To facilitate reading, use the table of content in hypertext and hop to the section of your choice.
Use the "**to Top of page**" link to return to the table of content.
I welcome comments and questions at : **d_lag@granby.net**. Thank you.

Addiction: the way in and the way out

© **Daniel Laguitton**, Sutton, Canada, 1993

Table of content

ABSTRACT

Addiction is defined as an attachment to internal or external objects used as anchors by individuals lacking alternative skills to cope with deep anxiety. Chemical dependence is a stereotype in a broad spectrum of addictions and, for that reason, alcoholism recovery models are used as examples to illustrate the role of mutual aid in breaking the cycle of addiction. Four key elements of mutual aid are described as essential to recover from addiction: identification, education, synergy and acceptance.

Introduction: addiction, a dependence on anaesthesia

In the 1990 International Classification of Diseases (ICD), the World Health Organization (WHO) defines drug dependence as follows:
Drug dependence is a state, psychic and sometimes also physical, resulting from taking a drug, characterized by behavioural and other responses that always include a compulsion to take a drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependant on more than one drug. (ICD, 9th revision, 1990, p.1131)

The definition of the "alcohol dependence syndrome" given in ICD is identical to that of drug dependence except that the word "drug" is replaced by "alcohol". Although it appears to leave little room for subjective interpretation, it is well known that individual and collective denial plays a critical role in the diagnosis of chemical dependence. A great deal of confusion arises from the fact that intoxication and addiction are obviously two different conditions although their correlation is quite similar to that of smoke and fire: when the former is seen, the latter is never too far. Alcohol intoxication is regarded as a disgrace in some cultural systems while it constitutes a colourful highlight, a comical habit or is even, in a somewhat twisted irony, considered as a rite of initiation in others (Sadoun et al., 1965, p.49).

The WHO definition of drug dependence is expanded below to include other forms of dependence in which there is no consumption of a substance identified as a drug, but where a psychological and sometimes physical dependency is nevertheless established between an individual and another person or a behaviour. Such an extension sheds light on the common denominator of all addictions, i.e. emotional anaesthesia, another name for what is meant in the WHO definition by "to avoid the discomfort of its [the drug's] absence". Although such a generalization of the concept of addiction is decried by some as fostering a hypochondriac or victim mentality, their objection does not hold because addiction is not a modern plague and humanity is not completely helpless when confronted to it. Addiction is, to put it simply, a widespread and misdirected attempt to avoid anxiety by resorting to behaviours to which individuals can easily become enslaved. The term "dis-ease" befits such an enslavement since it describes a condition characterized by a departure from a healthy sense of ease and harmony. In order to illustrate the generalized definition of addiction introduced above, a brief examination of the basic components of the human condition will help.

1- Desire and anxiety: two basic aspects of the human condition

The word "desire" comes from the latin root "siderus" which means "star, constellation, heavenly body". "De-sire" means literally "deprived of the star" which is a metaphor for the experience of "complete darkness" or "dark night of the soul". The most common form of darkness we experience is the disappearance of the sun behind the earth, every night. Every sunset amounts to the beginning of a total solar eclipse where the sun disappears behind the earth instead of disappearing behind the moon as is the case for "official" solar eclipses. "Eclipse" comes from the Greek "ekleipsis" meaning "abandonment". The natural response to abandonment, be it by the sun or by any other source of safety is anxiety. Children show anxiety in darkness and their forced seclusion in a dark space is still a too-frequent method of punishment. At dusk the animal kingdom undergoes a daily transition when the various species active during the day go into hiding while those who are active at night emerge from hiding. In most cultures, night is perceived as governed by dangerous forces, sometimes symbolized by the devil. Dr Jekyll was a daylight creature, Mr Hyde roamed at night. If darkness, in its visual sense, is experienced at night, psychologically, it occurs whenever our main source of security is "eclipsed". For a child, the mother figure is such a central source of security.

"Desire", in its root-meaning, is fundamentally an experience of psychological darkness marked by increased anxiety. Craving for light is the natural response of the human psyche confronted with darkness. Sometimes, especially when the prospect for a return of the light is not good, an ingenuous response to darkness is the denial of darkness or the numbing of the feeling of anguish that accompanies it. The power of denial is explicit in Ernest Becker's psychological analysis of the human condition entitled The Denial of Death (Becker, 1973, p179) where he writes: "We call the refusal of reality "normal" because it doesn't occasion any visible problems." The irony is that darkness is even made thicker by the denial of darkness. Furthermore, the darkness or emptiness corresponding to the root-meaning of desire is generally "whitewashed" by a pleasurable sense of craving for what we assume to be the object that will relieve our "desire". Beside the "light" versus "darkness" struggle, the human condition can be described by many other metaphors as found in the mythico-poetic works of every culture. Transposed in their acoustic equivalent, "light" becomes "sound" or "spoken word", "darkness" becomes "silence", "desire" becomes "ab-surdity" (from "ab-surdus", meaning deprived of sound), and the "lightning bolt" of "enlightenment" becomes the "thunder-clap" of "astonishment". "Marvel" and "miracle" also come from a root which means "thunderstruck". In yet another range of metaphors based on the concept of "spirit", (from the Latin "spiritus" which means "breath"), "darkness" becomes "loss of breath" or "choking" which is precisely the root meaning of "anguish" : "to be choked by a snake", (from the Latin "angere", whose relationship with "anger" is obvious).

Psychological theories propose intricate models of human personality development and pathology. It would be outside the scope of this article to enter the labyrinth of such models and the reader is referred to specialized psychological publications such as the extensive discussion of the psychodynamic theories of addiction by Philip Flores (Flores, 1988, Chapter 6). A determining factor in the character pathology ("flaws" may be a better word) predisposing an individual to addiction is described by Flores as a lack of "object constancy". Lack of object constancy is the inability of a child to maintain a mental image of the mother, (and by extension of other comforting objects), when she is not present. As a result, such individuals would be

prone to fill their inner void by developing attachments (addictions) to other immediately available external or internal objects. Bergeret expresses very similar views when he says: "the addict deprived of his reassuring object behaves like a child who sees his mother leave before he has developed the concepts of time and of return" (Bergeret, 1982, p60). The above psychological model is the scientific equivalent of the "eclipse" metaphor presented above. The underlying psychological problem of the addictive personality can therefore be described as the inability or difficulty to cope with "eclipses", (i.e. with desire) without resorting to attachment. Most spiritual traditions hold attachment as the root of all human suffering. It is a habit which limits personal freedom and can lead to self-destruction and even to death.

