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Narrative Means to Sober Ends: Treating Addiction and Its Aftermath, Jonathan Diamond
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INTRODUCTION

Remembering Addiction

> A word spoken from within the doorposts of the ancestral home can not go astray.
>
> —MARTIN BUBER

This is a book about passion, desire, sensual pleasure, lust, fears, pain, and insatiable hungers. It's about a love so powerful it's paralyzing and a need so strong it's greater than a person's will to live.

"Like drinking stars," is how some alcoholics describe the sensation of consuming alcohol. Imagine the feeling of being able to capture and hold the entire Milky Way in your hand, this is what the addict feels she is losing every time she puts down her bottle—marijuana, cocaine, heroin, pills, or food. In a personal account of her own struggle with addiction, author Caroline Knapp (1996) says that alcohol illuminated a calmer and gentler piece of her soul. Addiction, surmises Geneen Roth in *When Food Is Love* (1991), is the act of wrapping ourselves around an activity, a substance, or a person in order to pretend we have love in our lives. It helps people believe they are surviving, even thriving. It helps them tolerate an enormous pain they are denying.

Perhaps this explains, in part, why, in spite of the best efforts of substance abuse counselors, individual and family therapists, partial hospitalization programs, residential treatment centers, public health officials, and policymakers, we are losing the so-called war on drugs. When clinicians and mental health researchers pull out drug and alcohol assessment tools that try to measure the severity of a person's problem, they are missing the point. They are trying to measure something that cannot be measured and defies the logic of standard psychological instruments. If medical research ever develops a scientific approach to ad-

diction, it will not be a science of genes, neurotransmitters, biochemistry, or brain waves, it will be a science of desire.

We might get closer to the mark if these tools were to ask questions like the following: (1) What do you do if the only way to sate your craving for crack cocaine is to leave your baby unattended in a hot car with the windows sealed on an 80-degree day in the summer in a neighborhood occupied by gangs, drug dealers, and prostitutes? (2) Your doctor warns you that having another drink—even one beer—means losing your kidneys and starting dialysis immediately; do you follow her advice or go out and enjoy a six-pack because you realize you're going to die soon? Or (3) If continuing to ingest alcohol and refuse treatment meant severing your relationship to your only daughter and not being invited to her wedding, would you seek help or pour yourself a drink to ease the pain and suffering experienced from the impending loss of connection to your child?

These are not extreme examples, although the dilemmas they propose may seem unfathomable to anyone who hasn't felt their life controlled by or at the mercy of an addiction over which he or she was powerless. In fact, most of us wouldn't consider these real choices or serious questions at all—they are beyond anything we can comprehend. However, addicts have a different center of gravity, one that tends to organize itself along two axes: control and sensation (i.e., the maximization of pleasurable sensations and the avoidance of painful ones).

As a consequence, people suffering from addiction make lousy candidates for psychotherapy. One day a college professor remarked to Martin Buber that Freud is reported to have answered a question about the meaning of life by saying, work and love. Buber laughed and said that was good but not complete. He would say: work, love, faith, and humor.[1] This sort of badinage is not likely to uncover the meaning of life, but the terms "work, love, faith, and humor" do go a long way toward describing peoples' experience of therapy. In my view, a crucial omission from this list is "courage."

Therapy is courageous work, which requires letting go of control—having faith in oneself and others—and allowing oneself to experience a number of uncomfortable feelings, many quite painful. Addicts and alcoholics embrace a lifestyle that avoids pain at all costs, seek immediate gratification, and tend to rely on—put their faith in—chemicals more than people. In other words, for those who are addicted recovery means abandoning the very things that sustain them. This makes it difficult for therapists who treat addiction. I've always felt that if I haven't learned something during a client's therapy, chances are the client hasn't either. The upheaval and chaos created by addiction makes for a challenging

learning environment. Understandably, the task does not generate a great deal of enthusiasm, and where it exists it is often short lived and quickly replaced by pessimism, cynicism, and burnout.

