly gone away. I can't remember the last time I heard someone bring it up.

When is the last time you heard anyone talk about identifying "psychological dependence" as a feature of someone suffering from addiction illness (alcoholism, or a moderate to severe substance use disorder, etc.)?

Back in the 80s, psychological dependence was taught to me by university academics, clinical professionals, and patients too. They all taught me that psychological dependence can be a *feature of* addiction illness. It was also taught to me as a *developmental milestone* in one's progression in addiction illness. I was taught that when psychological dependence is present, it indicates further progression. I was taught that psychological dependence is also a concern all on its own, given its particular association with relapse potential. For example, back then, patients with cocaine addiction would say, "It's a mental thing."

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I paid particular attention because all 3 sources taught me about it. They all agreed. Over the last 20 years it seems this topic has been largely lost by academics, researchers, and clinicians trained more recently. I wonder why.

Physical Dependence
Likewise, back in the late 1980s, I was also taught about "physical dependence" by academics, clinicians, and patients. They all used this term and used it to mean the same thing: physiological adaptation to a drug such that if the drug was not taken withdrawal would begin. Moreover, physical dependence was taught to me as a developmental milestone in

addiction illness. How so? I was taught (by university academics, clinical professionals, and patients) to determine if a patient is physically dependent, and if so then to find out how many weeks, months, or years the person has continuously taken the substance to avoid withdrawal. The idea was that both the *presence* of dependence, and the *length* of dependence, are each related to disease progression of addiction illness. The longer someone successfully maintained physical dependence without being "sick" or going into withdrawal, the worse their condition, and the more concerned we should be.

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I paid particular attention to this information because all 3 sources taught me about it. They all agreed. But over the last 20 years this concept seems to have slowly gone away. I can't remember the last time I heard someone bring it up. Over the last 20 years it seems this topic has been largely lost by both university academics and by more recently trained clinical professionals.

I wonder why.

Lessons from Frank Lloyd Wright

I recently came across a portion of an interview Frank Lloyd Wright gave. The film footage of this exchange was less than 3 minutes long (an excerpt from the full interview) but I found it fascinating. I have written out the exchange below. The questions are from the interviewer, and the answers are from Frank Lloyd Wright. To me this gives us a window into the topics above.

Interviewer: How many companion students do you have?

FLW: There are about 60. They come from all over the world.

Interviewer: Do they….some of them have training?

FLW: Some have training.

Interviewer: But it doesn't matter if they don't?

FLW: And some don't have training and are quite ready to develop without it.

Interviewer: Well, now what's the minimum thing? They surely have to know some engineering.

FLW: No, because an engineer is only a rudimentary, undeveloped architect. They have to get the sense of the thing. The sense of structure. The sense of materials. They have to get the nature of the thing, which very few engineers know. An engineer is a "book man" as a rule. He gets everything out of books and formulas. And puts things together and takes them apart. Without ever knowing. Well, you know these characters who know all about everything and understand nothing. And you can say that of an engineer where architecture is concerned. He knows all about the architecture and knows nothing about it.

Interviewer: Where do you think they should get their roots from?

FLW: Nature study.

Interviewer: Terrain?

FLW: Not necessarily terrain. Nature with a capital "N". The nature of this hand – what is it? The nature of the nail on the thumb. The nature of this. The nature of this little thing here. What's the nature of that? That's nature, in that sense, that he studies. And from that he develops by way of experience. Trying this. Trying that. Seeing it tried. Out of our failures – they tell us. And when we make a bad thing, we have to take it down or do it over, he learns. And he learns more, as I have done in my lifetime, from my mistakes – than I have ever learned from my successes.

Interviewer: And from a professor?

FLW: Well, I don't know why professors are, any more than I know why the profession is.

To me, Frank Lloyd Wright is showing us the value of understanding the whole thing from a qualitative standpoint, rather than only relying on knowledge of certain facts.

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Next, I'll examine denial, present it in two versions, and describe its presence in the form of the disorder.

Part 6: Denial of the Problem and the Solution

At this point in my career I support the notion that one hallmark or central feature of addiction is denial.

I don't disagree.

But as I've been thinking about "denial" over more recent years, it seems to me there are *two forms of denial* in addiction illness. And each of them is with respect to a specific topic or object. The first form of denial is denial of the problem. And the second form of denial is denial of the solution. Here, I'll briefly discuss them both.

Denial of the Problem (Conscious Denial)
I would say that the *denial of the problem* is a conscious kind of denial. This is the argumentative, rationalizing, intellectualizing, blame-shifting type of reaction to objective evidence of the problem.