2- To be or not to be: living fully or accumulating an existential deficit

To further understand the addictive behaviour, two aspects of the human personality must be examined. They can be nicknamed "the scientist" and "the philosopher". The scientist is the symbol of man as an information gatherer, an experimenter and a theoretician. The scientist uses his intellect to free himself, as much as possible, from vulnerability to outside threats and to improve his comfort. We know how far we have gone on the road of technical domination of the planet. The philosopher, on the other hand, is the symbol of man as an explorer of his existential darkness, offering reassuring (or, sometimes, not-so-reassuring) models of the universe to his fellow humans confronted with the anxious probing of darkness about man's origin and his destiny. Humans have devised ways to store and improve their scientific knowledge from generation to generation, but they have great difficulty storing and refining philosophical knowledge, at least in its deeper aspect of "wisdom". For example, most of what was considered as advanced science two centuries ago has been updated and improved and is now taught in primary schools, when it is not altogether obsolete and scorned as primitive and somewhat amusing in its "naïveté". On the other hand, Plato, Lao-tzu, Socrates, and most ancient philosophers could still, today, qualify as advisers to the most prestigious institutions. It seems to indicate that "intelligence" as defined in its science and engineering aspect, is not an adequate faculty to gather and to store wisdom. Books of wisdom are subject to analytical interpretations and often fail to meet modern standards for scientific accuracy, at least in a classic mechanistic sense. Tradition, the main container of archetypal wisdom, loses its content with time and becomes out of date. This is how the word "archaic" which literally means "related to the beginning", "fundamental", has come to mean "obsolete", or "primitive" in a pejorative sense rather than "original and pure". Its root meaning is undergoing a slow revival largely due to Carl Jung's recognition that archetypes, i.e. fundamental transpersonal archaic themes, are at play in the human psyche. Meanwhile, humans continue to spend a considerable amount of their finite and precious vital energy and an increasing fraction of their time to seek "peace and happiness" through practices which have in common an obsession with quantitative and rational knowledge. Rationality, the faculty to divide a continuum into categories and to recognize cause-effect relationships between these categories, has achieved such apparent wonders in liberating mankind from a blind dependence on nature that abstract rational models have slowly eclipsed the continuum they were meant to map. In a scientific culture, the tree of knowledge hides the forest of wisdom and "left-brain supremacy" has been raised to cult status. Reading such blasphemous words, many a grand priest in the temple of rationality will already have torn his

robe: "what are your qualifications, Sir, to make such statements", "where is the database on which your model can be validated"? Without scorn, I simply extend my sympathy to such outraged grand priests and to their legions of left-brain supremacists. The pain of what amounts to a right-brain lobotomy is such that "happiness" is often confused, among them, with "relief". Anaesthesia is a short-term remedy for pain and is one of the most common practices in modern lifestyles, to such an extent that, as will be shown below, it amounts to societal addiction. The irony of such pain-killing practices is that they only mask the symptoms while stifling the very core of the human experience. "An-aesthesia" is, literally, "non-aesthesia", i.e. a loss of sensitivity, the function which differentiates a human being from an "intelligent" computer. Living under anaesthesia amounts to passing through human existence without being fully alive. Worse, as we evolve in numbness, we accumulate a deficit in terms of true life experience. Jo Numb, 1916-1985, addict, may have experienced not a single year of his life as a whole human being because he was never fully alive. Born in a family where his father had learned at an early age to "be a man" by suppressing his feelings, and where his mother, raised in a rigid God-fearing culture, spent her life placing duty and austerity before spontaneity, Jo Numb, PhD, never learned the language of sensitivity and emotions. Emotional illiteracy is indeed compatible with a PhD in any discipline. Without blaming parents for one's personality flaws, it is essential to recognize the important role of parenting and of family "culture" in the shaping of the addictive personality. The children of today are the parents of tomorrow just as the parents of yesterday were the children of yesteryears.

What was said above, using the scientist/philosopher and left-brain/right-brain imagery, can be transposed into a number of other metaphors describing a state of polarization: yang/yin, reason/passion, masculine/feminine, light/dark, rigid/flexible, etc. Some metaphors lose clarity when one has conceded too much power to the words in which they are expressed. For example, the current abuse of masculine/feminine terminology in discussions about power struggle between genders tends to disqualify the words "masculine" and "feminine" in meaningful discussions about human wholeness and about the harmonious integration of the masculine and feminine archetypes.

3- Anaesthesia: Numbing the pain of alienation from self and from others

Anaesthesia is one of the jewels of modern science. Surgery is usually done under anaesthesia. We all know the benign but much appreciated anaesthesia practised in the dentist's office. It is unfortunate that, although the short-term gain of anaesthesia is always recognized, the potential long-term penalty of generalizing its use is largely ignored. The price to pay for alleviating pain is a lowering of sensitivity, the very essence of being alive. Try a kiss next time you return from the dentist! Although it may be a bargain when dealing with short term situations, anaesthesia can, of course, if it becomes chronic, be a disaster. Beside its ingenuity at developing and using an impressive arsenal of synthetic and natural anaesthetic substances, manking (this typing error for "mankind" deserves to remain uncorrected!) has also developed or inherited a potent range of natural psychological techniques of anaesthesia. It is sensible for an individual to resort to these techniques of anaesthesia as long as the penalty remains "reasonable", i.e. is lower than the gain.

The loss of the enjoyment of being alive is the price of depending on anaesthesia, a high price indeed, further inflated by becoming destructive to others.

If addiction is often found in personalities affected by early developmental dysfunctions and childhood trauma, it is also widespread among individuals who, for various personal and cultural reasons, learn to sedate their anxiety as adults. There is usually nothing intrinsically "bad" or "wrong" in the various substances, objects and behaviours used in addictions. The individual and societal penalty paid in the form of hidden denial of self and of reality is the true yardstick that makes addiction (or should make it) acceptable or not. The complexity of the issue of addiction comes from the fact that a key characteristic of addiction is the loss of the ability to appreciate the extent of the penalty an individual or a society pays to remain addicted. When it comes to addiction, appearances may be quite deceiving. For instance, what may, on the surface, be celebrated as "hedonism", (i.e. the cultivation of pleasure) can also be motivated by a deep-seated "anhedonia", i.e. the incapacity to experience the joy and pleasure of wholeness. Superficial excitement often hides a lack of deep enthusiasm. Masochism itself can be motivated by apathy, a loss of sensitivity which amounts to a psychological amputation accompanied by a craving for completeness.

Addiction, in its broadest sense of "dependence on anaesthesia" can therefore be defined by paraphrasing the WHO definition of drug dependence as follows:
"Addiction is a state, psychic and sometimes also physical, resulting from resorting to anxiety avoidance behaviours, characterized by behavioural and other responses that always include a compulsion to repeat the anxiety avoidance behaviour on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one response."

4- Addiction: a submissive relationship

Various encyclopaedias offer detailed classifications of drugs in various groups, by degree of legality, by effect etc. Some substances are known to be highly addictive, i.e. they quickly generate a craving even after minimal use, others seem to be addictive for some individuals who seem to have a predisposition or to be allergic to them. It is ironic that "moon-shining" is a popular name for the domestic distillation of alcohol, considering that this substance is such a popular "eclipse reliever", as if to say : it will brighten your nights. "Moonlighting" similarly refers to carrying a second job. Since workaholism and economic necessity are not mutually exclusive, a great deal of "adrenaline moon-shining" is taking place unnoticed. Interesting variations are observed in the level of addiction to a given substance depending on the cultural value associated to its use. It is beyond the scope of this paper to discuss such considerations or to examine the pharmacological classification of drugs and their complex and much debated metabolism. Little is known of the chemistry of the human brain and of the nervous system or of the subtle chemical and electrical imbalances related to cravings and impulses. On the other hand, a few basic recipes of mental hygiene are common knowledge. For instance, physical exercise is known as a great reliever of anxiety and stress. Similarly, most meditation techniques use mental concentration, to trigger internal responses such as mental stillness or various altered

mental states, offering the busy left-brain a repetitious task which calms its frantic activity. Such techniques are mere refinements of the advice given to children to count sheep or to listen to a lullaby to overcome anxiety and insomnia. Autosuggestion can also serve as a powerful and useful anaesthetic. The difference between the mental anchoring practised by a genuine spiritual explorer and that of the addict (including the "spiritual escape" addict) is in the motive: the former seeks to filter the mental noise that hinders an intimate communication with the inner-self and the universe, the latter seeks to silence an unbearable inner pain and to escape somewhere else by repeating ad infinitum a numbing behaviour. The "somewhere else" needs not be a pleasurable place, it can even be somewhat uncomfortable, since relief from anxiety is its chief prize. Some depressions are clearly such detours into mild misery, a misery that seems to pay off since it masks the sheer terror of seemingly bottomless anxiety. If the induced "trip" out of oneself can be temporarily experienced as a "high", the more convincing the self-deceit and the thicker the denial.