My main objective in writing this book is to counter the therapeutic nihilism surrounding problems of alcoholism and addiction. Clinicians are all too willing to work with people in recovery but often dread taking on clients who are active addicts and alcoholics trying to change or who "want to want to change." Furthermore, many therapists don't share their colleagues' enthusiasm for collaborating with persons in recovery. They find the celebratory nature and testimonial style of some AA gatherings off-putting, and too dissonant with the more quiet and reserved sensibilities of psychotherapy. It's as if AA inherited all of people's strength, hope, and recovery, and psychotherapy their grief and pain. In treating addiction it is crucial to understand the amount of loss and suffering endured in the process of recovery—loss of jobs, homes, friendships, family relations, and other AA members. For every alcoholic whose sobriety results in his or her reconnecting with others there are five others whose stories are punctuated by abandonment, cutoffs, and death because of the way alcoholism and drug abuse continues to ravage their families and their lives. Persons in AA need to emphasize hope and celebrate one another's successes in order to counter the intense feelings of loss stemming from the knowledge of how many comrades and loved ones will not make it and eventually fall prey to the "disease" of addiction.

My wish for therapists who pick up this book is that after reading it they will approach these problems, and the people who struggle with them, with more hope and less dread. I hope that they will come to see compulsive drinking as an outward manifestation of the alcoholic's inner anguish. For alcoholics, addicts, and their friends and family members, it's my hope that the fear and trepidation with which they often approach therapy and recovery will be replaced with a renewed sense of faith in themselves, other human beings, and the possibilities of their lives.

BORDER CROSSINGS: COMMITMENTS OF A POSTMODERN PSYCHOTHERAPIST

> Everywhere I go I find a poet has been there before me.
> —SIGMUND FREUD

In his groundbreaking essay, "The Cybernetics of 'Self': A Theory of Alcoholism," Gregory Bateson (1972a) uses the challenges addiction and recovery pose us to call for a new understanding of mind, self, hu-

man relationships, and power. Bateson describes the alcoholic as having adopted an unusually disastrous variant of "the strange dualistic epistemology characteristic of Occidental civilization" (p. 321); he warns of the dangers this kind of "cause-and-effect" thinking can pose alcoholics and nonalcoholics alike. These problems or paradoxes are, according to Bateson, not unique to addiction but are more evident when one is dealing with it. In a dynamic process captured in the oft-used expression "mind over matter," addicts separate their "self" or "will" from their environment in an effort to control it (Berenson, 1991). In other words, the alcoholic's attempt at arriving at solutions through drinking is simply another piece of modern drama acted out in the Cartesian theater. Except in this version of Western philosophy's longest running show, the protagonist's signature line has been changed from "I think therefore I am" to "I drink therefore I am." Counter to prevailing beliefs that alcoholics drink for all the wrong reasons, Bateson concludes that for the alcoholic drinking offers "a short cut to a more correct state of mind."

Bateson reminds us that the "logic" of addiction has puzzled psychiatrists no less than the "logic" of the "strenuous religious regime whereby the organization Alcoholics Anonymous is able to counteract the addiction" (1972a, p. 309). While Bateson looked to cybernetics and systems theory for his new epistemology, he felt the nonalcoholic world had much to learn from the ways of AA. He used AA's spiritual outlook to help him construct a view of the world more relevant to our current problems as well as to deconstruct what is wrong with our current way of thinking about humankind and nature. If, says Bateson, double binds* cause anguish and despair and destroy personal epistemological premises, then the serenity prayer, with its promotion of noncompetitive spiritual relations, heals wounds and frees a person from these maddening bonds.

Epistemology is the branch of philosophy that concerns itself with the origins, nature, methods, and limits of knowledge. This term, however, has gained colloquial currency in the family therapy field as a synonym for the word "paradigm." While Bateson showed how our culture was caught in a frenzy of biological materialism, his aforementioned article, along with his other writings, generated a frenzy of paradigmatic thinking and what I call "epistemological speak" within the mental

*Such double binds are, in Bateson's theory, the painful and competing contradictory messages and directives about the self that contribute to the onset of mental illness.

health professions. Unfortunately, the focus of this new wave of family systems thinking was on the tools and methods Bateson employed and, for the most part, ignored the questions and mysteries that initially captured his attention.