This kind of denial, the conscious kind about the topic of the problem/the illness, is rather well known in the mutual-aid community, clinical community, and popular culture as well. One might be able to detect this kind of denial rather easily. One example of its detection is a frank "no" about the possible presence of the illness under circumstances that would otherwise make identifying the problem very obvious. Another example would be a kind of angry arguing or obvious rationalizing that is rather continuous.

Part of what can make this kind of denial rather easy to detect at times are its blatantly incorrect assertions delivered in an outspoken way.

But I would like to assert that there is also another form of denial, with a different object or topic as its focus. And that other form of denial is an unconscious denial of the solution.

Denial of the Solution (Unconscious Denial)
In my experience with patients over the years, the completely unacknowledged topic that gains no noticing, energy, discussion, or resistance is the solution.

To explain myself, I'll put what I have in mind in 12-step terms. The focus of this unconscious denial is *the solution in the Second Step.* (The Second Step is about restoration to sanity by a power greater than ourselves).

What is it that's so unthinkable it's not thought? So terrifying that it remains unacknowledged? And so fully and readily capable of evoking existential horror that it is outside of awareness and discussion?

The solution.

Facing the solution as is found in the Second Step, is so dreadful and full of existential awe, it's literally worse to consider than the illness itself.

The alcoholic would rather argue about not being sick than face the solution as a solution.

Being gazed upon from the solution side, by the solution, is a source of existential collapse. And is in the position of unconscious denial.

In cognitive psychology or psychodynamic clinical terms this kind of unthinkable status, that is before any idea of it being a possibility, can be referred to as "de-symbolized". Or perhaps, as I think of it, "pre-symbolized". This may sound technical but the idea is simple.

Imagine an idea so outside of our ability to think it that we have not yet formed any representation of the idea yet in our conscious mind. It's almost as if it's pre-thought, or at least not known to be thought – yet.

In what is commonly called the Johari Window this kind of content might be in the quadrant known as "not known to self or others". Over time, awareness of the topic might come into the mind of a friend or family member. But even then, there is no overt resistance or arguing within, or outward from the inside, of the person in this kind of denial. Their lack of awareness is out of their awareness.

What is the topic of this unconscious denial? The solution.

In my experience with patients with severe, complex, chronic addiction illness, the awe and magnitude and meaning of the solution (such as a higher power, the "we" of the therapeutic community of staff and peers, the recovery fellowship, etc.) presents such an existential threat to the status quo it is outside of all awareness.

And this lack of awareness of the solution, and the unconscious denial that maintains this lack of awareness, promotes progression of the problem.

In the upcoming section of this work, I'll take a look at the big-picture structure of the disorder as it progresses, and the characteristic form it takes in doing so.

Suggested Reading

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

Part 7: Progression

Cyclonic Devouring: A Metapsychology of Addiction Progression

It seems to me that addiction:

- is dynamic
- has a form
- consumes energy and manages affects
- is influenced by genes and is also developmental
- has substructures that are simultaneously independent and interdependent
- adapts to reality.

Let me expound each of those points in turn.

Addiction is fluid, not static. Once in place it undulates within, among, and between various factors including periods of abstinence, types of presenting problems, and primary chemical(s) being used.

Nonetheless, addiction has a form. And that form is captured at the screening level by its two first-rank symptoms, and at the diagnostic level by the Big 5 SUD criteria. Addiction includes impulses; these can impact cognition and be given a voice.

Addiction sets up an altered kind and ranking of priorities, as survival mechanisms are arranged. The complexity of this includes biological and social epigenetics.

During its course, physical dependence may form, psychological dependence may form, as may cravings and urges. The dissonance between premorbid internalized values and addiction-driven behavior leads to rationalizations and eventually dramatically different values to resolve or prevent dissonance. All of these constitute substructures that operate on their own and may interact.

Ultimately, addiction incorporates all external and internal reality into its central pathology, *assimilating what is* into its disease-state psychological framework and using-related mechanisms. In that way its imploding cyclonic nature slowly intensifies and progresses over time. The intensifying cyclonic implosion moves toward a maximized conclusion, but that phenomenon often called "hitting bottom" is covered in the next section, not this one.

Next, I'll present and discuss a positive and outward expansion found in recovery. And here I'll note that the list of bullet points above are ones I have borrowed from a previous author – and will name that author toward the conclusion of this work. For now, I'll use those very same bullets again in my discussion of recovery.

