Waiting for Rescue: An Attorney Who Will Not Advocate for Himself

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CASE REPORT

WR is a 32-year-old, adopted, biracial attorney with an eight-year history of multiple sclerosis (MS), bipolar disorder, and alcohol and marijuana abuse. He has been out of work for two years, relying on his adoptive mother for financial support. Crisis loomed when she threatened to stop paying rent. Fearing abandonment and homelessness, he vowed "I'll have to take care of myself"—which, as it always has, proved difficult for him to do.

WR traces his troubles to the summer of 1996, during a summer internship at a law firm. He developed MS, was hospitalized twice, stabilized with steroids, and then maintained on interferon. He had flares in 2001, 2002, and 2003, but has been neurologically asymptomatic since that time. His bipolar disorder emerged during treatment for MS. Prior to 1995, his psychiatric history had been notable only for alcohol and marijuana abuse, which had begun in college. He had a brief depressive episode in 1995, during his second year of law school, and then became depressed again when diagnosed with MS. He became hypomanic on fluoxetine and steroids, but stabilized on a short course of lithium. He became hypomanic again during his second MS flare in the absence of steroids, was diagnosed with bipolar disorder type II by his neurologist, and referred to the hospital's psychiatry clinic. Since that time, he has struggled with chronic depression, with three hypomanic episodes.

Working with a series of psychiatric residents, WR tried a series of mood stabilizers and antidepressants. He had the most, but still limited, success with lamotrigine and bupropion. He has often required a third medication for sleep and anxiety. He prefers clonazepam, which produces less morning sedation. His treaters have preferred olanzapine or quetiapine because of concern with his substance use. He controls his alcohol consumption with naltrexone, which produces a surprisingly immediate reduction in his interest in alcohol.

Although his MS and bipolar disorder have been quiescent recently, they damaged his already injured psyche. The threats to WR's self-esteem began before he was even born. WR's birth mother came from a poor white family. She began dating his father in high school, but her family rejected this relationship because he was black. When she became pregnant, he denied paternity and moved to California. She hid the pregnancy from her own family and gave the baby up for adoption at birth. WR was adopted by an older, white couple from Worcester, Massachusetts; they adopted another African-American baby six years later. His adoptive father, who directed a museum about abolition, walked with crutches because of childhood spinal surgery; WR has always assumed he was impotent. He died from cancer in 1997. A black attorney and his family briefly lived next door, but WR had little contact with them.

WR was frequently disobedient of his parents and teachers. He had to leave his predominantly white elementary school because of his fights during fifth grade. He then went to a predominantly black middle school, where he was teased by the black students for "speaking the Queen's English." His parents transferred him to a private middle school, where the white students called him a "nigger." He ended up at a private boarding school where he thrived, excelling in classes and at rowing. He went to an Ivy League college, where he quit rowing to focus on classes. He began smoking marijuana instead but managed to graduate with

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honors. Although he was rejected by Harvard Law School, he was accepted by a different Boston law school, where he initially did extremely well (first semester GPA, 3.94). He then "slacked off" and did much worse. Rejected by Boston law firms for summer internships after his second year, WR received a single offer from a firm in Worcester. His MS emerged that summer. After taking two years off from school while recovering from his initial flares, he returned and graduated with honors in 1999. Despite his success, WR has never been able to find a permanent job. He blames this failure on three major setbacks: rejection by Harvard Law School, rejection by the Boston firms, and MS.

Following his law school graduation, and after several months of looking for work, WR became discouraged and decided to focus on the Massachusetts bar exam, which he took (and passed) in July 2000. A guidance counselor found him a two-year clerkship with a judge. Although he reports that he easily completed all that was expected of him, process notes from that time describe significant alcohol use and absenteeism from work. When his clerkship ended in August 2002, he was again rejected by a series of Boston firms. His few interviews were unsuccessful: "The interviewers always said I was too laid back."

During his two years on leave from law school, and then during a total of three years of unemployment since graduation, WR accumulated significant credit card debt and defaulted on his student loans. He has been pursued by multiple collection agencies and taken to court several times; he then disregards the resulting payment plans: "They can't do anything to me; I have no money." Because his credit rating was so poor, he made no effort to find a new apartment when his lease expired in July 2000. At that point, however, his birth parents reappeared out of the blue: twenty-eight years after his birth, his biological mother tracked down and married his father. When WR met them he learned that his father also struggled with alcoholism and likely suffered from bipolar disorder; had made and lost millions of dollars; worked as an aid to a famous New York personality; and played in a rock and blues band. WR's birth mother initially offered to buy him a condominium, then reneged, but ultimately cosigned a lease at the last minute. He supported himself during the two years of his clerkship, but has depended on his unemployment payments, and then his adoptive mother, for rent ever since that time.

Out of work ever since his judicial clerkship ended, WR has isolated himself from most social contact. He had many friends, mostly white, in high school, college, and law school. He had one girlfriend in college for six months, whom he describes as a "white girl from Newport who was dating me to punish her father." He had another girlfriend for two years in law school. He was "dumped twice for being a slug." He reports having had an excellent sex life with both girlfriends, but has since lost interest in both sex and relationships: "I'm so good at having sex by myself that having someone else there wouldn't add anything except baggage." He has one good friend in Boston—a neurologist with whom he buys and smokes marijuana—but socializes rarely. He believes that when he gets a job, he will be more appealing, meet more interesting people, get married, and have a family.

WR frequently describes his substance use as a satisfying replacement for his social life. He began drinking regularly in college, typically a six-pack per week, with or without weekend binges. He once blamed an MS flare on a period of decreased alcohol use. He has had several periods of heavier use, up to 12 beers per day for several weeks. WR also began smoking marijuana in college. He initially cut back at law school but resumed when he realized that law school would be easy for him. Since then his use has ranged from 3–4 times per week to 2–3 times per day. He believes that marijuana improves his writing, decreases his anxiety, improves his sleep, and increases his pleasure. He gets intense cravings when he quits. He does occasionally decide that he should quit both alcohol and marijuana because they are bad for his health and his memory. Over the past year he has had several three- to four-week periods of abstinence.