It has been said that man is a creature of habit. A "creator" of habit might be a better term. The bridge between anaesthesia and addiction is precisely the creation of a habit. Any behaviour, action, thought, relationship with self and others can become an addiction. The fact that addiction is rampant in every aspect of our western culture does not make addiction less of a problem, on the contrary. The same is true of the broad range and hierarchy of addictions in terms of visible impact, some being perceived as "more severe" than others. This is where cultural values play an important role and where acceptability takes precedence over true impact assessment. At the top of the North-American hit-parade of addictions, chemical dependency is the "official villain". Greed ranks much further down or does not even make it to the list. Blaming it on drugs is, in itself, a policy of denial. The effort to curb addiction being virtually entirely based on the problems of alcohol, tobacco and drugs (the awareness of gambling addiction is rising proportionally to the profit of casinos and the spreading of electronic gambling machines). So much is written on chemical dependency that no further discussion of this topic is needed here. The reader is referred to specialized literature issued by all the major chemical dependency organizations, agencies and schools such as the Center of Alcohol Studies, of Rutgers University (Rutgers, in the reference list). Let us rather explore other addictions about which much less public awareness exists and for which much less help is available.

4.1- Codependency: addiction to people

Codependency has been the subject of much debate in the 1980's and the word has come to mean different things to different people. For instance, W.Mendenhall defines it as "a primary condition that results from the debilitating physiological stress produced by living in a committed relationship with an alcoholic or drug dependent person" (Carruth, 1989, p6). Melody Beattie defines the codependent as "a person who has let another person's behaviour affect him or her, and who is obsessed with controlling that person's behaviour" (Beattie, 1987, p31). Anne Wilson Schaef is more specific when she states: "Codependency denies the reality that people who are codependent are addicts. Until we look at that, there is no hope of recovery" (Meacham, 1990, p36). Marsha Utain, quoted in the same article, adds: "For me, codependency is another title for using relationships to avoid dealing with the trauma of our own emotions" (Meacham, 1990, p38). A cross section of experts in the fields of family, addiction and mental health meeting in Scottsdale, Arizona in September 1989 has produced the following definition:

"Codependency is a pattern of painful dependency on compulsive behaviours and on approval from others in an attempt to find safety, self-worth and identity" (Laign, 1989, p3). Dozen of other definitions of codependency (also written co-dependency or codependence) have been proposed, each stressing one particular aspect of dependence on an external object. Humour can also help to clarify what codependency is, as in the following remark: "what happens to a codependent seconds before he dies? He sees somebody else's life flash before his eyes!"

Codependency is, first and foremost, an anaesthetic dependence on a partnership. In short, it is usually the name given to addiction to another person. A codependent person uses others as mood-altering objects. As children, we depend on our parental figures to regulate our physical and emotional needs. As adults, we also live in a state of interdependence with others and with our ecosystem. The line between addiction and healthy interdependence is therefore elusive. The misdirection of dependence to avoid painful self-actualization is difficult to identify until destructive consequences become obvious. In recent years, the severe psychological impact of growing-up with emotionally "numb" parents has been recognized and has led to the development of large recovery movements such as "Adult children of alcoholics" and "Codependents anonymous". Based on mutual aid principles, such fraternities have drawn extensively on the experience of the giant of the alcoholism recovery field, Alcoholics Anonymous, whose philosophy is briefly described further down.

4.2- Food addiction: bulimia, anorexia, pica

Dependence on behaviours related to the ingestion of food characterizes food addiction. It takes many different forms such as "eating when not hungry", "being obsessed with one's weight", resorting to "food binges" or to "purge and diet cycles", or even ingesting non-food substances. There can be direct links between other behaviours and food addiction, for instance compulsive exercise can be driven by an obsession for weight control resulting from food addiction. Wrapping oneself in a thick obese "body armour" is often related to sexual abuse and avoidance of situations that would re-actualize the initial trauma. Less documented in recovery circles, but also quite widespread, "pica" is the name of a compulsive consumption of non-food substances such as clay, starch, paper, plaster, cotton fibres and others. Alice Miller summarizes the broad spectrum of "ingestion" addictions when she says: "Alcohol, cigarettes, nail biting, all serve the same purpose: to prevent feelings from coming to the surface, at any cost (Miller, 1990, p41). Food addictions belong to this broad spectrum even if specific physiological and biographical considerations may explain why someone reacts addictively to a particular food or feeding behaviour and non-addictively to another.

4.3- Sex addiction

Whenever sexual excitement is used as a habit to cover anxiety, one enters the broad range of sex addiction. The irony is that while liberating sexual behaviour from pathological repression under old moralistic rules, modern society has widely opened the door to sexual addiction by making it a widely available, guilt-free, reservoir of anaesthesia. Patrick Carnes in his description of sexual addiction distinguishes different levels of behaviours ranging from more or less controversial practices --such as "mild" pornography and prostitution-- to severely pathological and widely condemned aggressions such as rape and child molesting (Carnes, 1989, p79). The elusive line

separating addiction from free choice is especially thin in the area of sexual behaviours. For instance, it is legitimate to wonder why most sexual activity seems to take place in the early part of the night. The answer may simply be that it is an age-old human behaviour associated with the privacy of darkness and with the fact the day is devoted to other activities like food-gathering or bread-winning. On the other hand, "loneliness" is often perceived as "sexual deprivation", especially at night, thus blurring the distinction between the soothing of personal anxiety and healthy sexuality. A whole industry of nightly "entertainment" thrives on this confusion.

The issue of "covert" versus "overt" sexual abuse (including self-abuse) is only emerging in western societies and progress towards a clear understanding of sexual addiction versus "healthy" sexual expression, except in the most obvious cases, is also very slow. The fact remains that addiction is always self-abuse and is often abuse of others, always so if one considers that one cannot abuse a part without abusing the whole. If one human behaviour deserves to be protected from abuse, it is human sexuality, the behaviour from which each of us originates and which taps the very source of Life.

It is fairly obvious that being human is being as powerless over the forces of sexual drive as over the need to breathe or the weather cycles. This does not, however, exempt mankind from practising powerlessness management in this area just as in other areas. Umbrellas are a sensible answer to the reality of rain. The difference between "addiction" and "healthy practice" always lies in the inner reality of each individual. A characteristic of addiction is that this reality is always concealed under a thick cloak of denial, personal and collective. As William Blake puts it in "Proverbs of Hell": "A fool sees not the same tree that a wise man sees".