Outward Expansion: A Metapsychology of Addiction Recovery and Flourishing

But for now, it further seems to me that recovery:

- is dynamic
- has a form
- requires energy and manages affects

- is influenced by genes and is also developmental
- has substructures that are simultaneously independent and interdependent
- adapts to reality.

Let me expound.

Recovery shifts in time by the individual's type of path, nature of the current path, and the larger process of change.

However, at the population level its form is recognizable, combining stages and simultaneous changes that are continuous across stages. These simultaneous processes include extrication, accommodation, and shedding. Examples during recovery include serial abstinence by drug class, and the changes associated with each. Wellbeing and its management phase have their own content as well.

Social energy from individuals and groups is a hallmark. And affect management (in both the "do" and "don't" direction, related to both aversive and pleasurable sensations and feelings) is intrinsic to what recovery is.

Recovery is socially transmitted and socially epigenetic. Recovery is developmental by its nature and its stages of progress, resulting from the (person x environment) contemporary context. The recovery *process* and recovery *as a thing in itself* each have sub-structural components. The recovery model's meaning, value, content, and assistance from others found in language and behavior, constitute an external reservoir. And these may be internalized and even incorporated into self. These resources both *stand alone* and act *synergistically* with each other and with the person as they are.

Recovery also faces reality and grapples with reality as it is. This further sculpts the self, the (self x reality) intersection, and the lived and present recovery that is potential *in time* and in the *contemporary context*. In that way, recovery can take on an increasingly cyclonic nature, leading to an expansive kind of "better than well."

By the way, you will notice I borrowed that same framework once again, and this time applied it to recovery.

So, it would seem that both addiction and addiction recovery involve the human mind. As such, it might behoove us to grasp the nature, structure, and function of the human mind – insofar as we are able to do.

James Kelly-Smith: Unsplash

A Metapsychology of the Human Mind

Could we look to the same source for starting places related to the human mind as I used above for both addiction and addiction recovery?

The metapsychology of the human mind outlined by Sigmund Freud (as he was able to achieve with the tools available in his time), included the following assertions. He asserted that the human mind:

- is dynamic
- has a form
- is seated in energy and manages affects
- is influenced by genes and is also developmental
- has substructures that are simultaneously independent and interdependent
- and adapts to reality.

It is striking to me that this list is as relevant today, or perhaps even more so, than the era within which Freud developed it.

Perhaps further efforts applying this metapsychology specifically to our work on helping people overcome severe SUDs would be fruitful as a research agenda.

Next, we will take a look at the positive aspects of development and progress upon and after exiting the pull-force of the illness. And the characteristics of recovery in any form that are present in that context.

Resources and Suggested Reading

Coon, B. WHERE is Addiction? July 8, 2021. *Recovery Review.*

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Part 8: Positive Trauma

Positive trauma: the "Zero Spot"

Ernie Kurtz, in his study of the pre-founding and early history of Alcoholics Anonymous, and therefore of addiction recovery, identified a location within the human he called the "Zero Spot". In his discussion of that location and its role in turning from addiction illness to addiction recovery, he described what I would call a "positive trauma".

Before I get to that I would like to back up and briefly mention Michael Balint and what he called the "Basic Fault".

A complete treatment of the Basic Fault expounded by Balint is beyond the scope of this work. Suffice it to say that in his theory all of us as humans are broken at an essential level by life. And this deep essential fracture occurs early in our first few years of life.

Interestingly, in my opinion, the Basic Fault corresponds to what Kurtz refers to as the Zero Spot. In his exposition of the Zero Spot, Kurtz describes an innermost essential location at the core of our being as humans. And he notes that being regarded by others and giving others regard, at the location of our deepest and most essential and simple human frailty, is at the Zero Spot.

For example, as Kurtz puts it, being seen for the imperfect person we are, by similarly imperfect people as they are, without judgment, can produce a double-sided mirroring at the location of the Zero Spot. He notes that for some that kind of mirroring happens at their first AA meeting.

He then describes the turning from addiction to wellbeing.

This existential moment he expounds constitutes what seems in my opinion to be like and function as a "positive trauma". An analogy would be setting a broken bone.

In my opinion, these are included in the form of the disorder.

Consider this quotation from Denise Kagan, PhD (personal communication, 2026): "In your analogy about the broken bone to the basic fault, Balint would say that the scar the broken bone leaves - even though it is one no one can see (even the person with the scar) - is the basic fault. The scar informs everything that is built on top of the healing, and everything that happens after the initial injury. And it is where we learn resilience, strength, adaptability, out of pain and injury. The positive trauma."