In the absence of work or significant friendships, WR's main social contacts have been with his psychiatric treaters. Since the time of his initial referral in November 1997, he has been treated by six residents, none for more than two years. Some have provided medications and therapy, others have separated those roles. He joined a therapy group for young adults in February 2002. He began seeing me (DSJ) in June 2003 for both therapy and medications. Past therapies have used cognitive-behavioral therapy to help with the many concrete problems in his life, such as substance use and his job search, and dynamic techniques to explore why the CBT has been so unsuccessful. WR has experienced recurrent unemployment crises, with treaters encouraging him to find work, and with rejections triggering renewed shame and passivity. He uses his MS to explain past and current failures and has been nostalgic for his inpatient admissions. His relationships with his adoptive and birth parents have been a source of anger, guilt, and hope: he wants their help but is ashamed of needing it. Substance use has dominated countless sessions. One therapist wrote that he used alcohol "to avoid certain feelings (loneliness, boredom, anxiety) in his life, but then uses talking about it to avoid those same topics in therapy." She and others have shared this interpretation with him, which generally results in a short-term reduction in his substance use and also in his discussion of it. Despite the chronicity of these issues, his treaters have been optimistic at each termination, believing that he has made progress in the therapy. His most recent therapist, however, feared that WR "does not fully experience his connections to treaters and social contacts, in order to protect himself from potential loss and feelings of abandonment."

The following is a summary of how our treatment evolved, emphasizing what, in retrospect, have been recurrent themes or missed opportunities. WR began our first session with his most tangible and persistent problem: "I need a job." Then, as now, he came casually dressed, wearing jeans, t-shirts, and baseball hats, with a slouched posture, slow and quiet speech, and poor eye contact. No one would guess that he is an attorney. Even though his unemployment benefits would soon expire, he had not been looking for work: "I guess I just haven't been looking because of the changing psychiatrists. The past few weeks I've been on hold, thinking that once I start with you, then I'll get everything together." When I asked "How will you look for a job," he explained, "Some old professors might be able to help, or my judge. I haven't made good use of mentors. I should contact one." At the time I did not realize that this statement reflected his pervasive expectation that other people would provide for all of his needs. He stated a preference for task-focused therapy.

Over the next several weeks, he brought up a series of themes relating to low self-esteem. For instance, when asked about the appeal of marijuana, he explained, "It dumbs me down and makes TV more entertaining. I'm just a slacker. I was never the smartest kid in school, but I was excellent at playing the game, at writing what the professors wanted to read. I don't deserve any of my credentials." He also spoke at length about *Days of Our Lives*, which he has watched faithfully since the 1980s. I said that I was surprised that someone of his interests and talents would find soap operas interesting: "I agree. One time I was thinking of doing personal injury law, but a friend said that was below me as well. Right now not working is below me; I'd do anything."

In September his substance use began to increase. He came in to one session hungover, after an argument with his adoptive mother. During this same period he tried to cut back on marijuana use but became "panicky" without it: "It's not fear as much as longing, like longing for sex after my girlfriend dumped me." I asked whether he preferred marijuana or a girlfriend. He answered without hesitation: "Marijuana—it's more reliable, with less fighting . . . But if the choice were marijuana or a job, I'd take the job." He went on a fishing trip with his birth parents, drank heavily with his father, and continued to drink heavily (a six-pack per day) when he returned. He spent Thanksgiving and Christmas with his adoptive mother and brother (who had begun using crack) and further increased his alcohol and marijuana use. He described strong oral needs: "I lost ground over the holidays. My Mom always drilled us not to waste food. She did all this cooking over the holidays, but since she was fighting with my brother, he refused to eat anything, so I ate it all. He is mad because she is more supportive of me." During this time, my supervisor emphasized understanding WR's developmental arrests, and made note of the regression that occurred after contact with his parents. I was frustrated at times but remained confident that this formerly high-achieving patient would be able to overcome his current challenges.

One week WR reported that his group leader had suggested he was an infant, dependent on his adoptive mother. This remark rang true: "I don't like the label, but I can see the ways in which it is on target." He was afraid that if he found work, he would not have excuses: "People will realize what I'm really all about." He returned to the infant comment periodically over the next few weeks: "It's partly true, I do like being taken care of. My adoptive mother threatened to cut me off last summer when my unemployment ended. My plan had been to let my rent lapse, get evicted, and then move back in with her. When she heard this, she started paying my rent." When I offered an interpretation, noting that he had had trouble making progress in his life ever since his birth parents appeared, he disengaged: "I don't know. Oh, I need to get my medications refilled."

After a binge during the Super Bowl, he cut back on alcohol and marijuana, exercised more, and lost weight. We both became more optimistic. He began reading *Discipline and Punish* by Michel Foucault: "If it were 1763, I'd be in debtor's prison! But when I get a job, everything will be fine." When I asked when that would happen, he shifted the conversation to substance use: "I'll take naltrexone forever if I have to. Next week I'll quit marijuana." He continued to have strong cravings, however, and relapsed frequently. Each relapse started a cycle of self-loathing, sobriety, increasing anxiety, and relapse. "I smoke when I watch *Days of Our Lives*. It's my main source of pleasure . . . The characters are my friends, they have been with me since college." I asked how he felt about the advertisements being for detergents. "Yeah, and tampons. I'm not the demographic." My comment exacerbated his shame. "I know marijuana is outside of normal social values. Would a lawyer look down on a pothead? Hell, yes! I'm a lawyer, so I look down on myself. But it makes life more tolerable, like an anesthetic." He rarely mentioned dreams, but during one period of intense craving, he described a dream of "rubbing fresh buds between my fingers, only to wake up and find nothing."

His life was full of similarly painful reminders of his problems. "I watched the Boston Marathon on Monday, which is always demoralizing. It reminds me of things I should be doing." His adoptive mother again threatened to stop paying his rent. "I'm annoyed. She says she needs money to put an addition onto her house. I guess I'll just move in there." His COBRA expired in late April, and he ran out of medications. He did not apply for Free Care. "I know it's self-destructive. Part of me does want to get sick. I miss the hospitalizations: my only responsibility was being a good patient. Anything I did—even just walking around—was part of getting better. If I get sick, then I'll have something medically wrong,

which will explain why I'm not doing more." Worried that he would relapse while off medications, I felt obligated to intervene—and resented having to do so. Alluding to his group leader's comment about wanting to be an infant, I asked: "Are you waiting for someone to rescue you?" Feeling as if I had no choice, and worried that I was validating his rescue fantasies, I walked him to patient financial services to apply for Free Care. The next session he looked dramatically better. I asked how he felt about my intervention. "I felt a little infantile, like an impotent man. But it was also reassuring. It made it feel safer, less frightening."

