Chapter One

A PERSON ADDICTED IS A PERSON IN CONFLICT

Every patient carries his or her own doctor inside.
—*Albert Schweitzer*

Alan strode toward the exit with his head down and his hands making fists in his pocket. It's all over now, he thought. As a frontline supervisor, he was responsible for his unit's performance, and his numbers had been lagging. Some of his best people were taking long weekends, coming in late and leaving early to make up for it. Today he had it out with Simon about his absenteeism. But instead of playing humble, Simon had thrown it back in Alan's face, and Alan had lost it. "But I was really sick, you asshole!" Alan had shouted. Simon had got a sarcastic grin on his face and left Alan's cubby. Later that day, Alan was called in to the front office. Lowell, the HR boss, read him the riot act about losing his temper at direct reports.

When I first met Alan, we were both in an outpatient program, and the shouting incident in his cubbyhole was only a few weeks behind him. His angry outburst had shocked him more than it shocked his subordinate. As he was driving home, stuck in traffic as usual, his head was a war zone.

Part of him said, "Fuck it! The hell with them! I'll find another job!" Another part said, "Like heck you will. Simon was right. You missed as much work as he has. And you weren't sick, you were drunk and hung over. And he knew it. They all know it."

Alan didn't sleep much that night. The next morning, he had made up his mind. Alan went back to Lowell, the HR boss, and asked for a referral to the Employee Assistance Program.

He entered and completed outpatient treatment. Alan became a regular at LifeRing meetings. There, he met and married a sober woman.

Alan is now a vice-president of the company, with responsibility for two hundred employees. His name is in the papers from time to time when his firm launches a new development. His main job problem is whether to stay with the firm until retirement or to take a tempting offer from a different company that has been recruiting him.

Yolanda looked up from her glass as the band stopped playing. She hoped they would play another slow one. Then she would have enough courage to get up and ask the guy at the far end of the bar to dance with her. Her eyes lingered over the table to her left. A young woman in a white blouse and a loose blue skirt was laughing and flirting with her male companion. A cocktail sat before her. Yolanda had been watching. The woman had hardly touched her drink. I used to be like that, Yolanda thought. Damn. I hate that bitch, she thought. She got up, unsteadily, found her feet, walked slowly to the bar for a refill, and turned toward the guy at the far end. But when he saw her, he got up and left.

I met Yolanda online in a LifeRing e-mail group. After that evening in the bar, something changed inside her. She felt something like a pinpoint of light amid the gloom in her mind. That evening, she paced her studio apartment restlessly. She opened her closet. Her eyes came to rest on a battered black case with a handle, and on a pile of papers under it. Trembling, she took the case into her hands. Her flute. She hadn't played it in twelve drunken years. Her brain flooded with memories. She opened the case and assembled the instrument. She shuffled through the stack of sheet music and chose one.

Taking a deep breath, hesitantly, she began to play. She felt the pinpoint of light inside her growing brighter.

Today, Yolanda has eighteen years clean and sober. She plays flute in an amateur group that meets in one another's living rooms. She has a steady job. She's not serious about anybody,

but she's at the center of several extensive networks of friends, face-to-face and online, all of whom come to her for advice and empathy. She counts herself a happy woman.

Sandy heard the sirens far, far away. The next thing he knew, the air on his face was cold and he was being bumped and shaken. Then the air got warm again. He opened his eyes a slit and saw neon lights moving from his head toward his feet. He felt suddenly heavier, then lighter. More neon lights. Then he was pushed into a bed and things got quiet. He slept. When he woke up, a nurse was asking him questions. She explained that he was in a safe place and would be staying here for about seventy-two hours. Sandy groaned. Oh, no, he thought. I got 51–50'd. Again.

I happened to be present, waiting to lead a LifeRing meeting, when Sandy was brought into the intensive care psychiatric lockup on a gurney. Sandy's face looked white, almost blue. He had tried to slash his boyfriend's face with a pizza cutter and then locked himself up in the bathroom and shot up with heroin. The boyfriend called 9-1-1.

A couple of weeks later, Sandy looked like a new man. He had good color, his face was animated, he made jokes and laughed. He radiated love for life. His doctor, who prescribed buprenorphine for Sandy's detox, also referred him to LifeRing. Today, Sandy has four years clean and sober. He belongs to a gay comedy group. He has a "normie" boyfriend, who does not drink or use drugs. He is a legal assistant at a law firm and is studying for a teaching certificate.