Next in this work is my final delineation of the form of the disorder. In the upcoming section we will find remaining residue, patterns, and dynamics that take a latent presence during remission and recovery.

Reference

White, W. L. (2012). Reflections – Ernie Kurtz – Chapter 2: Spirituality. YouTube.

Part 9: Mental Relapse

"Every one of you will relapse. We just hope you don't use over it."
Tammy Bell, MSW

During my first two and a half decades working in addiction treatment, I was surrounded by the term *mental relapse*.

Let's talk about that term.

What is mental relapse? How is it defined?

For starters, mental relapse frames relapse as a *process*, not an event. It's the process that begins before using resumes.

To be clear, mental relapse occurs while someone is managing their recovery. It's not the set of events or processes that occur during periods of abstinence within the active phase of addiction illness.

Mental relapse can be described as a *pattern* consisting of two things: a relatively long, slow
1. degradation of recovery, and
2. return of symptoms.

Degradation of recovery refers to a diminishment of wellbeing indicators and self-care–related activities. Return of symptoms refers to an increase in problem indicators—the gradual return of active illness.

Does mental relapse always end in using?

The process of mental relapse might end in using, or it might not.

In that way, *mental relapse* differentiates a return to using from the return of other aspects of the illness that re-emerge before using occurs.

The patterns of the mental relapse process tend to be common across people, while the signals also tend to be specific to each stage in the process.

Imkara Visual: Unsplash

By learning the signs and routinely self-inventorying against them, patients can gradually clarify their individual relapse signature. That awareness can be strengthened further by incorporating personal identifiers drawn from feedback from peers and addiction counselors on the treatment team.

Learning to refine this list over time—and doing a daily self-check against a personalized version of it—is empowering.

Ultimately, the ongoing clarification of personal identifiers and daily inventorying of them supports self-efficacy.

How so?

Over time, the personal signs of mental relapse can come to be experienced as ego-alien and ego-dystonic. When that happens, and the process begins to emerge, the patient can name their mental relapse in group and "tell on the disease." Doing so greatly reduces its power.

In recent years, well-meaning advocates and critics alike have argued that *recovery* has a single objective identifier: abstinence. And that *relapse* has a single objective identifier: return to use. Both of these perspectives flatten the recovery lifestyle out of its meaning and reduce relapse to a using event devoid of antecedents. In that worldview, *mental relapse* disappears—the idea, the language, and the utility.

For decades, there were several common ways these ideas and practices were used.

One was the positive reinforcement of detecting any signs of mental relapse, even before the broader process seemed to have fully awakened. This could take on a fun, almost gamified quality—comparing one's own awareness to that of counselors and peers.

Another was the enjoyment, relief, and even humor involved in diverting off the mental relapse process, and back into a fuller recovery dynamic, by telling on it. This often enriches the content of therapy and benefits other group members as well.

A third use encoded recovery principles through a repeated script, role play, or similar enactment, such as:

Counselor: "Are you in mental relapse?"
Patient: "No, I'm not."

Which gradually transforms into:

Counselor: "Are you in mental relapse?"
Patient: "Let me go ask my peers. I'll be back."

Patients were often coached to ask one or two peers they felt closest to—and one or two who disliked them the most. The range of material gathered through that exercise is pure power.

As one of my clinical supervisors once told me, *"If they take away our terms, they also take away our ability to think about what those terms mean."*

I personally can't remember the last time I saw a CE training offered on this topic or term.

Our field is losing the concept of *mental relapse*. And it's part of the form of the disorder.

To close the general proposal of the form of the disorder found in this work, next I present a multi-dimensional array of things that are and how they can be known. This array may promote discovery across a wide variety of academic and clinical stakeholders of kinds of human experience within addiction illness.

Suggested Reading

Coon, B. Stigma, Humanizing Terms, and Taking On Hostility: A Little More. February 7, 2021. *Recovery Review*.

Coon, B. A Classic Practice In Addiction Counseling. January 3, 2025. *Recovery Review*.

Part 10: Addiction Ontology and Epistemology

Developing a More Complete Understanding of Addiction

Addiction counselors meet with addiction treatment patients on a regular basis. Do those interactions provide a complete understanding of addiction? Does that add up to seeing, hearing, and feeling addiction in its fullness? Or measuring addiction in its totality?

One counselor's reply might be, "Of course not. We're not with the patient while they're using."

But that reply dodges what's being asked. And doesn't address the question. The question being asked is if meeting with patients equates to a complete understanding of addiction as a nosological entity.