Fed up with his brother's continuing crack use, WR's adoptive mother threw his brother out of her house. WR became angry: "She said she felt like she was interfering with [the brother's] development, but that's just her therapist talking. It's part of her personal emancipation from the two of us. That's all bullshit. She just supports us because of her guilt about being a bad mother." I asked if she was interfering with his own development: "She does support my inactivity, but she doesn't mind. She says that I always tried hard and that I'm only this way because I got sick." I asked if becoming homeless would punish her. "It won't get that far." He applied for several jobs but was never invited to interview. He complained about having to look for work: "I'm not a salesman." His frustration turned to anger: "What's the worst thing that can happen? It's easier just to let the inevitable hell of life happen and end up on welfare." I asked if he was trying to punish society somehow. "That would only be fair." However, when his mother repeated her threat to cut off his rent, he described moving past the anger: "I was pissed when she told me, but I don't blame her, she doesn't owe me anything. It has lit my fire. I'll find a job, and everything will be fine."

Motivated by the looming housing crisis, WR sent out five cover letters but again complained about having to look for work. "I need an agent, like a rock star. They take care of everything." When I asked why he couldn't be his own agent, he mentioned that he had recently bumped into a former professor who promised to find him a job. Reassured, he stopped sending out applications. I became frustrated and challenged his fantasy: "Do you really think he can give you a job?" WR maintained his faith: "That's what he said, I'm all set. In the past things have always happened to me out of the blue. I never looked for any of the jobs that I received. I never have any power over it." I reminded (or threatened?) him that he had the power to make himself homeless, but he was unconvinced: "Is that powerful or powerless?"

I began to become concerned about my increasingly punitive feelings toward WR. Did his continued problems mean I had failed as his therapist? A new supervisor approached WR from a self psychology perspective, emphasizing shame and the need to understand his deficits and narcissistic injuries. She wondered whether his goal was to be forced to return to his adoptive mother—something I could not, and perhaps should not, try to prevent. She encouraged me to focus not on specific tasks, but on empathic connections. The power of such connections became clear one week when he arrived energized, almost grandiose, having decided to become a judge or politician. I asked what had happened: "Some old friends visited this week. One of them convinced me that I have the best credentials in the group, that I should be able to make a difference in the world."

WR had also been watching the Olympics, which made him nostalgic for rowing. "If I hadn't quit crew in college, I probably wouldn't have started smoking pot, and I'd be a good rower. Law firms love that stuff, especially if you've been in the Head of the Charles." I suggested that he join a rowing club; he thought his adoptive mother might pay. That August, however, she said she was making her last rent payment. When he received a warning from his landlord in mid-September, he panicked. He feared that his adoptive mother would reject him: "She isn't letting my brother return, she won't let me. My biological mother offered to let me stay with her, but she'll get sick of me after two weeks." He had begun thinking about suicide but preferred to "endure this living hell, which at least might get better," instead of gambling with his unknown fate in the afterlife. My naive hope—that crisis would bring a breakthrough—ended when he walked into the next session calm and relaxed: "My Mom wrote me a check last week, out of the blue." I felt both furious (at the loss of a potentially therapeutic crisis? at the realization that he had been correct?) and ashamed about my fantasy that suffering would be good for him. He had not asked her if she planned to continue paying his rent: "We didn't really talk about that, so I'm not sure what will happen next month. My life is just a roller coaster."

Two weeks later he came to session stoned after a marijuana binge: "Being clean from marijuana for a month didn't get me a job—so I figured, why quit?" I told him there was no point in continuing the session if he was stoned. He protested: "It's been a few hours, my thinking is clear now. Also, my [adoptive] mother left a message saying she had spoken to someone at the law firm, saying I should give her a call. If they offer me a job, I'll take it." I asked he if had called her back. "I didn't want to find out yet. It's nice just to think that it might be an offer."

QUESTIONS TO THE CONSULTANTS

1. This patient has many sources of shame and low self-esteem: abandonment, substance use, unemployment, debt, and so on. How would you understand which are most prominent for him? How would you decide which to confront initially? How would you intervene?
2. Many mental health specialists argue that substance use must be the initial focus of treatment in an actively

using patient. Past efforts to focus on substance use have failed with this patient. What strategies would you use to treat his substance use? Is substance use for WR more a cause of shame or his means of managing his shame? Does it make a difference in the treatment?

STEPHANIE KROTICK, LICSW, BCD: A CLINICAL PERSPECTIVE ON BIRACIAL ADOPTION

In *Inside Transracial Adoption*,[1] Gail Steinberg and Beth Hall quote an adoptee, Liza Steinberg Triggs:

> Before I was adopted I was separated from two families, my birth mother's and my birth father's. I was also separated from my culture and from my race. These losses have been huge. People interpret honest talk about them to mean I wish I weren't a part of my family or that I am not connected or maybe, even, that my mom and dad did something wrong by adopting me. Or that I am not grateful. But, you know what? I am not grateful that I had to be adopted. I do not feel wonderfully lucky that I was raised in a different culture from the one I was born into. What I do feel is that I love my mom and dad very much. I do feel connected and would not trade my family for any family in the world AND I still know what I have lost.

Therapy with adopted children and adults focuses on the major issues of loss, abandonment, rejection, and attachment—themes that are especially pertinent in the context of WR's adoption in the 1970s.[2–7] As Phil Bertelson has shown in his film *Outside Looking In: Transracial Adoption in America*,[8] transracial adoptions were common in the 1960s and 1970s; the hope and assumption was that "love is enough" to raise the children well. But there was also a sense that black children were "easier to get," "not as wanted," "not the pick of the litter." In 1972, the National Association of Black Social Workers called for an end to this "cultural genocide."[9] In the wake of the ensuing debate, it became less common for white families to adopt black children, but tens of thousands of black children had already been transracially adopted, and the adoptions did not, in any event, completely stop. In an America still profoundly affected by racism, the relative peace and security of the black children at home with their adoptive white families was in sharp contrast to the racism encountered outside—which affected the black children's perception of themselves, producing insecurity, poor self-esteem, even shame. Many black children in these circumstances considered themselves to be at the bottom of the adoption barrel. Another source of confusion involved irreducible matters of physical difference; white families simply did not understand the adjustments that needed to be made in caring for black skin and black hair. Further complicating this already difficult mix was a range of adoption-associated questions and fantasies: for example, on the child's side, questions and fantasies about the birth mother and adoption process, and on the family's side, white fantasies of rescuing black and biracial children.