Alan, Yolanda, and Sandy are three of the hundreds of people I've met during my involvement with LifeRing. Not everyone I've met has been as successful as these three. I tell their stories here because they embody the great mystery of recovery. Every day, wherever people use addictive substances, a certain number of them turn around and stop.

At first, you see them enraged, stupefied, intoxicated, passed out, or otherwise in the grip of their addiction. They're isolated and alone, or they're at war with those around them.

At a later time, they are lively, intelligent, warm, sympathetic human beings leading sober, fulfilling lives. You see them in a recovery group or another social setting, laughing heartily at themselves and one another, enjoying the company, sober and having a good time. You might ask yourself the following questions:

- What happened to bring about this transformation?
- How is it possible that these are the same people?
- Where did these bright, warm, lively, sober folks come from?
- Where had they been hiding during their active addiction?
- How can we make this miracle happen more often?

That's the great mystery of recovery from chemical dependency.

The Divided Self

The person in the grip of dependency on an addictive substance is a person in conflict, with a personality that has split into two antagonistic camps.

There is the old, original person, the person that existed before addictive substances became a priority. And there is the more recent person, the addict, who lives in the person's mind and body like a parasite, sucking up more and more resources, and driving the person toward premature death.

The inner struggle between these two personalities inhabiting the same person is the central psychological reality of life as an addict. So typical is this inner split that "Dr. Jekyll and Mr. Hyde" is hands down the favorite modern metaphor for the condition.

In Robert Louis Stevenson's *The Strange Case of Dr. Jekyll and Mr. Hyde*, Hyde was the addict who committed unspeakable crimes while under the influence. Dr. Jekyll was the rational

physician, a pillar of the community, always helping and doing good. The great hair-raising thrill of the story to this day is the audience's gradual dawning that they were in fact one and the same person.

In this chapter, I will show that this inner division is characteristic of addicted persons and that a number of leading authorities recognize it as such. In so doing, my intent is to show that the inner conflict within a person suffering from addiction, although it is often uncomfortable and even painful to the point of torture, actually carries great hope and is the basis for positive change.

The Divided Self Is a Clinical Reality

The addict's divided self is more than a literary metaphor. It is a clinical reality. A number of writers with long clinical experience and with the empathy of nonjudgmental observers have seen this conflict and characterized it as a defining experience of addiction.

The historian William L. White, whose book on the two hundred-year history of recovery from addictions in America has opened many eyes, and who is himself a veteran clinician and trainer of counselors, makes this profound generalization:

> Addicts simultaneously want—more than anything—both to maintain an uninterrupted relationship with their drug of choice and to break free of the drug. Behaviorally, this paradox is evidenced both in the incredible lengths to which the addict will go to sustain a relationship with the drug and in his or her repeated efforts to exert control over the drug and sever his or her relationship with it.[1]

The physician/journalist/photographer Lonny Shavelson, author of a portrait of five addicts in San Francisco (*Hooked*), expresses the same insight in fewer words:

> [T]he fierce power of an addict's obsession with drugs is matched, when the timing is right, by an equally vigorous drive to be free of them.[2]

The senior researcher Professor Edward Senay of the University of Chicago, speaking from decades of clinical experience, approaches the issue via a critique of the notion that addicts are always in denial and therefore blind to the downside of their situation. That may be true of some, he says, but he also says the following:

> The majority of substance abusers . . . are intensely ambivalent, which means that there is another psychological pole, separate from and opposite to denial, that is in delicate, frequently changing balance with denial and that is a pole of healthy striving.[3]

Professor George Vaillant of Harvard, a psychiatrist with a long experience in treating and studying alcoholics, says:

> Alcohol abuse must always create dissonance in the mind of the abuser; alcohol is both ambrosia and poison.[4]

Dr. George Koob of the Scripps Institute in San Diego, an eminent neurobiologist, writes that addictive substances set off an "opponent process"—part pleasurable, part antipleasurable.[5] In other words, there is a neurochemical foundation for the feeling of being torn that is at the core of addiction.

Recognition that the inner world of the addicted person is in conflict is also embedded in the *Diagnostic and Statistical Manual (DSM-IV)*, the book that defines what symptoms psychiatrists and psychologists must find in order to make a diagnosis and submit a bill for insurance payment.