4.4- Occupational addiction: workaholism

In this group of addictions, compulsive activity constitutes the central technique of anaesthesia. The range of activities that can be used in this type of addiction is endless, from the 80 hour-week at the office to the meaningless fidgeting of the idle individual. House-cleaning as well as frantic activity at the keyboard to write an article on addictions may unquestionably constitute addictions if they proceed from a habit meant to achieve emotional anaesthesia. Some workaholics are generously rewarded by society for their achievements. Prestigious promotions and solemn eulogies are their fate. Others lose their jobs, unable to achieve consistency at work: sidetracked in the detail, they easily lose sight of priorities and commit huge oversights. Compulsive physical activity (in sport) is the close cousin of workaholism, although it can also be the manifestation of an obsession for body weight or shape and be the twin of a food addiction. Stress management by compulsive physical exercise is often a cherry on the cake of work addiction: the fashionable "workout" can be the telltale appellation of a new refinement in work addiction: work as a stressor is fought by work as a stress anaesthetics.

The "helping profession syndrome" is another form of occupational addiction leading to professional burn-out (also known as "compassion syndrome"), a very frequent outcome in the "helping" professions. Why can't workaholism be diagnosed before the resulting burn-out is? Without denying the value of some of the services rendered by the compulsive helper, one should remember that the invitation "to love others like oneself" becomes an irony when the therapist- patient or helper-"helpee" relationship is used to anaesthetize one's feelings of

inadequacy and anxiety. In such a situation no genuine healing of dependence can take place since the therapeutic relationship is itself a blueprint of codependency. Many other forms of occupational addictions could be added to this brief discussion, such as addiction to television or videotapes. Much could be said also about the popularity of horror movies and thrillers and their role as converters of fear into excitement. By importing filmed scenes of terror into our living-rooms and watching them avidly before going to bed behind carefully locked doors, do we really hope to forget our personal anxieties? Finally, videogames need to be recognized as channels where violence and anger are both released and amplified in a perverse interactive loop of electronic fantasy. Furthermore, "desensitisation", another name for anaesthesia, is increassingly recognized as a direct result of videogame addiction,

4.5- Addictions related to the control of material objects

Material objects can be used in addictive relationships and be given a magic power. That power is evidently transferred by the addicted person as a way to divest his responsibility to assume his own reality. Examples of this type of addiction abound in a culture where "my car", "my money" or "my clothes" are attributes sought by individuals who do not believe they are worth anything without their precious belongings. In a pervert misuse of the word, the need to belong is soothed by collecting personal "belongings". Such a use of objects amounts to idolatry.

Compulsive shopping is an example where not only chronic insecurity but also insecurity resulting from being in a public place (e.g. agoraphobia) are anaesthetized by shopping binges. "I shop therefore I am" is an advertisement read on the side of a bus the day this paragraph was written. If one could truly read the ultimate motive of a compulsive shopper or of some bidders at auctions, the desire to acquire a specific object would often be distant second to the refusal to "let go" or to be defeated by competitive bidders and face the resulting sense of humiliation. This being said, when compulsive shopping (consumerism) becomes the lifeline of a socio-economic system, one touches the true meaning and measure of "collective addiction".

Compulsive gambling is a dependence on money games. As mentioned above, videogames are often used as an addictive activity and cannot be distinguished from compulsive gambling if money earning is the mental focus of the user rather than the audiovisual escape they provide. The highly addictive impact of video gambling machines has started to be recognized in areas where such machines had been irresponsibly allowed in public places like bars, laundry parlours, shopping malls, etc. In a private face-to-face encounter with the machine, individuals who would not dare gambling publicly (say, at a black-jack table) because of shame issues, can try to force the hands of fate in an intimate face to face with machines designed to suck-up their money and, in hours of semi-consciousness, may spend substantial amounts of money directly substracted from their family budget. Among the many governments that allow, encourage and actively exploit gambling and lotteries, some call themselves "social democracies".

Obsessive counting of objects, stairs, tiles, sidewalk blocks, mental rumination of lists and compulsive body language like symmetric gestures, rotations and counter rotations are all manifestations of inner anxiety pacified by ritualized mental anchors and repetitive gestures. They stand somewhere on the continuum of compulsions, between active and passive behaviours, our next and last category to be discussed.

4.6- Obsessions

Sometimes, the only "action" needed to perform emotional anaesthesia is "thinking". Mental "rumination" can be an addiction. Most addictions involving concrete actions start by conscious obsessive thinking. Some alcoholics describe being already on a high on their way to the bar; sex addicts may be quite content with passive eroticism such as printed pornography or passive night cruising in red-light districts or simply fantasizing; workaholics wake up in a mental haze, previewing their day while taking their shower and having breakfast; codependents immerse themselves in romantic idealization; compulsive athletes obsess over images of triumph and cheering crowds. Fantasy is no more an addiction than food is a drug, but both can easily be diverted to induce chronic escapism from painful emotions. The invisible line lies in our individual and collective psyche in which anxiety can be sedated by fantasy.

Religious addiction, also called idolatry, is rooted in obsessive thoughts used to deny the earthy plane of existence by focusing on another level. Bakan, quoted by Philip Flores writes about idolatry: "Put it simply, engaging in ritual, painting religious pictures, reading religious literature, and such activities are not idolatrous unless they themselves become the objects of the worship, rather than the means towards the fulfilment of the religious impulse." (Flores, 1988, p274). The line between addiction and religion is therefore the same as between idolatry and spirituality : motive (conscious or denied) is the determining factor. The same holds true for rational addiction found in some "scientific" circles. In this case, the line seems to run directly across the "Corpus Callosum", a part of the brain between the two hemispheres. To quote a voice from science itself, Roger Sperry, Nobel Prize for Medicine in 1981, "there appears to be two modes of thinking, verbal and nonverbal, represented rather separately in left and right hemispheres, respectively, [...] our educational system, as well as science in general, tends to neglect the nonverbal form of intellect. What it comes down to is that modern society discriminates against the right hemisphere" (Edwards, 1989, p29). One should therefore not be surprised that advocates of wholeness and those who claim to experience a reality that escapes rational expression are denounced as "anti- intellectualists" or lunatics by left-brain supremacists.

To sum-up, addiction is another name for habitual anaesthesia of painful feelings, the stereotype of which is anxiety. The result of addiction is a loss of freedom, a shrinking of one's sensitivity and vitality, the accumulation of an existential deficit. Addiction, the number one cover-up of chronic anxiety, amounts to a choking of individual vitality, a progressive regression towards the death of body and spirit. The most brilliant rational intellect is powerless in front of such automatic alienation because intellect is itself involved in the conspiracy of denying conscious access to the experience of pain. It often takes an unexpected surge in pain awareness, such as a traumatic confrontation with severe losses and even death to give the addict an impulse to change. Short of that, the existential deficit that comes with anxiety-numbing requires an ever increasing use of anaesthesia and the addicted person eventually sinks into despair, and loses balance on the thin edge between life and death.

Recovery is the reclaiming of all the denied parts of an addict's life. Such a healing is slow and requires a therapeutic environment which mutual aid is particularly well suited to provide. Let us examine how.

5- Recovery from addiction

Since alcoholism is the stereotype of addictions from which most psychological insight of the last 50 years on the addicted personality has been derived, the most successful methods of recovery used in the field of alcoholism can also be used as examples to describe the key components of addiction therapy. In scientific terms, this is called "best practice dissemination".