Another counselor's reply might be that given their own addiction and recovery, they do understand addiction. For example, their answer might rest on their lived experience as a person who formerly used drugs and is now in recovery. Or rest on their experience as a close family member of someone who had addiction illness, and is now in recovery.

But that reply doesn't address the question being asked. The question being asked is if we have a *complete* understanding of addiction as a nosological entity.

Can our personal experience of life (our own addiction, our own change process, or our own provision of counseling) provide a complete understanding? I would suggest it cannot.

A structured approach

We can develop a structured approach to guide us toward a more complete understanding of addiction illness.

What approach can we develop that is more systematic and covers more facets than our own personal or clinical experience?

We could develop a methodology that is structured normatively, yet allows for individualization. And that could include aspects of addiction that are objectively real, as well as those that are subjectively experienced.

Can such a method be developed? If so, what might it look like?

The approach I propose breaks it down in 3 ways.

- One way is to include things that exist only subjectively as experiences. And also, things that exist objectively regardless of whether they are experienced or not.
- Another is to include both objective and subjective ways of knowing.
- The last one is a list of categories from philosophy, through biology and down to math.

All three of these are presented in a grid. The challenge is to fill in every box within the grid.

Some caveats
Before I share the grid, I'd like to provide some caveats.

First, I want to stress that there is no superiority or hierarchy of explanatory power in the vertical list of row headers. "Math" is not "better" than biology or psychology or philosophy.

Another is to stress that there is no implied "verification" of what's in one box by what's in another. Whatever is in each box of the grid stands alone as a fact, plus nothing.

Further, every clinical discipline can complete the grid in its entirety. Every discipline can and should. No discipline "owns" some quadrants while being encouraged or allowed to ignore others. No box on the grid is "outside the scope" of any clinical discipline.

Unsplash: Annie Spratt

A profound truth
This accumulates to a profound truth – that a more complete understanding of addiction can result from two kinds of effort.

One is to start the work of filling in the grid, and working to completion. (But realize this – what we would include are only examples. Filling in the grid would never be "complete").

The other is to associate with people from other clinical disciplines that are also seekers of awareness, knowledge and understanding as outlined in the grid. And to combine the awareness held across disciplines into a more complete understanding of what addiction illness is.

Are you ready to see the (empty) grid?
Looking at the grid might initially be a bit overwhelming.

- Realizing what it shows might be like seeing the Grand Canyon for the first time.
- Or you might struggle with some of the formal academic-style words I've chosen to use.
- On the other hand, you might realize both the scope and detail of what can be filled in. And when thinking about getting started, you might realize how limited you are when trying to fill in some areas.

Those were my reactions when I first got started building the grid. And they got even worse when I tried to start filling it in.

But I found the exercise of building and filling in the grid very helpful.

My simple hope is that by completing the exercise of filling in the grid with real life examples, one will improve the whole, range, and precision of their clinical awareness. The grid is not meant to be immediately applicable toward the project or effort of "diagnosing". Or even identifying or ruling out the presence of addiction/alcoholism.

Ok, the grid appears immediately below.

Subjective and objective existence and truth across levels of considering	**Subjective Existence** Exists only as an experience. Example: an itch.	**Objective Existence** Exists independent of being experienced. Example: a mountain.	**Subjective Knowing** True as determined by individual experience. Example: one's taste preferences.	**Objective Knowing** True as determined by outside verifiable means. Example: thermometer.
Philosophy				
Sociology				
Psychology				
Biology				
Chemistry				
Physics				
Math				

Below you can find a draft of the grid in a "completed" form. I hope you find your own way through the challenge and fill the grid out in various ways over time.

Level	Exists subjectively	Exists objectively	Subjective knowing	Objective knowing
Philosophy	Using is a human right	Addiction treatment that is not smoke-free is harm reduction	Tell me your notion of how to live the good life	Time study of behaviors
Sociology	"I don't like non-drinkers."	Signs and symbols of using culture	Tell me what people and people groups are important, and how	Time study of relationships
Psychology	"I'm going to cut back and quit."	Rationalize	Tell me why you use	Functional analysis of using behaviors
Biology	"My medication isn't holding me."	Associated features	Tell me how your gut feels	Toxicology & blood work
Chemistry	"Let me cook this bag up for us."	24-hour substance, OTC, and prescription schedule	Please rank this list of opioids in order of preference	Controlled substance query
Physics	"I like smoking it. I never eat it or shoot."	Track marks.	"That's a waste."	Blood level: peak and trough.
Math	"Can I have one more? Make it a triple."	They should be home any minute.	I can hold one more.	Collateral source: number of quit attempts

The grid can also be completed by clinical disciplines other than addiction counselors, from their perspective(s): addiction medicine physician, psychiatrist, clinical psychologist, spiritual care, family system therapist, nursing, recovery coach, etc.