Among the DSM criteria for substance dependence is "a persistent desire or unsuccessful effort to cut down or control substance use" or the "knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance."[6] In other

words, a dependent person can be recognized not only by the use of substances but also by the recognition that the substances are causing problems and by the desire to cut down or control personal use. In other words, by inner conflict.

No wonder, then, that I get a strongly positive reaction whenever I speak to recovery audiences about my own Dr. Jekyll and Mr. Hyde experiences. I turn to my listeners and ask, "Am I the only weird one who has two people living in one head?" Nearly all the hands go up. "Me, too." "Yes, that's me exactly!" Inner conflict centered on using or not using the substances is a core psychological reality for everyone in the room.

Addictive Substances Hijack the Brain

In this book, I use the term *addictive substances* or just *substances* to refer to nicotine (the addictive ingredient in tobacco), ethanol or ethyl alcohol (the addictive ingredient in alcoholic drinks), cocaine (powder and crack), opiates (such as heroin, morphine, Vicodin®, Oxycontin®, and the like), methamphetamine and similar stimulants, THC (the addictive ingredient in marijuana), and a miscellany of other harmful habit-forming drugs, such as club drugs and benzodiazepines (tranquilizers). Whether caffeine should be included here is a matter of debate in the literature, and I leave the issue for another time.[7]

Altogether, out of the millions of known chemical compounds, only this small handful of substances has the property of causing human beings to digress from whatever other pursuits they were following, including the quest for food, shelter, social esteem, and sex, and of engendering the pattern of repetitive use despite the negative consequence that is called *addiction*.[8] For this reason, these chemicals have been called *addictogenic* substances.[9]

Lumping the legal substances (ethanol, nicotine) together with the illegal may surprise some readers. Many of us are

accustomed to seeing the legal substances as less harmful than the illegal. The numbers tell just the opposite story. Each year in the United States, more than half a million people die as a result of putting the legal substances nicotine (four hundred thousand plus) and ethanol (one hundred thousand plus) into their bodies. The number of deaths attributable to all of the illegal substances combined is fewer than thirty thousand.[10]

Alcohol, in particular, tends to get put in a special mental category, separate from the other addictive substances.[11] Phrases such as *alcohol and drugs* rest on this artificial separation. There is no scientific basis for such a distinction. Ethanol (ethyl alcohol) is the addictive ingredient in alcoholic beverages in the same way that nicotine is the addictive ingredient in cigarettes. As Dr. Avram Goldstein says quite rightly, alcohol is a dangerous addictive drug.[12] An alcoholic is simply a person who has become addicted to the addictive substance ethanol.

To understand how the repeated use of these substances drives a wedge into the human personality and splits it into two antagonistic personas, it's helpful to know some basic brain chemistry. Scientists discovered in the 1980s that the healthy brain contained its own built-in opiates, together with microscopic areas known as *vesicles* and *receptors,* which transmitted and received molecules of these native substances.[13] The discovery of endogenous equivalents to nicotine, cannabis, cocaine, methamphetamine, and other drugs followed.

Ethanol is special in one sense: it not only mimics the action of opiates and enters dedicated opioid receptors, it also bypasses receptors altogether and penetrates directly through the membranes of brain cells in numerous locations of the brain.[14] It is in that sense the dirtiest, most polluting among the addictive substances.[15]

Wherever they go, these external substances combine and interfere with chemistry that is already present in the normal brain. They travel along brain pathways that have evolved over

millions of years and serve useful survival purposes. Despite their different immediate effects—uppers, downers, and sidewinders—the addictive drugs all appear to affect the level and distribution of the neurotransmitter *dopamine*, a versatile chemical workhorse that is found in many areas of the brain. Like oil in a mechanism, it facilitates a wide range of important functions, including learning, memory, movement, and emotion.[16]

It would be different if there were a specific "addiction gland" in the brain, not serving any other function but just sitting there waiting for addictive substances to come activate it. Suffering from addiction might then be something like having swollen tonsils or an infected appendix. If the surgeon's endoscope could reach the offending organ deep within the folds of the brain, the end of addiction would be just a snip away.[17]

But the biology and neuroscience of alcohol and drugs don't work like that. Because addictive substances seize on active mainstream brain circuits that do a great deal of necessary and useful work, their entry into the brain is often compared with a hijacking. The normal operation of the brain is en route to *x*. Along comes the outside drug and redirects it to *y*.