A specific definition of what is meant by recovery is important before proceeding further. Two very different definitions seem to prevail and cause much misunderstanding between those who use them. For some, recovery is the elimination of the specific substance or behaviour around which a dependency took shape. For example, an alcoholic who becomes alcohol abstinent is, according to that definition, a "recovered alcoholic". For others, recovery is the acquisition of a dependence-free lifestyle allowing a former dependant individual to develop his full human potential. The implications of choosing one definition or another are considerable and it would be futile to compare the success of therapies aiming at breaking a specific dependence with that of therapies aiming at addressing the root problem of anxiety management and fostering the human potential. Under the second definition, a "dry alcoholic" is the name given to a person who abstains from consuming alcohol without changing other behaviours although, in many cases, a compensatory increase of other compulsions is observed, whereas a "recovering alcoholic" is someone who has not only stopped using alcohol but has also undertaken to recover his wholeness. Along those lines, a senior chemical dependency counsellor addressing a forum of alcohologists at the 1991 Summer School of Alcohol Studies of Rutgers University admonished bluntly her audience in the following terms: "If you are a recovering alcoholic and are addicted to nicotine, I am sorry, but your recovery is a fraud!" Had she not added, in the same tirade, hopefully tongue-in-cheek, "you'd better be codependent on the God of your understanding, or you are in trouble", her point would have been crystal clear.

Recovery is defined in this presentation as a movement towards non-dependent and mutually enhancing relationships between the recovering person and external or internal "objects", i.e. with oneself, with others and with the entire universe. It is a recovery of personal integrity, the end of personal fragmentation and of denial. It is a movement towards attitudes that foster personal growth. Under this definition, abstinence from alcohol for an alcoholic can be called recovery only if is accompanied by a resumption of personal growth rather than by the replacement of alcohol by other forms of anaesthesia. Ultimately, the decision to call oneself "recovering" belongs to each individual. Recovery, in the context of this discussion, is a weaning of anaesthetics and a learning of life-skills. It cannot be dissociated from the healing of psychological wounds from the past. The severity of these wounds dictates the intensity of the therapeutic support needed to clear the backlog of suppressed pain. Some addictions have a clear pharmacological component due to the particular chemical response of a person to a substance. Some others appear to depend on a more subtle gratification for which science may some day find also a chemical explanation. In all cases, recovery is the road to freedom.

Four key elements can describe the environment where recovery is possible: **identification, education, support and acceptance.**

5.1- Identification, the door to individuation and to a sense of belonging

The word "identity" holds an important cue to better understanding the recovery process. It is used to describe similarities as well as differences between two objects. A complete similarity between two objects is an "identity" and yet, an "identity card" is used to avoid any confusion between two persons. As discussed by Kurtz, identification is therefore the process of becoming both "the same as" and "distinct from" others (Kurtz, 1991, p60). The first role of identification in recovery is to establish a contact with someone else, to break the sense of isolation which characterizes addiction. Individuals with a shame-based personality are, by nature, isolated at a deep level even if, on the surface, they have adopted a socialite lifestyle. Some alcoholics are lone drinkers, but many like to call themselves "social" drinkers. The truth is that they all suffer from a sense of not belonging. Identifying with someone else, even if only to recognize that one is an addict like him or her, is already a glimmer of hope in a dark tunnel of despair. In therapy, identification means "I am not alone any more", "someone else understands, because he has been there too", "I belong". A key moment in the history of Alcoholic Anonymous is the encounter of Bill W. and Dr Bob S., the former having sought "an alcoholic he could help" to avoid drinking again. The consequences of this meeting have touched millions on all continents since. Identification was experienced by Dr Bob who became sober shortly after the meeting where Bill "told by using his own story, his own experience, the literal facts of his own life, rather than by offering abstract theory or even scientific facts" (Kurtz, 1991, p35).

Identification goes well beyond breaking isolation, as illustrated in Yukio Mishima's confession: "I wanted the elimination of the witnesses of my shame. Gone the witnesses, any trace of my shame would also be eradicated from the surface of the earth. Others are all witnesses. If they did not exist, one would not experience shame" (Dictionnaire de citations du monde entier", les usuels du Robert, p523). This radical statement by someone who eventually committed a public "Hara Kiri" is the equivalent of Sartre's "l'enfer, c'est les autres" (hell is others). Its flip-side reveals the role of identification in the healing of shame, because by revealing his shame to me, the other is no longer a witness of my shame, but a brother in shame and eventually a partner in shedding shame. Shame is another name for self-hatred, a deep sense of inadequacy, of shortcoming, of being flawed. The eradication of others is felt as the only remedy to shame because shame is a relationship dysfunction. Identification is the only healing of shame that is compatible with remaining alive. As an alternative to the eradication of others, or of oneself, identification offers the alternative of an interpersonal bridge that is crossed WITHOUT denying personal limitations, real or perceived. This bridge is never stronger than when it rests on foundations of mutually acknowledged limitations. Here lies the value of self- disclosure in recovery groups: the real individual stands-up in front of others, unabridged, unedited, uncensored, unmasked, and experiences the relief of having "identified" himself, of having claimed his "identity". Identification is the road to humanization, a grounding into humanness: "humility" and "human" have a common root in "humus", the soil, dirt, dust. Shame is deeply related to anxiety, it is a sense of being incomplete, of not having an inner access to light, of lacking and desiring "something" in order to become complete. Anguish, has its root in a word that means "snake" and "choking". No wonder why spirituality, "the experience of breath", is a remedy for anxiety, "the suppression of breath" !

5.2- Education: examining our intellectual filters

Habits are born in practice, practice is learned from examples. It is from examples and by trial and error that we acquire our life-skills, from handling food with a fork or with chopsticks to more subtle cultural and psychological traits. The family, the school, the Church, the army, the corporation, television, are the warehouses where we pick our models. It is wise, therefore, to examine the type of models found in these warehouses in terms of anxiety management. Without over simplifying, one can safely state that the golden rule in all these warehouses is "Thou shalt not feel". To be consistent with this injunction, these various institutions offer a variety of recipes for anaesthesia. The fact that habits are efficient dampeners of genuine feelings has lead Pierre Reverdy to say: "We should develop good habits very early, especially the habit of knowing how to often and easily change our habits." Recovery is first and foremost a process of unlearning habits, combined with a healthy management of the freedom gained in the process. Meister Eckhart wrote that the soul grows by subtraction, not by addition. Like learning, unlearning requires models and a reliable source of support. Models and support are widely available in the next component of recovery to be examined : the synergy of mutual aid.