WR consistently talks of his conflict—"I have to take care of myself" versus his rescue fantasy that his adoptive mother, his birth mother and father, doctors, and law school professors will all come to his aid. Since 1997 he has had six therapists. Can he really feel attached or connected in any meaningful, therapeutic way, or does he hide out under the radar screen? According to the case history, his maternal birth family was shamed by his birth mother's relationship with a black male, who was presumably considered not good enough—an issue that parallels some of the issues in transracial adoptions. His birth mother's pregnancy and subsequent relinquishment of WR also raise issues of shame and rejection. His birth father's denial of his paternity is another rejection. What is the quality of his relationship with these birth parents?

WR's adoptive family appear to have been liberal "do-gooders"; for example, his father ran an abolitionist museum. What does this mean to a biracial child? WR's assumption concerning the father's impotence mirrors his own emotional—and functional—impotence. WR mentions that, for a short time, he had black neighbors, but what was the meaning of this to him?

In his middle school WR was subject to teasing: he was not black, not white. He faced the common adoption issue of not fitting in anywhere. He displays decreased functioning during this crucial developmental period—when he might have begun to be autonomous and increasingly competent. WR later describes three major rejections but does not mention the perceived rejection by, and loss of, his birth parents. In describing himself as too laid back for interviews for positions in law firms, is his passivity and lack of engagement a defense against rage and a feeling of inadequacy?

WR talks of dating a white woman who was thereby punishing her father—what an injury to his sense of self, if he has one at all! He says "I'm so good at having sex by myself that having someone else there wouldn't add anything except baggage." Here one can see his lack of attachment and his aloneness, schizoid hiding out, and narcissistic bravado. Where is WR in all of this?

WR's belief that when he gets a job he will be appealing, meet more interesting people, get married, and have a family is couched in fantasy, another major way that adopted children cope. What do his fantasies mean, and where do they come from? Why would simply having a job make these things available? His lack of depth and his damaged self-worth make him want to be a chameleon: I can fit the part, get married, and work. These fantasies are ones that he manages with marijuana and his prescription drugs. He is

alone, passive, and drifting. People made early life choices for him: his being given up for adoption eventually led him to conclude that people make decisions for him and about his life: what was he to do?

The central issue now is what WR's treaters can do to help him, especially taking into account that he has apparently always had attachment problems with them: he "does not fully experience his connections to treaters and social contacts, in order to protect himself from potential loss and feelings of abandonment." WR's life began with loss. Most births are celebrated; his began with losing his birth family and entering into a world where he looked different from those he lived with. His early understanding of these events would be important to explore; his feelings of cultural and racial identity must be deeply hidden. He watches soap operas, but why not? Fantasy lives mirror his own, perhaps.

WR says, "I don't deserve any of my credentials," with the implicit suggestion that he's a fake. Am I white? Am I black? Whom do I belong to? Whom am I connected to? Who will help me fight to be someone? He becomes panicky, filled with fear and longing. He may be longing for his early need for connection and reassurance to be met through the mirroring process; instead, due to his physical differences from his adopted mother, he may wonder, "Whom do I see when I look into my adoptive mother's eyes?" As an adult he experiences conflicts with both mothers: he feels that nobody really wants him there, that they pay to keep him away. In therapy, I would explore from his present perspective both his feeling like an infant and his needing to be nurtured and soothed in order to calm his panic and anxiety. Often adoptees use thumbs, bottles, pacifiers, and blankets—or, as adults, therapeutic emotional holding—to calm and soothe. What does it mean to him that his group leader wondered about WR's still wanting to be an infant, in lieu of exploring his inability to move from an infantile position to one of an autonomous adult?

When WR was talking of the soaps as a main source of pleasure, was he injured by the question about how he felt about the detergent ads? The therapist's empathic failure here blocks access to exploring both the pleasure WR does receive from immersing himself in the fantasy of these stories and how WR may feel connected there in ways he does not experience in his real life.

WR finds ways for treaters to rescue him; he keeps them away from his deep shame and his feelings of inadequacy. When his adoptive mother throws his brother out of her house, WR deflects what she says by rationalizing that it is "just her therapist talking." Is *his* therapist just talking? Maybe he is having a deep reaction to what his adoptive mother has done; adoptees, at their core, always fear that that will be their fate.

When WR's therapist asks him if it felt infantile to be walked into financial services, he says it did: he felt impotent, but it was also reassuring, safer, less frightening. Here is the everyday conflict for him. Not long after that, when his therapist asks if welfare was WR's way to punish society, he states that that would only be fair. Explore this: society caused him to be raised in a white home at a time when such adoptions were referred to as "cultural genocide"—yet home was safe, and the outside world filled with discrimination, stereotyping, and racism.

WR states that his adoptive mother supports him because of her guilt over being a bad mother. Was she? His therapist asks if he is going to punish her by becoming homeless. WR says that he would not go that far. I say that he has already been homeless: he was rejected by his birth family and placed with his adoptive family. We can all believe that there were days of aloneness and fear. WR says that things happen out of the blue. Adopted children have had no control. His therapist says that he has the power to make himself homeless. WR says powerful or powerless? This is a war of words: how much of this is now, and how much of this is from before?

WR says that his friends say he has the best credentials. What a narcissistic fantasy! Credentials on paper cannot make him into a productive person. He needs convincing that his credentials have real value. He knows that he feels detached, numbed out, alone, that he is sleeping emotionally through his life. No one cares, but he'd "rather endure this living hell" than kill himself. His masochism is pervasive. "My life is just a roller coaster"; since he perceives adoption as having left him with no control, he just takes the ride.

BRIAN JOHNSON, MD: A NEUROPSYCHOANALYTIC PERSPECTIVE

A neuropsychoanalytic approach to a patient (following Kaplan-Solms and Solms)[10] involves understanding how this patient's brain has been changed by the drugs he has been ingesting, coupled with the usual psychoanalytic view that considers development, drives, unconscious motivations, defenses, and transference to bring out and articulate how this person's brain (as changed by drugs) is unique. The goal of treatment is to use this understanding interpersonally to improve the patient's level of functioning.