A Narrative Approach to Psychotherapy

The early stages of any fresh practice or discipline are always poetic. This book proposes a narrative metaphor for people's recovery and healing. A narrative approach to psychotherapy offers therapists an alternative to the dominant biological and disease metaphors for human suffering inherited from science and medicine. From the standpoint of narrative: Stories, not atoms, are the stuff that hold our lives—and our world—together. Put another way, when it comes to treating alcoholism and addiction, therapists employing narrative practices (including me) are more interested in knowing what sort of person has a disease than what sort of disease a person has.

Why is it that we invest so much time, energy and money into exploring the medical and biological aspects of addiction? Or, said another way, why are we so afraid of looking beyond the biology of addiction? Could this be a manifestation of something Bateson was trying to tell us about the "disease" itself and our will to control the experience and make it more manageable? In other words, if we describe addiction solely as a genetic illness, then we can "cure" or eliminate it. Ironically, the third of the "three C's" of the Al-Anon program—"You didn't cause it, you can't control it, and you can't *cure* it"—stands in contradiction to what is generally considered sound medical practice and the standard scientific approach to research. What is it about this simple credo practiced in quiet meditation by millions of men and women every night in church basements and community halls, in small towns and big cities in every country on every continent, that is so frightening and too much for many of us to witness?

The disease concept as embraced by AA has been a very helpful metaphor to people.* However, the way AA thinks about and employs the terms "disease" and "illness" is very different than the way these concepts are applied in medicine and science. Most notably is the manner in which AA conceptualizes addiction as a spiritual *dis*ease with

*Some of the many ways the disease concept has assisted people's healing and contributed to our understanding of the problems they face are discussed extensively in Chapters 4 and 6.

physical symptoms, whereas medicine looks at addiction exclusively from the standpoint of pathology.

Clearly, there are genetic profiles that lead to more successful metabolism of alcohol and higher incidents of addiction among certain groups of people. But how does this research account for the large numbers of people who share these genetic profiles and who aren't and don't become alcoholic? Further, I've known people to work hard to overcome a pronounced physiological aversion to alcohol because other aspects of their ecology conspired so strongly on behalf of their addiction.

Finally, if science were to establish the presence of a proto-alcoholic gene, what would this minute piece of DNA programming represent? DNA is a chemical template of life. Cultural conditioning and trauma leave their footprints in these molecular sands in the same way the HIV virus can create mourning rituals (e.g., the AIDS quilt and the Names Project) and can change public policy and other cultural practices. As Bernstein and Fortune (1998) observed, "Biology is not the ground on which the social gets overlaid: We and our laboratory kin are not organisms 'first' and social, cultural, or symbolic 'second.' Just as the sciences are all these things at once so are we" (p. 225). Science is not a careful construction of theories based on the laborious accumulation of neutral facts but a contingent social activity, and we mythologize and story our relationships with chemistry and biology the same as we do all other human experience or activity. Peter Kramer (1993) has us listening to Prozac, Bernie Siegel (1986) asks that we embrace our chemotherapy, and many clinicians have produced intimate biographies of mental illness in the form of their own memoirs, such as Kay R. Jamison's story (1995) of her struggle coping with bipolar depression.[2]

There is a term in medicine and epidemiology, "Koch's postulate," which refers to a set of principles clinicians use in their search for a "single unitary cause" of an illness when tracing the origins of a disease. The rationale for seeking the sole cause of an illness is the assumption that, once you discover its causative agent, you are likely to find a "single unitary solution"—that is, a so-called magic bullet treatment. The classic example is syphilis. They used to say that if you knew syphilis, you knew medicine. Called the great masquerader because it affected every organ of the body, once diagnosed, the solution for these myriad symptoms was, amazingly, a single dose of penicillin.[3]

This is the miracle of modern medicine. Its methods, scientific and objective, epitomize the zeitgeist that has colored thinking in the physical sciences from the Enlightenment to the present.[4] This is the model social science and psychotherapy try to emulate. Despite having received

the Goethe Prize for literary merit and being nominated for the Nobel Prize for literature rather than medicine, Freud—the founder of psychoanalysis from which most modern psychotherapies derive—desperately sought to demonstrate the scientific character of his work.