Thanks to modern chemistry, the outside drug is much more powerful than the internal equivalent. Eating food, for example, increases brain dopamine levels by 45 percent. A dose of methamphetamine or cocaine registers at 500 percent.[18] When the outside drug dissipates, the inside drugs have to try to pick up the pieces and resume their normal course. The conflict between the priorities of the brain's natural chemistry and those of the external chemicals is one dimension of the psychic split arising from substance use.

The Impact on Our Lives

Addictive substances also have a way of splitting personal priorities, schedules, and other resources. A graduate student phoned me

from a Western state last week. He was supposedly working on a Ph.D., he said, but he was actually spending a lot of time drinking.

I know a young father who was trying to be a good dad to his daughters, but he was spending their new-shoes money on drugs.

A mother was trying to help her youngster with asthma but having a hard time quitting smoking.

An athlete dreamed of a career as a professional race car driver, but his marijuana habit got in the way of serious training.

Practically every substance user has a similar "but" story to tell. Using substances, after all, takes time and money and energy away from other priorities.

Some people fool themselves with the argument that the substance use fits in with or advances their other goals. Creative types are especially liable to buy into this dodge. But this illusion breaks down over the long run, as harmful consequences pile up. Eventually, the contradiction between the dream and the drug flashes in neon.

The split between the person's positive self and substance-using self is so characteristic that one effective school of counseling—Motivational Interviewing—trains its practitioners to look for it and help the client see it and articulate it, as a way of bootstrapping recovery.[19]

"A" (Addicted Self) Versus "S" (Sober Self)

If you are trying to clarify who is who and what is what in the inner landscape of a substance-using person, perhaps you yourself, you may encounter frustrations in reading the expert literature. If you read deeply enough, you will find that the mavens in the field disagree about basic issues of definition.[20]

Should we call it *addiction* or *dependence?* Are either of them basically different from *abuse*, or is it a matter of degrees? Is there really such a thing as *alcoholism*, and if so, is there one kind of alcoholism or several? Are tolerance and withdrawal essential to defining addiction or not? Is addiction even a scientific term?

What do we really mean by *craving?* Is it or are they *diseases* or something else, and if so, what? What do we really mean when we say *recovery?* And so on.

The disjointed definition of *substance dependence* in the DSM-IV, where any three hits on a laundry list of seven criteria make the diagnosis, is symptomatic of the underlying discord in the field about basic concepts. This is a definition-by-committee, and it is still evolving.[21]

A Radical Simplification

To move past this pit of definitional and political quicksand, so that we can get on with the project of change, I propose that you and I adopt a radical simplification.

Everything that speaks for, promotes, or defends the use of addictive substances, I will call "A" for *Addicted Self*.

Everything that speaks for, promotes, or defends living life free of addictive substances, I will call "S" for *Sober Self*.

Do you hear an inner voice that suggests a cocktail? That obviously comes from your "A." What about the voice that suggests a bike ride in the hills? That probably comes from your "S," unless your drug connection happens to live on your usual hillside bike route, in which case the idea probably came from your "A." You can eavesdrop on your inner message traffic and with a little practice learn to distinguish the voices of the "A" and the "S" on an ongoing basis.[22] You can spot the "A" and the "S" messages in movies and all around the culture. You can survey your friends and acquaintances and group them into mainly-A or mainly-S types. The A-and-S metaphor is a general tool for making sense of the inner and outer world of addiction.

Feel free to use any other abbreviations that make sense to you. For example, if you feel comfortable with the disease concept of addiction, you might substitute "D" for disease in place of the A, and "I" for immune system in place of the S. If other concepts and abbreviations work better for you, go for it.

Similarly, if the Jekyll *v.* Hyde or Sober Self *v.* Addict Self metaphor veers too closely to schizophrenia or multiple personality disorder for your comfort, then by all means substitute a less-threatening metaphor, such as perhaps Jiminy Cricket on one shoulder and Foulfellow the Fox on the other, as in the movie *Pinocchio* (which is, however, plenty scary to small children).

My point is not to propose a new nomenclature or to insist on an anthropomorphic metaphor but rather to create a functional basis for thinking about and working productively with the inner conflict that arises from addictive substances. Any labels and any metaphors that help you understand, accept, and work with these contradictory inner drives are fine. The essence is not in the label, but in the contradiction.