I'd like to extend these ideas into two additional areas. One is the unconscious. And the other is addiction recovery.

The unconscious

I enjoy demystifying the unconscious. One of the main reasons I enjoy demystifying it is the way I was brought up in radical behaviorism.

Concerning the unconscious, let me keep it simple and say it this way. There doesn't have to be anything odd or mysterious about the unconscious. We can consider it as simply as things and processes we are not aware of, in self and others.

Thus, doing the homework of attempting to fill in the grid, over time, can help raise our awareness. For example, we might realize things we knew, but didn't know we knew. Or, on the other hand, we might have to put in some effort and learn new information. But guess what? Learning means we are doing discovery. It does not mean that what we learn is true for the first time when and while we discover it.

Putting in the work can cause material to rise from the status of "unconscious" to that of "conscious".

Addiction recovery

Further, one could fill out the grid concerning the topic of addiction recovery, rather than active addiction illness.

The relative paucity of empirical literature evaluating large numbers of people, prospectively across decades of recovery, is interesting to me. For reasons like that, I find literature such as *Living Clean: The Journey Continues* compelling.

And lastly, below, I show a figure that contains two grids. One is "above" the limit of awareness and labeled "conscious". The other is below that limit and labeled "unconscious". But remember, it's up to you whether you want to do the project on the topic of "addiction".

Or the topic of "recovery".

Or both.

I'll be filling out a "recovery" one next.

Conscious

Subjective and objective existence and truth across levels of consideration	Ontologically subjective Exists only as an experience (e.g. an itch)	Ontologically objective Exists independent of being experienced (e.g. a mountain)	Epistemologically subjective True as determined by individual experience (e.g. one's taste preferences)	Epistemologically objective True as determined by independently verifiable means (e.g. a thermometer)
Philosophy				
Sociology				
Psychology				
Biology				
Chemistry				
Physics				
Math				

Unconscious

Subjective and objective existence and truth across levels of consideration	Ontologically subjective Exists only as an experience (e.g. an itch)	Ontologically objective Exists independent of being experienced (e.g. a mountain)	Epistemologically subjective True as determined by individual experience (e.g. one's taste preferences)	Epistemologically objective True as determined by independently verifiable means (e.g. a thermometer)
Philosophy				
Sociology				
Psychology				
Biology				
Chemistry				
Physics				
Math				

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Coon, B. Recovery: Let's Do the Math. December 26, 2020. *Recovery Review.*

Coon, B. What Biases Do You Observe Among Many of the Scientific and Medical Experts in the Field? December 7, 2021. *Recovery Review.*

Coon, B. Addiction: Understandings and Enactments of the Current Era. March 3, 2022. *Recovery Review.*

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Brown, A. M. Recovery Review as an Archive of Recovery Knowledge. December 12, 2025. *Recovery Review.*

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Part 11: Summary, Counter-Arguments, and Closing

Summary

To summarize the form of alcoholism/addiction as a single syndrome, I would say that it takes on a certain nature.

This is a nature that consists of a rather all-consuming progression over time. That progression is fueled by the consequences it causes. To initially spot the form, the tip of the iceberg might be a broken gas pedal that resembles using more than planned once using starts on any occasion. Or a broken brake pedal that resembles an inability to stay stopped once stopping has commenced. But these will tend to reveal a constellation of 5 particular DSM-5-TR SUD criteria that together comprise the essence of the disorder.

Beneath the surface, the structure and function of the disorder relative to one's identity, defense mechanisms, and reality testing will be in the psychotic to borderline position – and not at the neurotic level of organization. Propulsion to and living within that level of central disorganization will make physiological dependence and psychological dependence key presenting features.

Inside that pathology is a dual-sided denial: conscious denial of the disorder and unconscious denial of the solution. The existential and central essence of the person remains intact, and that Zero-Spot is the location of the remedy's impetus that begins with a positive trauma centered in mirroring and being mirrored.

The bio-psycho-social-spiritual impacts of the magnitude of the progression of the disorder leave a latent capacity for regression into some features of the illness independent of, and prior to, returning to use. The forms of these returning symptoms are reminiscent of the form of the individual's specific addiction illness/syndrome. And that dynamic is called "mental relapse".