Narrative and other postmodern perspectives undermine modern approaches to "valid" knowledge. If the example of syphilis, presented above, represents medical science's past and present, then alcoholism and addiction represent its future. If alcoholism research throughout the 20th century has shown us anything, it's this: *if you know alcoholism, you know where science and medicine are going.* Developments in the field of addictions have had a revolutionary impact on the way we practice medicine and therapy and on the way we view societal problems. The problems of the alcoholic are now seen to impact upon and be influenced by the entire culture. One reason for this is because the potential causes for alcoholism cannot be narrowly defined within the discourse of contemporary science. In other words, there is no "magic bullet" cure. The crucial point being made here is that the phenomenon of alcoholism defies Western medicine and know-how and cannot be captured with a 20th-century mindset.

This book, like its subject matter, is a creative literary endeavor. It hopes to inspire more projects and investigations that emphasize narrative metaphors over biological ones for psychotherapy and other human sciences. However, neither the book nor its author advocate abandoning or ignoring biology, physiology, or brain functioning and other neurological research. This would be impossible in the case of addictions, and ill-advised in any effort to understand human beings whose bodies produce, every moment, thousands of chemical reactions independent of any foreign substances introduced into them.

It would be foolish to ignore the stories chemistry, neurobiology, and other sciences produce about alcoholism and addiction, because when you ignore or stay away from something you are not allowing its story to be part of the larger one. Studies that emphasize the importance of the mind–body connection in coping with stressful illness and psychological trauma top the best-seller lists and abound in the professional literature as well.[5] In certain stages of recovery it can be incredibly helpful to get information on the biology of addiction to clients when they're ready for it.[6] This is vital work. However, it is not the focus of this book and, what's more, there are many others more qualified than me to speak to the science of addiction and plenty of primers and texts on this subject available to readers in need of them.[7] When all is said and done, I simply feel that stories have as much to

tell us about human nature as theory and that when it comes to understanding addiction psychotherapy's specific contribution is more literary than scientific. The two perspectives (science and therapy) are not mutually exclusive.

Deconstructing Alcoholism

Psychiatrist and author David Berenson (1986) likens alcoholism to the story of the five blind men and the elephant, each one feeling a different part and trying to describe his discovery based solely on the evidence at hand. As is well known, one, his arm wrapped around the elephant's leg, thinks it's a tree; another, holding the trunk, believes it to be a giant snake—and so on, each of the five describing the part he's encountered but never grasping the whole picture. Similarly, how a person's condition is defined by a clinician or counselor depends on the latter's vantage point. The physician treating damage to the person's liver and esophagus or broken bones from a drunken driving accident defines it as a physical malady. The psychiatrist might respond to the depression that many alcoholics suffer with medication or therapy, without exploring the connections between the person's drinking and her feelings (maybe forgetting that alcohol itself is a depressant that suppresses the central nervous system). The social worker may see the environmental factors—unemployment, poverty, racism, homophobia, and so forth—at play in the person's life. The family therapist may trace the condition's origins to the dysfunctional patterns of communication that feed the cycle of shame and blame in which family members so often become mired. The pastoral counselor may see the condition as a spiritual crisis that has compromised the drinker's values, belief system, and self-worth. What we have here, from the standpoint of the alcoholic, are five blind theories. Collectively, they're onto something; individually, they have nothing.