5.3- Mutual aid : the power of synergy

The return journey from numbness to sensitivity and aliveness is painful and, above all, extremely scary. True courage on that journey does not consist in attempting to travel alone but in accepting help from others. The proliferation of recovery groups is an indication of the importance of a group approach to recovery. Individual therapy constitutes a reduced version of a team approach and may provide a complement to group therapy. In group therapy, the recovering addict learns to accept help from others, but also to help others. Service to others is held as one of the pillars of recovery in many organizations. It is hardly a new concept since the word "therapon", in Greek, meant "servant" and the word family comes from "famulus" which also means servant. Ralph Waldo Emerson, the 19th Century free spirit philosopher, describes the magic of service to others in these terms: "It is one of the most beautiful compensations of life that no man can sincerely try to help another without being helped in the process." Undoubtedly, one rarely joins a recovery group because of an urge to help others. Newcomers enter therapy to get help or to try to learn how to control someone else's life. Typically, relatives of alcoholics or of drug addicts are stunned when their initial plea for help is answered by the friendly advice to "look at themselves" and to "change the things they can", i.e. themselves. If they do not run away but stay to listen and learn, their compulsion to force others "to become sober" slowly gives way to a genuine discipline of personal recovery and compassionate detachment. Service to others, in the context of mutual aid, is not to be confused with service to others as "care-taker". The English language allows some distinction, in principle, between a "care-taker" and a "care-giver" but it is ultimately the inner motivation which determines whether service to others is a gift or a theft in disguise, a mere technique of self-avoidance and denial or a way to break compulsive self-centeredness, the only true goal of recovery. It is not unusual to hear new members of mutual-aid groups, especially women, walk away from fraternities where the importance of service is stressed, complaining that their need for self-empowerment cannot be met by practising their chief compulsion of serving others at the expense of themselves. Of course, such a view fails to recognize that by staying and learning to say "no" to this type of service and by sharing with others one's struggle to be free, one is a true

servant in the therapeutic sense of the word. "This is a selfish program" is, paradoxically, often heard in groups where service is hailed as a prime healer. Such a statement is obviously directed to the addict's ego, ridden with low self-esteem even when disguised in narcissism and grandiosity. The power of synergy amounts to a complex addition that amplifies limited individual energies when they produce a tremendous resonance. From addiction to addition, the letter "c" has been removed to build a "circle", a mutual aid inner and outer configuration where "the whole is more than the sum of the parts". From times immemorial, the circle has been used as a symbol of health and wholeness.

5.4- Acceptance: the door to freedom and growth

Acceptance shares the same root as conception. It means "taking by reaching out" as opposed to "taking by grasping in". Conception occurs in the context of a union: the male and the female unite to conceive. The creative mind conceives as a result of inspiration, a union with the spirit. Similarly, cognition (a word meaning co-birth) of an external object (event or person) requires a phase of acceptation. Accepting "what is" is both a conception and an instant birth. Accepting is also what makes us distinct from what we accept without loosing our sense of belonging to a background of "isness". We are born in acceptance just as what we accept is born. Acceptance has nothing to do with approval, sometimes it actually confirms disapproval and remains acceptance nonetheless. Acceptance does not mean passivity either. "Moral outrage" figures as "a heroic virtue" with "Wonder", "Empathy", "Heartful Mind", "Right Livelihood", "Enjoyment", "Friendship", "Communion", "Husbanding", and "Wildness" in Sam Keen's Fire in the Belly (Keen, 1991, p152). Acceptance is therefore the outcome of a pregnancy since both the person who accepts and the reality that is being accepted are born of it. Denial is the opposite of acceptance, it is an abortion in the true sense of "ab-oriens", i.e. opposite to "the orient", opposite to the direction of "the birth of the star", the rising sun of enlightenment. Denial is therefore the root of desire, the prime cause of darkness, a behaviour that maintains the eclipse of meaning, a chief abortionist of sunrise. Overcoming one's denial is the goal of recovery, a goal never completely achieved if one believes Ernest Becker's thesis that human character is a "vital lie" (Becker, 1973, p47). If being human is being in denial, freedom from human bondage is to be found in the light of awareness, including awareness of the prevalence of denial. There is wisdom in knowing that one doesn't know or doesn't want to know.

Acceptance is found at the root of all fellowships for recovering alcoholics. Members of Rational Recovery are invited to accept that "their use of these substances is an irrational choice". In the Twelve Steps of Alcoholics Anonymous, words of acceptance are frequent: "We admitted..." in Step one, "Made a searching and fearless moral inventory" in Step four, "Admitted" in Step five, "Were entirely ready" in Step six, "Humbly" in Step seven, "Made a list" in Step eight, "Continued to take personal inventory" in Step ten... In such acceptance- oriented terminology, concrete action is required to implement acceptance and to foster personal rebirth. Of course, a passive interpretation of the Steps veils such understanding when words like "humbly" are given the sado-masochistic meaning of "low" and "debased". The most ordinary dictionary of synonyms lists words like "unpretending, simple, unselfish, unobtrusive, unostentatious, plain, modest", as synonymous of "humble". One can therefore question the tendency to single out in that long list of synonyms the self-deprecating terms like "lowly, abased, meek, submissive, backwards, shy, coy and shrinking". In a context where acceptance is an affirming decision,

humility is understood as "affirming one's humanity", nothing more and nothing less. The thirteen affirmations of "Women for Sobriety", an American recovery movement, are called "Acceptance Program". SOS, Secular Organization for Sobriety, starts its suggested "Guidelines for Sobriety" by the following statement of acceptance: "To break the cycle of denial and achieve sobriety, we first acknowledge that we are alcoholics or addicts."

Perceived as the most ego threatening concept, acceptance is actually the most empowering step of recovery as well as of healthy living. This should hardly be a surprise since the bondage of a compulsive ego is the oppressive power that must be defeated in recovery. The amount of personal energy invested in anaesthesia is such that a tremendous surge of power is felt when acceptance takes place. This power can be redirected towards constructive purposes in a context of personal growth. Acceptance amounts to a leap of faith into the unknown of life. "Pack your parachute" is the sound advice given to candidates for such an experience. Indeed, repressed emotions will not fail to rise and to be painfully felt and the importance of the cushioning effect of a support system must be stressed. Experts in the addiction field have sometimes voiced the opinion that addiction, however painful, is the ultimate refuge of many and protects them from suicide. Reference to a death-wish is common in the sharing of recovering addicts. It would therefore be irresponsible for a therapist or for anyone to try to induce acceptance by psychological confrontation or by other means without giving due priority to building first a safe (i.e. supportive) environment for the birth that is to take place in acceptance.

Having made the case for safety networks in recovery, let us conclude by describing, as examples of mutual aid, five recovery environments, all taken from the alcohol addiction field from which most insight on addiction has been derived in the twentieth century.

6- Mutual aid and addiction: five examples from the alcoholism field

The following presentation is limited to mutual aid group therapy for alcoholism. This is not to say that some pharmacological or medical intervention may not be required to repair the damages of a poison like alcohol, nor that other specific considerations must not be taken into account in other recovery programs. Work addiction, for instance, often requires hospitalization for burn-outs or stress-related heart-attacks. The psychosomatic illnesses related to all sorts of addictions are also too many to be listed. However, these medical aspects of recovery are damage-control measures rather than therapy for the roots of addiction. Similarly, the important contribution of social and political systems in spreading addictions cannot be ignored in proposed solutions. However, the context of this discussion is "mutual aid" and not medical education or socio-political science. The reader is referred to medical publications on alcoholism and to publications where the social dimension of addiction is explored (e.g. Schaef, 1987). An exhaustive handbook on group psychotherapy with addicted populations has already been referred to above (Flores, 1988) where an impressive bibliography can be found. Although Flores describes group therapy directed by a professional, he also provides substantial comments on the power and value of mutual aid fraternities like Alcoholics Anonymous. The following description is an attempt to present the main features of Alcoholics Anonymous (AA), Secular

Organization for Sobriety (SOS), Rational Recovery (RR), Women For Sobriety (WFS) and of a systemic approach known as the Bio-Psycho-Social Model of addictions.