Counter-arguments

A wide range of counter-arguments against my basic notion of *the form of addiction illness*, and the *specific proposals* within this work could be launched.

Here, I'll name and respond to a few in no particular order.

First, it could be said that my proposed *first rank symptoms* are already present in the DSM-5-TR SUD criteria. And so, this part of my proposal on the form of the disorder adds nothing.

I would respond by saying that my proposal is different with respect to the possible utility of first-rank symptoms. I suggest they should constitute criteria for screening *out* those *without* alcoholism or addiction. Because they *are present* in the form of the disorder.

Second, one could say that using *for relief* (vis. Dr. Holman's quotation) and the presence of *psychological dependence*, are both accounted for in one part of DSM-5-TR's criteria # 4: "urges".

I don't disagree. But I would point out that what I have in mind is different from that observation. What I have in mind pertains to a propulsion over time that consumes aversive consequences as a fuel and accommodates them to drive the disorder. In my opinion that is both a qualitative and functional distinction from mere "relief".

Third, it could be stated that *physiological dependence*, as I have outlined it, is already present in the DSM-5, and sliced therein three ways:

1. cravings (which are normally thought of as physical),
2. tolerance (which is a physical indexing of decreased effects over time), and
3. withdrawal (which indicates the presence of the body's adaptation to the presence of the drug and acquired need of the chemical to preserve homeostasis).

That could be true in a purely quantified and empirically discreet way. My focus is on physiological dependence as *a single total factor* and experience. Not those 3 factors considered separately.

After all, some genotypes seem to provide existential relief upon the first drink and set up immediate craving. That is not the total form of the disorder I have in mind. And some genotypes seem to arrange for paradoxical or other atypical reactions to opioids and other compounds. Some of those may match physical indicators that could be improperly interpreted as evidence of addictive disease progression.

Fourth, one could assert that the *cyclone* that consumes the person and their life over time is present in the combination of DSM-5-TR criteria 5 and 7, which Norman Hoffmann describes as "life getting small".

I don't disagree. I would only respond that in the later stages of addiction illness, the form of the illness I am accustomed to seeing over decades of my career is such that much more has been consumed than what criteria 5 and 7 represent.

If I wanted to agree, I would add criteria 3 (time spent) as one additional factor consumed by the cyclone across the development of disease progression. But addiction consumes so much more.

Fifth, one could raise the "So what?" question. Possible examples of this include:

- So what if addiction or alcoholism has a form? How does that even matter?
- So what if addiction is a single entity comprised of a central problem related to limiting one's use? And incorporates consequences, that would otherwise attenuate use, into the disorder? That takes the shape of a specific and recognizable constellation of general SUD criteria? And that cyclonically devours the person and their basic array of life areas in an increasing pattern over time?
- So what if alcoholism and addiction as you describe it are characterized by limited reality testing, an unstable identity, emotional lability, and generally primitive defenses?

In general, if I was going to respond to such questions centered in "So what?", I would mention patient sorting and making recommendations for various kinds, levels, and lengths of care accordingly. In the instance of treating addiction or alcoholism as described by the form of the

disorder outlined in this document, I would tend to consider an initially higher level of care, and an interdisciplinary approach focused on initial disease management and later recovery management. Such a method is described in the following practice guideline:

Coon, B. April 8, 2025. 5 Year Continuing Care System for High Severity, Complexity, and Chronicity SUD's: Clinical Targets, Methods, and Increments of Time. (2022 monograph). The RM & ROSC Library of the William White archives at Chestnut.

Closing

Preparing to close, I'll leave you with a cartoon image to look at and consider. The diagram resembles a single cell, as you might see in a biology text book. The cell is not real. Nor is it meant to convey anything that is real. But it does include terminology from this monograph labeling portions of the fictional image.

If the image isn't real, why have I included it?

Because we can gain from *considering* (thinking in advance) and from *recognizing* (apprehending what we encounter) *the form* of the disorder.