It is, as Stephanie Brown (1985) observed, the rare alcoholism text that does not include a review of the most current and controversial models of addiction. Berenson's adaptation of this parable does a nice job of summarizing some of the more prominent ones as well as exposing the pitfalls of wedding ourselves to any one point of view—be it psychological, spiritual, systemic, social, or biological. Absent from this illustration is the behavioral psychologist who emphasizes conditioning principles, both in understanding the development of addiction and in its treatment. To paraphrase D. W. Winnicott, we don't just use words and language, language and words use us. Our theories

condition us in the same fashion. They determine what we look for. Like the character in the old folktale, first we shoot holes in the fence, then we paint the bull's-eyes around them. Another goal of this book is to put the voice of the person before the voice of the text—that is, to privilege people's stories of addiction over our theories and methods of understanding them.

A further lesson Berenson's allegory holds for us also has to do with language, as well as the problem discussed earlier of our falling into "cause-and-effect" thinking when addressing issues of addiction. Not only Bateson but physicists, biologists, information theorists, and social scientists across many disciplines have long demonstrated how our notions about cause and effect are inaccurate and outmoded. However, in the field of addiction, as in the story of the elephant, many clinicians are still looking for "absolute" causes, trying to find out, as Berenson describes, if alcoholism is caused by an antecedent biological condition, if alcoholics are "oral dependent people," if a person's family environment causes his or her addiction, or if alcoholism is caused by a breakdown in our social institutions and supports.

As Efran, Hefner, and Lukens (1987) write, "The issue of alcoholism is neither pharmacological nor not pharmacological, neither a learned habit nor not a learned habit, neither a social protest nor not a social protest. It is all of these and none of these. . . . [A] pattern of behavior, such as problem drinking, can never be fully described in one set of language terms" (p. 44). Therapists trained differently use different paradigms, and so our language about our work is bound to be different. The language we choose to describe our respective experiences with addiction or "deviant" reality may vary, but the urge to facilitate change and transform the way we perceive our lives is the same. We all want to create conditions that let experience speak in a way that heals. The whole idea of theory and method is to get close to that experience, to honor the sacredness of the therapeutic relationship. Intimate moments of engagement Martin Buber called "I–Thou." Language and words can only hope to approximate this experience, although some come closer than others. That's why I find writing such a powerful tool. Ultimately the only authentic speech is silence. Writing is often better able to capture and express the sense of the ineffable about our work.

The idea of this book is to get close to the experience we call addiction. Consequently, this is, more than anything, a book about relationships. It is a collection of people's experiences with alcohol and drugs and I–Thou encounters in therapy and recovery. As their stories unfold a definition of addiction emerges, as well as a language that describes it.

WORKING ASSUMPTIONS

> Trying to describe the process of becoming an alcoholic is like trying to describe air. It's too big and mysterious and pervasive to be defined. Alcohol is everywhere in your life, omnipresent, and you're both aware and unaware of it almost all the time; all you know is you'd die without it, and there is no simple reason why this happens, no single moment, no physiological event that pushes the heavy drinker across a concrete line into alcoholism. It's a slow, gradual, insidious, elusive *becoming*.
>
> —CAROLINE KNAPP

In her book *Drinking: A Love Story*, Caroline Knapp (1996) describes her own process of becoming addicted—from drinking as mere social convention, a companion on the path to self-enlightenment, to viewing alcohol as the single most important relationship in her life, something she couldn't fathom living without.

The present book will not resolve the questions "What is addiction?" and "How does one become addicted?" However, it does hope to expand our understanding of the experience of addiction, and broaden our descriptions of alcoholism, substance abuse, and other addictive phenomena. Consequently, the book does not present a comprehensive theory of alcoholism and chemical dependency or new method of treatment. We already have more than we need or know what to do with. It merely attempts to locate a set of ideas about psychotherapy and narrative practices that help people address some of the problems they face in recovery—ideas that readers can easily apply to their own lives and experiences.

In addition to fleshing out a *working* definition of addiction, the remainder of this chapter presents a list of principles, biases, and assumptions that will help map out some of the landscape covered, and offer the reader a kind of glossary for a number of, what I call, "tent terms" used throughout the book.