6.1- Alcoholics Anonymous (AA)

Writing about AA is a challenge in itself since this dean of the recovery movements values direct experience more than concepts. However, out of the AA experience, shared by close to 3 million members in 100 000 groups distributed in about 180 countries, a few words can be distilled to convey the broad lines of the AA path of recovery. Aldous Huxley has said of Bill W., one of the AA founders, that he was "the greatest social architect of the century" (Wing, 1992, p75). In his history of AA, Ernest Kurtz reports that by 1987, 83 different fraternities had requested permission from AA to use the Twelve Steps or variations thereof (Kurtz, 1991, p287). The importance of the AA philosophy can therefore hardly be understated. It relies on three central "legacies": Recovery, Unity and Service, each explained in a series of 12 statements, the Twelve Steps, Twelve Traditions and Twelve Concepts, respectively. The Twelve Steps sum-up the experience of AA pioneers in travelling the road from the acceptance of their addiction to a spiritual awakening in sobriety. The Twelve Traditions describe a code of ethics aiming at preserving AA's unity while maintaining group autonomy and fostering individual recovery. The Twelve Concepts describe the distribution of responsibilities throughout the service branches and the entire AA community. The reader is referred to the abundant literature published by or about AA, but above all, to the living testimony of recovering alcoholics practising these principles in all their affairs. The wording of the Steps is the basis of most criticism directed towards AA, especially because of its undeniably religious connotation. One may argue that giving specific words the power to bar one's access to a recovery program is a clear case of self-disempowerment hardly consistent with a criticism of the Steps for not being an "empowering program".

The following interpretation of the Steps is meant to illustrate how different a given philosophy may look when dressed in different clothes or stripped to its bare essentials:
1- We were dying;
2- We wanted to live;
3- We decided to trust life;
4- We faced and acknowledged our addicted personality;
5- We stated and accepted our humanness;
6- We opted for wholeness;
7- We gave ourselves, body and soul, to a process of healing our fragmentation;
8- We examined unsettled guilt from the past;
9- We healed our guilt;
10- We adopted a discipline of wholeness;
11- We adopted a discipline of growth;
12- We practised these principles in all our affairs.
Same spirit, different words.Temporalily borrowing new words is sometimes necessary while old words are being washed or repaired after years of abuse or misunderstanding, "God" is such a "high maintenance" word!

The main features of Twelve Step recovery are :
1- Acceptance of the overwhelming power of addiction;
2- Exposure to ego-deflation by accepting help;
3- Therapeutic transformation through service, introspection and healing of guilt and shame;
4- Personal growth fostered by a spiritual discipline and service to others.

The Steps were written in 1939 and their terminology has been the subject of much criticism especially from those painfully aware of abuse committed under religious or spiritual banners and from feminists circles where "turning our will and our lives to the care of God as we understood Him" (the actual wording of Step 3) resembles too closely a recipe for victimization. It is symptomatic that the Steps are frequently reworded and as frequently rejected in women movements. "I told the others that I either had to reword these steps or stop coming to the group, because to say the traditional steps was to violate myself" is a statement that sums up this reality very well (interview with Dr. Charlotte Davis Kasl, by Jim Christopher, 1993). One may regret that little seems to be done in the AA fellowship to acknowledge this difficulty which is so easy to understand and could be easily overcome were it not of the virtual enshrinement of the wording of the Steps. Claiming that the Steps are incompatible with empowerment somewhat overlookis the fact that they assign very specific and difficult tasks to the recovering member of a Twelve Step group. Each individual has to do the leg-work between denial and acceptance to become sober, to heal and to grow. The fact that "empowerment" is not to be confused with the delusion of "almightiness" but to be understood within the context of human limitations is another matter, vividly described by Ernest Kurtz under the eloquent title "Not-God" (Kurtz, 1991). In other words, the true issue about the spirituality of the Twelve Steps is not as much to determine "who or what is God" as to accept "who is not God". In the Twelve Steps, another implicit word for God is "not-me".

Philip Flores addresses quite specifically six of the most common misconceptions of AA (Flores, 1988, p212):
1- AA promulgates a simplistic, naive disease concept of alcoholism;
2- AA ignores psychological etiological factors;
3- AA is substitute dependency;
4- AA forces members to admit to being an alcoholic;
5- AA rejects controlled drinking on purely ideological beliefs;
6- AA is a religious organization.
His dismissal of these misconceptions does not need to be repeated here and could be matched by an equal number of critical statements by others, all of which do not come from rationalistic and secular circles. For example, spiritual scholar and theologian Matthew Fox writes: "AA can be criticized for its excessively patriarchal religious imagery and language and its almost exclusive emphasis on the "word" as distinct from other kinds of healing rituals that could be employed, as well as for its almost nonexistent political, sexual, and class consciousness. All these weaknesses simply underscore the historical and cultural limits of its founders" (Fox, 1991, p132). Such opinions are a sure sign that AA is a recovery movement of such a stature that it commands debate and criticism (including, as M. Fox points out, by those "who love it enough to criticize it"). AA's wisdom is such that it is also protected by its Traditions from being drawn into public controversy, much to the chagrin of its detractors (The 10th Tradition of AA states: "Alcoholics Anonymous has no opinion on outside issues, hence the AA name ought never be

drawn into public controversy"). The existence of divergent views also confirms that complete objective answers are not to be found in AA or in any particular movement or ideology but in the exercise of free-choice by each individual open enough to consider the experience of others. The word con-sider has the same root as de-sire and means "to join under the same light", to expose oneself to whatever shines in a particular experience. The availability of alternatives to AA is, in that sense, very good news indeed and no-one should ever be forced to attend AA meetings.

Identification, education, service and acceptance are at the very core of the AA program of which Edward Dowling, a friend of Bill W. has said: "AA has proven that democracy is therapy" (Kurtz, 1991, p121). The interested reader is referred to the abundant AA literature for further information (see "Alcoholics Anonymous" in the reference list).

6.2- Secular Organization for Sobriety (SOS)

SOS offers a secular alternative to the spiritual approach of AA. Most, if not all non-AA recovery movements in the alcoholic field, tend to define themselves by stressing how they differ from AA. SOS was initiated in 1986 by Jim Christopher. In its "Guidebook for group leaders", SOS explains that "secular is the word that distinguishes our groups from other widely available groups". It acknowledges borrowing largely from the AA Traditions of group autonomy and others, but insists on separating spiritual issues from recovery issues, the former being identified as "religious" rather than "recovery" concerns. For example, the first SOS suggested "Guidelines for Sobriety" parallels the First Step of AA in slightly different language: "To break the cycle of denial and to achieve sobriety, we first acknowledge that we are alcoholics or addicts". But where the Second and Third Steps of AA introduce the concept of "a power greater than ourselves" and "God as we understood Him", SOS Guidelines suggest to take "whatever steps are necessary to continue our Sobriety Priority lifelong". The wording "whatever steps" can hardly be fortuitous and seems to include AA Steps for those who wish. Such a broadmindedness seems to prevail throughout SOS documentation with affirmations like "we certainly should be able to accept a non-secular person's sharing of experience, even if that experience is of religious nature". However, members are also reminded that SOS takes a "reasonable", secular approach to recovery and maintains that "sobriety is a separate issue from religion or spirituality". The main title on the recommended reading list of SOS is "How to stay sober: Recovery without Religion", by James Christopher (Christopher, 1988). SOS has about 20 000 members in some 1000 groups, mainly in the USA. SOS seems to be slowly extending its approach to other addictions like drugs. For more information, the reader is referred to SOS documentation (see "SOS" in the reference list).