The diagnosis of alcohol and marijuana abuse is, in my opinion, not correct. This patient meets the DSM-IV criteria for cannabis dependence. The patient uses marijuana to avoid withdrawal symptoms and in larger amounts than intended, has tried to cut down or stop without success, watches television while stoned for huge amounts of time, has given up his work and given up relationships in order to

use marijuana constantly, and continues to use marijuana despite the history he gives that it impairs his functioning. Although a non-analyst might consider this view "an error," I suggest that the incorrect diagnosis is actually a manifestation of codependence in the treating physicians,[11] which will be discussed later. Use of the term "abuse" incorrectly serves to minimize how much trouble this patient is in with addiction; it can be seen as the psychodynamic defense of "minimization."

To say that the patient is abusing a drug, but without being dependent upon it, generally means that the drug use is interfering with aspects of his life. Dependence, aphoristically speaking, means that the patient's life is interfering with his drug use. This patient wants to sit home and smoke marijuana all day, and is annoyed that he has to speak to his family or pay his rent. He is dependent.

The addictive diagnosis then affects the other diagnoses. Active drug addiction makes the treatment of MS difficult, as described in the case. Patients who seek to remain actively addicted will try to bend the treatment of comorbid psychiatric disorders toward the provision of other abusable drugs; subsequent addiction to other drugs is the rule rather than the exception. This patient is now abusing alcohol, which is cross-tolerant with clonazepam. The complaints of anxiety and insomnia can be summarily dismissed as consequences of active addiction. The treating physicians feel some responsibility to ameliorate these sequelae of addiction with clonazepam, which is another manifestation of codependence.

I have used a neuropsychoanalytic approach to refine the long-standing dichotomy between psychological and physical addiction.[12] I suggested that it would be appropriate for the DSM to include the following criteria for "addictive character":

1. Has a denial system that allows persistent engagement in the addictive activity despite obvious harm;
2. Shows evidence of three (or more) of the following:
   - Responds with an addictive activity when feeling helpless (includes engaging in the addictive activity when experiencing intolerance of affect)
   - Idealizes the addictive activity
   - Resorts to addictive activity in preference to interpersonal support
   - When engaged in a relationship and conflict arises, resorts to addictive activity in place of effective interpersonal communication

This character style is usually adopted during adolescence to facilitate moving away from the family of origin.[13]

The case presentation contains evidence that the patient smokes marijuana and drinks alcohol because of psychological addiction. He began smoking marijuana heavily when he went away to college. His denial is evident in many of the comments recorded in the presentation.

A main defense of his denial system is his insistence that his most important problem is getting a job (displacement). "He believes that when he gets a job, he will be more appealing, meet more interesting people, get married, and have a family." Despite this putative problem, he was accepted into an Ivy League college before the period of heavy intoxication began. And when he cut down or stopped his marijuana in the first semester of law school, he had a 3.94 GPA.

Sobriety is the key to employment. There is a displacement of anxiety about the consequences of addiction to anxiety about employment. The value of this defense is that he can feel and acknowledge his anxiety but assign it a cause that allows him to continue using marijuana.

Marijuana causes disruption of psychomotor behavior and impairs short-term memory via its action at the CB1 cannabinoid receptor. Monoamine neurotransmitter release is inhibited in the hippocampus, amygdala, and cerebral cortex.[14] Deficits in attention and memory worsen during the initial period of withdrawal, especially the first week.[15] The worsening of cognitive impairment during withdrawal is reversed by a return to smoking marijuana.[16]

We would not be surprised to anticipate that job readiness is low during intoxication or drug withdrawal. Marijuana causes amotivational syndrome. The patient says he is "too laid back" to be successful at job interviews. There are important biological factors, however, that explain why this patient cannot get a job while he is actively addicted, and these factors need to be articulated to the patient. His explanation—namely, that his problem is not having a job—could well be interpreted as part of his denial system.

The patient's inability to have social relationships is explained without reference to his addiction. He says he was "dumped for being a slug." "He uses his MS to explain past and current failures." He says, "Next week I'll quit"—which is classic behavior. All these manifestations of denial, as they come up in his psychotherapy, need to be interpreted. The central message of the interpretations of denial should be: "Your addiction is what is making your life intolerable. If you continue to be actively addicted, you will continue to function poorly."

In addition to having a denial system that enables the patient to continue to use marijuana despite its negative consequences, all the other diagnostic criteria listed above are met. Response with an addictive activity when feeling helpless is shown in multiple vignettes; for example, in self-treating feelings of panic, or (as one former treater wrote) in using alcohol "to avoid certain feelings (loneliness, boredom, anxiety) in his life."

Idealization is seen in his description of his pleasure in watching daytime television. "(Marijuana) dumbs me down and makes TV more entertaining." He has a magical view

that drinking helps with the misery of having a chronic illness, "He once blamed an MS flare on a period of decreased alcohol use." This idealization serves to project the terror regarding the adverse effects of the addiction into the treater.[13] The splitting of the ego in addiction is nicely seen in the case description.

The patient's underlying vulnerability, based on his adoption and the conflictual nature of his relationships with his birth and adoptive parents as he was developing, is tailored to an addictive adaptation starting in adolescence. The treaters have been observing the right side of the text box (see below), whereas the patient has been luxuriating in his experiences of the left side; this splitting has been expressed interpersonally in projective identification. Interpretations should serve to help the patient experience both sides ambivalently rather than keeping them dissociated (splitting).

Resorting to an addictive activity in place of interpersonal support is shown by his preference for drug use and masturbation to relationships. It should be noted that persons one uses drugs with are not "friends." The neurologist who buys and uses marijuana with the patient is just a part of his addiction. A friend is someone you can count on to help you when you are in trouble, and this individual is just making more trouble for the patient.

Another prior treater "feared that [the patient] 'does not fully experience his connections to treaters and social contacts, in order to protect himself from potential loss and feelings of abandonment.'" This observation is well founded,

Divergent Interpretations of Patient's Experience	
View of the experiencing ego/fantasy	View of the observing ego/reality
The addiction	The addiction
• is close (invites punishing mother to intervene)	• makes close relationships impossible (wards off fear of control/merger)
• creates pleasure (fusion with symbiotic mother)	• creates pain (punishment for wish to separate)
• gives a sense of omnipotence (regression to symbiotic period)	• makes one impaired (acts out the wish to be a dependent infant)
• is a rebellion that creates a feeling of separateness	• complies with the attacking introject, undercutting the use of aggression needed to be separate

and the dynamic itself is a consequence of the patient's addiction. Once a person starts relying on drugs to avoid depending on people, it becomes a vicious cycle. The longer it goes on, the harder it becomes to pull out of the nosedive and to feel that one can count on other people to help. One can avoid any potential sense of abandonment by making the relationship with the addictive drug(s) more important than relationships with persons.