One Addiction: The Addiction to Control

"At the heart all addictions," writes Knapp, "are driven by the same impulses and most accomplish the same goals; you just use a different substance or take a slightly different path to get there" (1996, p. 134). I have been using the terms addiction, alcoholism, and chemical dependency interchangeably because one of this book's fundamental premises is that there is *one addiction—the addiction to control.* Alcohol, marijuana, cocaine, heroin, and other (what I call) "tissue-based" substances,

as well as addictive processes such as certain relationships and types of behavior (e.g., eating, gambling, or debting), all are mood-altering technologies. Certainly some of the dynamics and specific interventions will vary according to the substances abused, but the overall treatment framework will remain unchanged.

Nor, as a quick aside, is it just the "high" alcohol or chemicals provide that is hard to give up; a gesture associated with a particular drug or habit roots the experience in the addict's experience of selfhood and can be just as captivating and difficult for the person to let go of:

> I loved the sounds of drink: the slide of the cork as it eased out of the wine bottle, the distinct glug glug of booze pouring into a glass, the clatter of ice cubes in a tumbler. I loved the rituals, the camaraderie of drinking with others, the warming, melting feelings of ease and courage it gave me. . . . [D]rinking seemed as natural as breathing, an ordinary part of social convention, a simple prop. (Knapp, 1996, pp. 6–7)

The issue of control—over actions, feelings, and other people's behavior—is central to any addiction or compulsion. Alcohol and other substances help people believe they have control over events. People suffering from addiction, says Geneen Roth, cannot bear to surrender to the truth of their lack of control for fear it will bring the pain they felt when they were open to love and it wasn't there; addiction at its most fundamental is lack of love: "Our compulsions help us avoid the feeling that no one is *really* there for us. We become compulsive to put someone there for us" (1991, p. 21).

Escape from pain and the illusion of control are core issues for all addicts and persons in recovery. For the addicted person consuming alcohol (or their drug of choice) provides an extraordinary affective experience. Feelings of power, freedom, connectedness, and safety are the primary characters in this compelling drama. According to therapist Roget Lockard, "This experience is so potent and consistent that the individual prioritizes the act of drinking to provide these feelings. In effect, what has happened is the discovery of an *instrument* for the manipulation of feeling states—the discovery of a *technology of feelings management*" (1993, p. 3; emphasis added). For Miranda (the girl whose letter was presented in the Prologue), being under the influence of drugs and alcohol allowed her access to powerful feelings of anger and rage that countered cultural messages she received dictating acceptable and unacceptable ways for girls to act. Drinking and drug use also provided her with a sense of comfort and security in an otherwise unsafe world.

Once we accept the premise that alcohol and other mood-altering chemicals are a technology of feelings management, we must recognize that, like all technologies, they come with a body of laws or principles that govern people's behavior and actions when operating under their influence. The problem is that most addicts and alcoholics drink or use drugs themselves because they're tired of "playing by the rules." Alcohol provides the freedom and power to ignore social convention—to be who they want to be and feel how they want to feel. It's a rude awakening when a person discovers that the mood-altering technology they've always depended on to help them escape or feel more in control of their environment comes with its own set of rules and laws that severely restrict the consumer's choices and options for living.

A gifted and talented artisan who is also addicted to heroin cannot contemplate leaving a job she hates in order to pursue her craft because she can't be without the money she needs for her fix—even for one night. An alcoholic father wants to fulfill the promise he made to his son to spend the day at the ballpark together. However, his addiction reminds him he must stop at the bar on his way for just a couple of drinks—stopping at "just a couple" being something he's tried to do every day for many years without success. As the Chinese proverb tells us, "First the person takes a drink, then the drink takes a drink, and finally the drink takes the person." Drugs and alcohol come to represent yet another area of the alcoholic's or drug addict's life in which he or she is no longer in charge.

The road to recovery, which will occupy more pages of this book than my descriptions of people's drinking problems, takes a similar path—in which the alcoholic moves from a position of "I cannot control my drinking," through "I cannot drink," to "I can *not* drink."