In Conflict Lies Hope

Inner conflict is no fun. Ambivalence is like standing on the fulcrum of a teeter-totter, constantly fighting for and losing balance. Some people react to the stress by using even more substances—"hair of the dog." No wonder that many feel powerfully seduced by the promise of a conflict-free mental state—enlightenment, serenity, satori, nirvana, or the ultimate great quiet, death.

Yet, without this pain, there is no gain. Imagine a substance-using person whose inner experience is entirely like the rational, sober Dr. Jekyll. This person is highly successful in school, career, and social life. The pattern of substance using is present, but it makes no negative impact on the person's consciousness. This person is not conflicted. There is no psychic discomfort. So long as that remains the case, the person is not going to change.

Now imagine the opposite: a person whose psychic reality is entirely that of the drug-demented Mr. Hyde. This person has no career or social life other than in pursuit of the substance. There

is no tug to realize any higher goals in life. No ambivalence, dissonance, or pain related to substance use. This person revels in the substance, identifies with it completely. This person is not going to change. This person is going to die.

Our brains seem to be hardwired to favor simple, one-sided beliefs.[23] Perhaps this explains why both outsiders and insiders to the reality of substance use have so much difficulty wrapping their minds around the painful yin-yang that defines the condition. Users themselves tend to flip-flop between two irreconcilable absolutes:

"I don't have a problem. I can quit any time I want to."

But "I can't help myself. I'm powerless to change."

Both are phrased in absolute terms, and both are wrong. The oft-quoted metaphor that the addicted person's self-image is a "baby at the center of the universe" expresses the same abstract dualism. You're either an absolutely helpless baby, or you're the power that rules the world.

Outsiders have the same trouble. Much of the time, outsiders are blind to substance use. They see the tightly wound, competent performer and never guess at the flipside of substance dependence. Then, when they do come face-to-face with addiction, they flip into seeing only the addiction and nothing else. "The addict" becomes a comic-book monster, a chemically determined robot with but a single focus—the destruction of self and everyone within range.

It took decades before scientists understood that electricity has both a negative and a positive pole and that you cannot make any practical sense of it before you grasp this inner opposition. It took even longer to decide whether light is a wave or a particle and to realize that it is both.[24] Part of my purpose in writing this book about LifeRing is to nudge the understanding of addiction away from one-sided flip-flop stereotypes and toward the recognition and embrace of the inner conflict that substance use creates in the self.

Absolutist approaches are neither true nor useful in bringing about change. If we don't see the power of the addiction in ourselves or in others, nothing will change. If we don't see the power to get free of the addiction, nothing can change. Absolutist approaches look at the phenomenon with one eye shut. To see it in its three-dimensional reality, we have to open both eyes and see both the A and the S inside the addicted person at the same time. So long as there is this inner conflict, there is hope.

The great virtue of understanding the addicted person as a person in conflict is to recognize that the force Dr. Senay called "the pole of healthy striving" is always in there, so long as the person is alive.

As Albert Schweitzer said, "Every patient carries his or her own doctor inside." The S inside the addicted person is that physician.

Archimedes said, "Give me a place to stand on, and I can move the earth." The S inside the addicted person is that place to stand.

This chapter has focused on learning to recognize that the use of addictive substances tends to split a person's "self" into two antagonistic camps. For simplicity's sake, I've labeled these as the "S" or sober self, and the "A" for addict self.

If you have been using the substances long enough and heavily enough for them to have had an impact on your life and on your sense of who you are, you will find yourself pulled in these two different directions. You will have not only two selves but also two lives in which these selves play the leading roles.

If you have this experience, you are not alone. A divided self is a natural consequence of using addictive substances in our society, or in any society, and this phenomenon has biochemical as well as psychological causes. Leading clinical scholars have seen this dualism and described its main features. It is recognized in the official diagnostic manual.

Most approaches to the person who suffers from addiction see mainly (or only) the A and launch one or another therapeutic attack on it from outside. In later chapters, I will show why those approaches are often counterproductive. The LifeRing approach, while keeping the A in clear focus, operates instead by lending support to the person's inner S. Instead of hammering on the A, LifeRing pumps up the S. The S then does the job of taking the A down to size.

In the next chapters, I will suggest some methods for reinforcing the addicted person's own inner recovery powers. First, we'll discuss some ways to boost one's confidence for making the decision to put addictive substances aside. Then we'll talk about how the LifeRing meeting process works to empower the sober self.