Numerous vignettes describe the patient's devolution toward addictive behavior in order to handle conflictual relationships. He came to a session hungover after a fight with his mother. He increased his alcohol use during a fishing trip with his birth parents. He increased his use of alcohol and marijuana over holidays with his adoptive parents. This use of addictive behaviors to manage aggressive feelings within interpersonal relationships has been discussed by Dodes.[17,18]

In my view[12] physical addiction is not causally related to withdrawal from drugs or alcohol. Instead, it is, at least in my judgment, the product of craving that is induced by upregulation of the ventral tegmental dopaminergic-seeking system.[12,19] Since this system is identical to the dream-on mechanism,[19–21] the hallmark of physical addiction is drug dreams. The dream described in the case report is about marijuana, of "rubbing fresh buds between my fingers, only to wake up and find nothing." This is a classic drug dream—seeking the drug with no gratification. The patient is quoted as saying that when he decreases his marijuana use, "It is not as much fear as longing, like longing for sex after my girlfriend dumped me." This quality of feeling should be understood as an expression of the dopaminergic-seeking system built into animals so that they crave food, water, and sex. There are no words for a midbrain phenomenon, so we all struggle with metaphors.

Once craving for a drug has been created by recurrent exposure, the craving will be lifelong;[20] it must be communicated to the patient that he can no longer use drugs or alcohol recreationally—EVER. The lifelong character of craving is why members of Alcoholics Anonymous go to meetings for decades on end. They have observed the phenomenon of physical addiction, and since craving never ends, reexposure leads to a recurrence of out-of-control use.

While codependence has been described as a potential DSM diagnosis,[22] it is raised in this discussion in order to caution treaters regarding a countertransference. I have suggested[11] that three qualities embody codependence: a sense of power and mastery that hides helplessness and low self-esteem in both patient and physician; fear of being abandoned unless one abets active use of an addictive drug; and fear of being controlled in a hostile way, accompanied by disengaging behaviors such as issuing an ill-advised prescription. In codependence the treater enters the denial system of the patient.

There are suggestions throughout the case presentation that codependence is an impediment to effective treatment. This patient appears to have a neurotic, rather than borderline, level of functioning; he was capable of doing fairly well in love and work until overtaken by the dire consequences of active addiction. He has been through six psychiatric residents in seven years of treatment, and seems to be worse than ever. So we need to determine what the obstacles to effective treatment might be.

The first indication that codependence may be active is the lack of a central focus on addiction. The diagnosis of "marijuana dependence" as the most important issue to be resolved—and with the obvious necessity that this patient stop the use of alcohol and drugs—does not seem to have been effectively communicated to the patient.

Treaters have been complicit with the patient's displacement of his anxiety from addiction to employment. For example, in the last vignette the patient arrives for his therapy session stoned. He claims, "Being clean from marijuana didn't help me get a job."

The psychiatrist made a good start to raise the issue, telling the patient that they should not continue the session since he was stoned. The patient responded, however, by displacing the issue to employment, and the psychiatrist complied, asking questions about the conversation with his mother. The issue of marijuana use, so trenchant in this hour, was defensively turned into a discussion. In a psychoanalytic approach, one prefers to discuss issues as they enter the treatment, as they come up directly between the therapist and the patient. There was an opportunity here for the psychiatrist to communicate very concretely to the patient that his abuse of marijuana made work—or in this instance, the effective use of an hour of therapy—impossible.

The psychiatrist asked me what I recommended doing when a patient arrives intoxicated on marijuana. The answer is that we treat patients whether they are sober or not. The only exception is that we do not spend time with patients who cannot use our treatment. In this particular case, it is quite possible that the patient could speak and think adequately, but would not be able to remember later what had happened. After explaining this likely outcome to the patient, I would have asked him to come back when not intoxicated. In addition, I would question the value of psychotherapy at all if he continued to smoke marijuana. I would probe with questions regarding what had happened in previous hours, with a view to answering a crucial question for both of us: is he so impaired by the marijuana that, while he derives a wonderful sense of being cared for by coming to therapy, he cannot use any of the information transmitted to change his life, because of the short-term memory impairment induced by the drug? It is an open question how much of his seven years of psychotherapy he actually remembers. Hence, the question about whether this patient can work while using marijuana can be discussed directly via a discussion of whether he can do the work of psychotherapy while using marijuana.

Addicted patients behave in a way to get their feelings into those around them; for example, by paying rent for this able man, the patient's adoptive mother is helping him avoid the consequences of his addiction (and enabling herself, in turn, not to feel anxious about his becoming homeless). Parents of addicted children should be advised to support treatment as much as possible, but never to pay either to give their children a base for drug use or to help avoid the legal consequences of addiction (such as credit card debt or being in default on student loans).

The psychiatrist stated, "Feeling as if I had no choice, and worried that I was validating his rescue fantasies, I walked him to patient financial services." This comment nicely describes the visceral experience of projective identification. In a codependent countertransference the concerned physician empathically identifies with the patient's distress. Through this identification, the physician experiences some of the patient's anxiety and suffering as his or her own, and wants the suffering to stop. We want all our physicians to have these emotional experiences without stepping off the cliff of losing their sense of self/other boundaries.

Codependence means that the physician fails to consciously identify with the patient's helplessness in the face of an addictive process. He or she fails to appreciate the cardinal importance of the unconscious aspects of the interaction, and instead defends against this painful sense of helplessness by assuming a mantle of power and authority that does not match the reality of the addictive process. In this case, instead of admitting to himself and the patient that the marijuana addiction was making the patient so impaired that he could not even register for Free Care, the psychiatrist took over—with enough self-awareness to put this event into the case report for discussion.

The psychiatrist bore out Freud's truism that affects are never unconscious, but that the associated words are repressed. Hence the psychiatrist is aware that something is wrong, but he was not able to describe exactly what it is. I would suggest that what we see here is a codependent enactment in which the ability to use marijuana was preserved by the treater's willingness to fulfill every actively addicted person's fantasy: keeping the drug and being spared the consequences, for the patient received his free care.