More will be said about "controlled drinking" in the following chapters, but it bears comment that obviously some alcoholics are able to exercise control over their drinking on some occasions, whereas others who can no longer control their drinking could at one time. Clearly, changes in a person's ability to exert influence over his or her own use of chemicals can be explained, in part, by the natural progression of addiction or thickening of its story plot in a person's life. However, it may also be a result of the strong sense of shame associated, in our culture, with not being able to control any part of our personal world. In therapy, the emphasis on helping clients' develop self-control and belief in their ability as individuals to exert "free will" in any situation can interfere with recovery. This is especially troublesome when either the client, the therapist, or both feel that a person *should* be able to control his or her drinking and would be able to if only he or she could find the proper

solution to certain problems or the right approach. Even among therapists who recognize that controlled drinking is not possible for their client and abstinence must be the goal, self-control, observes Stephanie Brown (1985), often remains the ideal and those who can't achieve it are viewed as weak or flawed.

Toward a Working Definition of Addiction

Dylan Thomas said that an alcoholic was someone you don't like who drinks as much as you do. Current metaphors and myths view the chemically dependent client as "bad" (i.e., immoral), "crazy," "stupid," or "sick." As one colleague, in recovery herself, pointed out to me, alcoholics don't do much to dispel these misconceptions and bear some responsibility for them, as they often, when under the influence, act crazily, do and say stupid things, and can—especially toward the end of their drinking—engage in bizarre and unusual behavior. However, I prefer to regard clients who are suffering from these types of troubles as blocked.

The "disease" (or biological) model can be a useful metaphor for families trying to break out of the cycles of shame and blame that grip persons facing problems with drugs and alcohol, but it does not explain the complexity of the phenomenon we call addiction. More important than how I define or label a problem is how I position myself in relation to it. Years of experience have helped me come to the understanding that I am as powerless over my clients and their drinking as they are, and I try and model that understanding in my relationships with them.

The word "addict," in Latin, means toward (*ad*) voice (*dict*), and I find that people often prefer to listen to (or move toward) that voice, rather than their own or that of the therapist.* Put another way, the alcoholic is caught in an epistemological bind:

> For those whose relationship with alcohol will eventually manifest as addictive, the use of alcohol is proving to answer a question perhaps even more fundamental than "how can I manage my feeling states?" and that is, "*who am I*?" In other words, the relationship with alcohol makes a critically significant contribution to the experience of a more adequate identity for the consumer, such that over time the use of alcohol and the experience of authentic self seem to be inseparable.

**Another Voice: A Handbook on Addiction, Recovery, and the Survival of the Human Species* is the title of a manuscript in preparation by addictions therapist and author Roget Lockard (1999).

> For some drinkers, this "identity consolidation" aspect happens almost instantaneously; for others it accumulates gradually over varying time spans. Eventually, however, the experience of existential adequacy is absolutely contingent on the drinking of alcohol. It is this development that gives the behavior the remarkable *author*ity, as it were, to overrule common sense—if the very experience of selfhood seems at stake, then virtually all other considerations become subordinate. (Lockard, 1985a, p. 3; emphasis added)

This description of a person's alcoholic belief system has profound consequences for treatment. The implication is that people drink for good reasons. Or, as a client once explained it, "Jon, the best idea I ever had in the world was to get sober. The second best idea I ever had was to pick up a drink." These themes will be explored fully later in this book; here, I merely note that there is a false dualistic logic—which AA calls "all or nothing" or "drinking thinking"—that keeps the addict blocked, unable to see other options other than living with drinking or dying without it.

Problem Drinking versus Addiction

There is in both the psychotherapy and recovery communities much debate over the dividing line between substance abuse or problem drinking, on the one hand, and substance dependence or addiction, on the other. However, I find when it comes to drugs and alcohol we often don't know what kind of problem we're dealing with until we try to do something about it.