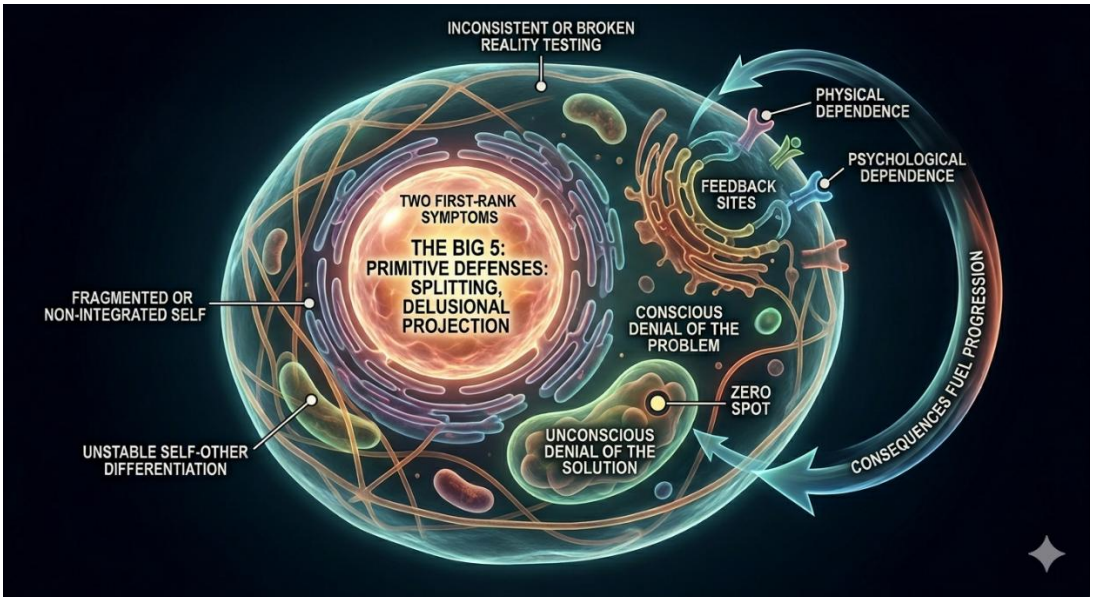

Image generated via OpenAI's DALL-E 3 based on user prompt. June 3, 2026.

I hope my proposal that addiction illness *is a syndrome with a recognizable and understandable form* has been made clear. For now, I encourage anyone who identifies caveats, alternative explanations, and contradictory data (from lived experience, research, theory, or clinical practice) related to my proposal, to return to Part 4 and Part 10.

My reason for that encouragement is as follows. Part 4 highlighted my notion that the combined area of the borderline and psychotic formation constitutes the kind of disorder addiction illness is. And Part 10 provides a structured method for a more comprehensive considering of what is, and how to know. Perhaps the person with caveats or disagreements can work in the "do" direction toward Part 4 using the tools of Part 10 – to help me revise or confirm my proposal.

About the Author

Brian Coon has been working full time in residential addiction treatment programs from the time of 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) that shared a physical plant and staff 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 Center for Substance Abuse Treatment (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, a one-year outpatient SUD aftercare program for FBOP, an addiction counselor on the city/county adult Drug Court team, and a dedicated agency-wide case coordinator for referrals from US Probation, 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-Oriented Systems of Care" and "Recovery Management" 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 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. In doing so that workplace was chosen to participate as a clinical site in a United Nations project – the International Network of Drug Treatment Resource Centers.

Since 2008 he has worked in a freestanding interdisciplinary program that includes specialized services for public safety-sensitive professionals and young adults. He served as clinical director there for 10 years starting in 2011. He also provided the admission approval vs. referral decision in the substance use and psychiatric domains for all prospective residential admissions across 12 years, totaling more than 4,800 cases. In 2013 he assisted that organization's senior leadership with transformation to a smoke-free approach to treatment, and the successful sustaining of that approach to the present time. His current 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 over 285 continuing education presentations at state, regional and national conferences as well as various clinical organizations. He has authored or coauthored 15 publications including peer-reviewed research, a book chapter, and clinical-applied articles and contributed to or been acknowledged within 35 additional publications. Brian 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 Brian has written over 175 additional articles and 12 monographs as a Contributor at *recoveryreview.blog,* and serves as an Affiliate at *addictionandbehavioralhealthalliance.com.*

Other monographs available at *Recovery Review*

Conditioning Theories of Addictions: An introduction to theory, research, and practice

Addiction Treatment Except for Tobacco and Nicotine: A Call for Change

An Introduction to Psychodynamic Foundations of Counseling and Related Clinical Supervision for SUDs

5 Year Continuing Care System for High Severity, Complexity, and Chronicity SUD's: Clinical Targets, Methods, and Increments of Time

Essays on Addiction Counseling

The Recovery Alliance Initiative: History, Methods, and Purpose

Screening and Assessment of Substance Use Disorders

Clinical Supervision of Clinical Supervision

Depth Psychology Applied to Addiction Counseling

Addiction and the Stages of Healing

Topic From the Field: The "Rat Park" Experiment

Notes on Resistance in Addiction Counseling