A final concern relates to premature interpretations of shame, deficits, and narcissistic injury. Psychoanalysts always want to help patients understand which experiences come from the present, and which ones are actually caused by current experiences triggering memories of past difficulties. Needless to say, this patient *should* be ashamed of himself; he is an extremely capable, professionally trained person who is smoking marijuana all day and asking others

to take care of him. But an interpretation about his shame or "narcissistic injury" coming from the past would be out of place in this treatment. The advice of Alcoholics Anonymous to live one day at a time obtains here, and the patient should be using his intellect and resources to work on getting sober. An interpretation that feeling ashamed is a neurotic memory of the past would function in a codependent manner by offering the patient another way to deny that his shame and distress is a consequence of his current active addiction.

The case report indicated that treaters have used a combination of commonsense advice, behavioral techniques, and psychodynamic therapy to try to help this patient. The value of commonsense advice falling under the rubric of "12-step facilitation" is evident in a number of studies.[23] This patient has had active addiction for so long that he may soon fall to the level of "skid row deterioration," a technical term which means that the addiction has resulted in the loss of job, home, and family. The advantage of his position is called, in Alcoholics Anonymous, "the gift of desperation." Commonsense advice for this patient would be to enter a working halfway house, get a good grounding in Alcoholics Anonymous, possibly join Lawyers Concerned for Lawyers—the sobriety organization for the legal profession. With some solid sobriety he will be capable of performing occupationally.

If a cognitive-behavioral approach was used, Kathleen Carroll's workbook[24] presents what is considered the standard of treatment. The need to keep the addiction in remission is her central focus. Issues involving such matters as 12-week or 12-month plans—also addressed in her workbook—come up later, both as goals in themselves (such as securing a job) and as a means of highlighting the adverse consequences of returning to active addiction.

In my own work I employ a neuropsychoanalytic approach. I assume that if I let patients free associate, they will bring up the most trenchant issues. I then use four basic interventions that have been described by Kernberg:[25] clarification, confrontation, defense interpretation, and transference interpretation. For example, I would listen to associations about work and marijuana, and give a marked response to these associations, something along the lines of "you seem to be having an awful time!" As the material developed, I might do a confrontation, an observation of a conflict within the patient's associations, perhaps along the lines of the following: "Marijuana causes short-term memory impairment and psychomotor retardation. How can you imagine getting a job and using marijuana at the same time?" As the patient defended the use of marijuana, I would make defense interpretations—for example, "You seem to be minimizing the impact of the marijuana on your ability to function. When you stopped it during the first semester of law school, you got a 3.94 GPA. Now all you can do is smoke marijuana and watch soap operas."

Psychoanalysts anticipate that transferences will be brought up as resistances to moving forward in treatment. For example, if I had worked hard within a single session to interpret the need to be sober, and if the patient in this case report then failed to arrive for the next appointment, I might be tempted to suggest that there was a real question of abandonment, which was very hard on the patient. I would clarify that right now nothing was more important to me than the patient's using my help to get sober, but that there might be something he was experiencing along the lines of my not caring what happened to him, and that this experience related to his memory of physical and emotional abandonment by both sets of parents—which we needed to discuss rather than enacting it by his not arriving to allow me to continue caring for him. (Remember the earlier discussion of abandonment as a central dynamic in addictive splitting and in codependence.)

In summary, a neuropsychoanalytic approach to this patient involves starting with how marijuana has changed his brain. Assuming that the basic pathophysiology of addictive drugs is that they upregulate the ventral tegmental dopaminergic-seeking system, the result is lifelong drug craving. Once one drug is established in this pathway, other drugs easily follow; alcohol is apparently coming on as a second physical addiction. A second neurobiological change is short-term memory impairment and psychomotor retardation. These changes are exacerbated by withdrawal. Even an Ivy League graduate who could get a 3.94 law school average cannot function with these drug-induced changes.

Starting with the biological understanding of how this individual's brain is unique, the usual psychoanalytic approach is added. Interactions with the patient communicate the treater's understanding of what is wrong. The assumption is that if the patient were to become consciously aware of what prevented him from functioning well, he would take ordinary measures (as described above) to eliminate those obstacles and to improve his life.

The reason that this treatment was brought in for consultation was that it was not going well. The fundamental misstep was, in my view, the failure to consciously acknowledge the power of an addictive illness. By making this issue the central one, and by helping the patient to become aware that he cannot be actively addicted and have a good life, his chance of becoming sober and functioning at a much higher level will be improved.

ANDREW P. MORRISON, MD: SHAME AND NARCISSISM

I gather that I am to represent the dynamic psychotherapeutic perspective on this interesting case, and I am pleased to uphold that position. Let me emphasize from the beginning

that I also believe strongly in the dual treatment approach for people with alcohol and addictive problems, and I certainly aim at abstinence where possible, with the particular aid of AA. WR is a fascinating man who cries out for a long-standing connection and commitment with a therapist who is able to help him face and deal with his deep self-doubt and despair. I will start by presenting my own diagnosis of WR and therapeutic recommendations for his treating psychiatrist, after which I will turn to a theoretical discussion of why I believe these to be valid and potentially useful.

Toward the end of the case history, it is mentioned that the new supervisor emphasized "shame and the need to understand his deficits and narcissistic injury." In fact, I could not state the issues any better or more clearly than that. WR is a narcissistically damaged man who is particularly shame sensitive, and whose major issues with self-esteem have to do with deep, primary feelings of shame and humiliation. His defenses against feeling his unbearable shame are expectable, including grandiosity and haughtiness, apathy and withdrawal ("laid back"), displacement (illness), and fantasy ("when I get a job, everything will be fine"). His therapist needs to stay with WR's underlying feelings of self-doubt, self-loathing, and despair, rather than continuing to focus on his behavior and (non)actions.