For the purposes of this inquiry I will keep things simple. Most of us can relate to the experience of abuse. Even a child who makes one too many unauthorized withdrawals from the cookie jar can identify with this experience, for example, the physical hangover—upset tummy and sugar headache—that reminds the child it has had one too many. A problem develops once a pattern of abuse has been established. While the frequency of a person's abuses and volume of alcohol or drugs consumed in any given episode is often relevant when we are trying to situate a person on a continuum of addiction or when we are treating their medical symptoms, it is not as important for identifying a problem. The person who drinks to the point of intoxication on every occasion that alcohol is present is in trouble regardless of how often the opportunity presents itself or how much of a given substance it takes for him or her to achieve the desired state of euphoria.

Clinicians who invest a great deal of time determining the volume and frequency of a person's consumption are missing the distinction between individual acts of drinking or drug abuse and alcoholism or addiction. The issue gets blurry when we are trying to determine when a person crosses over the invisible line from problem use to full-fledged addiction. Many find the discussion of a dividing line between substance abuse and addiction profoundly misleading. Indeed, talking about crossing over the invisible line from "problem use" to "addiction" is like talking about crossing over the invisible line between emphysema and lung cancer. They are two distinct plights, which just happen to share many experiential and circumstantial features.[8] While I agree with the supposition that substance abuse and addiction are two separate phenomena, because they present clinicians with so many common features I still find this a useful way of conceptualizing them.

Again, simplicity seems prudent, as I do not intend to spend much time arguing the minutiae of these categories, especially since this book is more concerned with how to help people who are suffering from these kinds of problems. The most useful answer to this dilemma I've found is that, for the problem drinker or drug abuser, once she's determined she has a problem with alcohol or drugs she'll stop, or at least make adjustments to prevent further problems from developing. This point is often reached when a person reaches a crossroads where the solutions to her problems provided by chemicals are overshadowed by the problems that these substances create in her life. Lockard (1985b) calls this "the point of common sense." The problem drinker who makes an effort to change is usually successful—maybe not right away, and maybe not without help, but eventually her patterns of abuse are arrested. The addict is the person who continues to use substances beyond "the point of common sense" despite her best efforts to quit or control her drinking and despite many people's best efforts to help her.

Simplifying even further we might say, along with Knapp (1996), that "when you're drinking, the dividing line between you and real trouble always manages to fall just beyond where you stand" (p. 30).

Hitting Bottom

"Hitting bottom" is another "tent term" found in most addictions therapy and treatment and is used here as well. This experience, which will be explored in more depth especially in the book's second part, consists, according to Lockard (1993), of three events that converge simultaneously in the life of an addict: (1) the intersection of pain and under-

standing; (2) the ownership of powerlessness; and (3) an occasion where the individual is no longer willing to live with the person he or she has become—what AA calls "deflation at depth."

Several crucial points about these ingredients: First, the person's understanding may be incorrect. People often hit bottom in a resounding and painful fashion, and then proceed to take action based on a totally mistaken understanding of their situation, such as "My life depends on learning to control my drinking better!" When a person draws this conclusion from a life-threatening experience with alcohol or drugs, recovery cannot follow. Second, powerlessness (a concept that will be discussed in more depth in Chapter 4) is manifested in different ways at different stages of recovery. The most adequate generic definition of powerlessness in this context, writes Lockard (1993), might read: "*I am powerless to achieve fulfillment through the exercise of control*" (p. 13). Third, the last point, regarding those individuals who are no longer being able to live with the persons they've become, has a spiritual quality referred to in AA as "the gift of desperation." This is for Lockard and for me the most viscerally satisfactory characterization of hitting bottom, because it captures the existential emergency at the heart of the experience: "Imagine that someone has held your head under water for the last 90 seconds or so, what are you prepared to do now on behalf of being able to breath? Well, of course, anything! Because you are feeling that your survival—the continued viability of your elemental self—is at stake" (R. Lockard, personal communication, 1999). This is the experience of people in advanced stages of addiction when they are confronted with the prospect of relinquishing their drugs—or whatever substance or experience their addiction has coalesced around. Paradoxically, this is where healing must start if their problem is to be not merely managed but transformed.

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