Shame has been one of the most important, and most neglected, feelings in the psychotherapeutic inventory. Starting with Freud, therapists have avoided shame because it is so painful and because it is strongly contagious. To recognize the shame and humiliation of our patients usually puts us in touch with our own shame—a place we might rather not explore. Shame did not take a prominent place in psychotherapy until the 1970s, when narcissism and narcissistic injury began to be acknowledged and studied, particularly in the work of Heinz Kohut. Shame is the predominant affect in narcissism and the sense of self insofar as guilt tends to predominate in neurosis and intrapsychic conflict (although shame and guilt clearly play parts in each). The title of one of my own books on shame is actually *Shame, the Underside of Narcissism*.[26]

So what leads do we have about the importance of shame and humiliation in understanding WR's difficulties? But first we need to ask, "What is shame?" It is a sense of the *whole* self as inferior, failed, worthless, defective, flawed, unimportant, small, dirty, weak, insignificant, different, ridiculous, or pathetic. The first things we learn about WR are that he was adopted, that he is half black, and that he developed a chronic illness. He expresses these in terms of feeling rejected and abandoned. There is ample evidence that his experience of being adopted represented to him a sense of rejection and of overwhelming defect. In the upper middle class in which he grew up, we might also speculate that his blackness in white society, and whiteness among blacks, denoted inferiority and flaw. He experienced rejection from Harvard Law School and from the Boston law firms as confirmation of his inadequacy, and the onset of MS as another stigma of his weakness and physical defect.

Each of these self-definitions represented his own experience of shame and humiliation—and as noted by the supervisor, were also designations of narcissistic injury. What evidence do we have that narcissism and narcissistic injury are important indicators of WR's difficulties? In talking about sex, WR speaks of his preference for onanism—he felt so good having sex with himself that anyone else would just be baggage. In this statement, the self is all—no need for an object—the traditional expression of the narcissistic condition. Then, as examples of manifest superiority and his inflated sense of self, he sees the field personal injury law as being "below" him and feels that he ought to have an agent to help him get a job, "like a rock star."

But are these truly indications of genuine narcissistic grandiosity and a stable sense of self? The answer, most clearly, is negative. About his own judgment of himself, he speaks of his credentials and education, and of his ability to assess his own accomplishments. "I'm a lawyer, and I look down on myself"—a judgment that, by dint of his training, he feels qualified to make. In watching the marathon, he can only use this to castigate himself for his own failures. "It reminds me of things I should be doing." About his therapist walking him to the finance office, WR states that he felt safe, but fundamentally infantile and impotent (perhaps another reason for his preference for solitary sex).

One of WR's major concerns has to do with his "need" for others, his requests for help (as from his adoptive mother, his other parents, an agent to help him get a job, etc.). In a representative narcissistic role, he feels he should be totally independent, autonomous, need help from nobody. He recognizes that he feels "safe" when he is getting help and support, but also feels humiliated in turning to others out of need, as when his therapist accompanies him to the financial office.

I hope that I have made a case for the role of shame as central to WR's difficulties; for narcissistic phenomena and narcissistic vulnerability as the characterological underpinnings—the "underside"—of his shame sensitivity; and for his conflict over strivings toward complete autonomy and independence, contrasted with yearnings to be taken care of and to "merge" with the powerful other. Also, he hides his despair over rejection in his job quest through his fantasy/expectation that before long he will get a job and all will be well (as though that would settle, once and for all, his shame propensity and narcissistic vulnerability). His inclination toward depression is, I believe, a shame-based despair reflecting all of these elements and his deep conviction that things will, in fact, never really change.

So where does that leave WR's therapist and the psychotherapy of WR? Early in the process material, the therapist spoke of WR's interest in "task-focused therapy" and his difficulty following through on the tasks—that is, on getting a job. It seems that the therapist took as *his* task the job of getting WR to apply for, and succeed in getting, work. After all, WR is a lawyer who is not working and not living up to his potential. Most of the therapist's interventions seemed to focus on WR's inhibitions and his inability and lack of motivation to get a job. This stance led the therapist, I believe, to overlook many of the shame signals and related emotions that WR expressed or implied in the course of their work together. Some examples:

- About not looking for a job in the context of a change in psychiatrists, WR says that he has been "thinking that once I start with you, then I'll get everything together." This remark suggests to me a whole line of investigation about his expectations from, and fantasies about, his new therapist, what he hopes the connection to his new therapist will provide, how his new therapist will help to structure and empower his self, and so on. But sticking to the task, the therapist asks, "How will you look for a job?"
- About smoking marijuana, after the therapist had asked about the fear that smoking was meant to ease. "It's not fear as much as longing, like longing for sex after my girlfriend dumped me." Such a rich image to explore—longing; longing for sex; and what about "after his girlfriend dumped him"? The therapist asked, "Would you rather have marijuana or a girlfriend?" This question had, it seemed to me, a critical, judgmental ring, one that might well itself induce shame. In this instance, as in some of the others already mentioned, I believe that the therapist's work with WR could clearly benefit from his examination of his own countertransference feelings about WR's life style and his inability to reestablish his professional status.
- "I need an agent, like a rock star. They take care of everything." Here, besides the element of grandiosity noted earlier, WR introduces the whole question of need—the ubiquitous stimulus for shame in the narcissistically vulnerable—and of "being taken care of." Rather than picking up on the matter of need, the therapist focuses on the task of autonomy in getting a job by asking, "Why can't you be your own agent?"
- Finally, in talking about rowing and his wish to have continued to row, which would have impressed the law firms (especially in having rowed in the Head of the Charles regatta), the therapist sticks to his practical task by suggesting, "Why not join a rowing club?" Instead, I might have asked WR how he thought the rowing credentials would improve his image with a potential employer, how he thought rowing might have prevented his smoking pot, and so on.

I don't like the position of Monday morning quarterbacking, but in the short space allocated to me, I wanted to open a new line of inquiry regarding the therapy of WR. I think that the therapist got stuck into the role of being WR's employment coach, focusing on the goal of helping him rehabilitate his skills as an attorney. This approach only plays into WR's grandiose defense—his stubbornness—and enables him to avoid bringing his shame and despair to light. I would suggest, rather, that his therapy should pick up on the affective moments, on the various words of disparagement and self-deprecation that constitute what I have called the language of shame. Given the opportunity to explore such matters, I think that WR would come to feel great relief at *finally* being understood, at being able to uncover and expose, to himself and to a trusted therapist, his deepest, most concealed feelings—feelings of shame at having failed so profoundly at his own self-appointed, grandiose tasks.

The salve for shame is *acceptance*, by self and other, for those elements of self that have been so carefully concealed. With this approach, and being able to share his shame with an accepting therapist, the focus that he initially requested—and that the therapist took as his mandate—might paradoxically be achieved. Kohut spoke of the "transformation of narcissism" that can occur through a therapy based on empathy and appreciation of the other's feeling state. In the protective arms of such a treatment, WR might well straighten up and succeed as a lawyer.

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