6.3- Rational Recovery (RR)

With RR, an important step is taken towards strict rationalism as opposed to the secular free spirit of SOS. Antagonism with the AA Twelve Step program is explicit in RR documentation. The list of titles issued by RR includes: *The Small Book*, by founder Jack Trimpey, (Trimpey, J. Delacorte Press, 1989) an explicit counterpoint reference to AA's Big Book. More revealed: Critique of the 12 Steps, by Ragge is another self-explanatory title of this list as well as *Kicking the Twelve Steps - One Step At A Time*, an audiotape from the First Annual Conference of Rational Recovery Self-Help Network. The RR program is based on the principles of Rational

Emotive Therapy (RET). Charles Bufe's *Alcoholics Anonymous, Cult or Cure* (Bufe, 1991), prefaced by Albert Ellis, President of the Institute for Rational-Emotive Therapy, although not officially representing the views of Rational Recovery, is explicit enough about its views on AA and on alcoholism recovery to be classified as a "manifesto" of the rational recovery school. The author describes himself as "an investigator with decidedly mixed feelings about AA" (p10) and concludes after a thorough and interesting investigation of the links between AA and the controversial Oxford Groups Movement (the central theme of the book): "Is Alcoholics Anonymous a cult? No, though it does have dangerous, cult-like tendencies" (p101). The book title finds its complete answer on page 115: "AA is not a cult, neither is it a cure for alcoholism". To the question of whether AA is "totally useless as a treatment for alcoholism", Bufe answer is "perhaps not" (p112), a somewhat candid conclusion considering the overall radical anti-AA stance and the author's opinion that "contrary to popular belief, alcoholism is not a progressive and incurable disease" (p108). The book ends with a presentation of "The case against religiosity", an article where Albert Ellis attempts "to make a succinct and cogent case for the proposition that unbelief, scepticism, and thoroughgoing atheism not only abet but are practically synonymous with mental health..." (p134). A rather bold and self-righteous statement to say the least.

The 14 "Rational Recovery Concepts" consist of "irrational" statements meant to paraphrase AA's philosophy (as RR sees it) followed by their "rational" counterparts. For example, concept number six (five in some fliers) says: "Because I have committed certain acts, or behaved offensively, or harmed someone, I should therefore moralistically blame and condemn myself and feel worthless and guilty, instead of the rational idea that I am a fallible human being. While I may feel regrets, remorse, or sadness for my alcoholic behaviour, I need not conclude that I am a worthless person." Most recovering addicts in AA, SOS, RR or in other fraternities would all-heartedly agree.

RR views addiction as a conflict between the primitive brain (The Addictive Voice) and the more sophisticated "thinking cap", (The Rational Voice). Addictive Voice Recognition Technique (AVRT) is therefore a key to becoming rationally sober. "There is no requirement of faith in a higher Power, no fearless moral inventories, no self-labelling of yourself as an "addict" or "alcoholic", no sponsor or buddy system, no "spiritual" teaching, and no lifelong commitment to "recovering"". In short, if Ernest Kurtz could summarize AA's philosophy by the title "Not-God" (Kurtz, 1991), RR's philosophy can be described as fundamentally "Not-AA".

RR recognizes nevertheless that individuals are either rationally-inclined or spiritually-inclined and should choose their recovery program accordingly. This distinction is somewhat related to the distinction made above between "the scientist" and "the philosopher", or between left-brain and right-brain perception of reality, with the important distinction that there is ample evidence that both aspects contribute to man's wholeness rather than a single one as RR seems to imply. Against such reductionism of the human intellect to mere logical thinking, it can be argued that full potential for an individual is likely to be more a matter of dichotomy than of lobotomy.

RR meetings are held to discuss members difficulties to control the addictive voice by the power of reason. RR groups exist in some 500 cities in the USA and a few in Australia, Japan and

Panama. Rational Recovery addresses other problems like food addiction. For more information, the reader is referred to RR documentation (see RR in the reference list).

6.4- Women For Sobriety (WFS)

Both an organization and a recovery program for alcoholic women, WFS was founded by Jean Kirkpatrick in 1975. In its documentation, WFS explains its existence by the belief that "women alcoholics require a different kind of program in recovery than the programs used for male alcoholics." The "New Life" Acceptance Program of WFS relies on thirteen affirmations that include acceptance, education, empowerment and love of others in a sequence that is somewhat similar to that found in other recovery movements. Acceptance comes first: "1- I have a drinking (life-threatening) problem that once had me; 2- Negative emotions destroy only myself". Empowerment comes next: "3- Happiness is a habit I will develop; 4- Problems bother me only to the degree I permit them to". Other affirmations are more rationalistic such as "5- I am what I think", a modern version of "cogito ergo sum" while others are clearly spiritual such as: "8- The fundamental object of life is emotional and spiritual growth". WFS has about 5000 members in some 350 groups, mostly in the USA and some in Australia and New-Zealand. For more information, the reader is referred to WFS documentation (see WFS in the reference list).

6.5- The Bio-psycho-socio model of addiction

This general heading describes a philosophy rather than a specific fraternity for recovering addicts. The central idea in this model is that addiction must be considered as a three-fold relationship: Body- Mind-Environment. In a slightly different formulation called the "Social Model", the relationship is defined as Person-Substance-Environment. It follows that recovery cannot be achieved without considering all components of the problem. Such models stress that for every recovering addict, a non "recovering" social environment produces new addicts and that, no matter how "clean" the environment, a non-recovered addict will find his way to a toxic substance or behaviour to feed his addiction. The historical failure of alcohol prohibition makes this latter point absolutely clear. Such a broad approach is implemented in a variety of ways in treatment centres and service facilities where recovering addicts are shown how to access physical and psychological resources for social reintegration and healthy choices. Membership in specific recovery movement is encouraged or even required as a key element of recovery. Many regional and local implementations of such ideas have evolved from pioneer movements such as the CLARE Foundation in California in the late 60's. The interested reader is referred to more detailed documentation in specialized literature such as a monograph prepared by T.Borkman for the National Institute for Alcoholism and Alcohol Abuse (NIAAA) and entitled: *A social-Experimental Model in Programs for Alcohol Recover*y.

Conclusion: Mutual aid and addictions, a liberation alchemy

The widespread phenomenon of addiction takes many different forms, from overt substance abuse to covert compulsive behaviours. A common root of all addictions has been linked to a systematic attempt by humans to anaesthetize their psychological pain, including the anxiety associated with the limits of rational thinking to "secure" an explanation of the human condition and to provide a predictable future, free from anguish and suffering. The "eclipse" of meaning results in the experience of "desire", a deprivation of enlightenment and a craving for answers and/or relief. Anxiety is a natural response to darkness when safety rests entirely on rational grasping and it amounts to choking spiritual breath, the very breath of life. Anaesthesia of such pain by the active denial of anxiety assisted by psychotropic substances or mood altering behaviours provides a survival route which takes the individual even farther into darkness. The cycle of addiction is locked when anaesthesia becomes a habit over which individuals have lost control. Psychological theories are quite consistent with this description when they link the addictive personality to developmental flaws in the ability to integrate (interiorise) healthy models, thus creating a constant need to anchor one's life on outside objects, persons or substances and/or on inner narcissistic obsessions.

Mutual aid provides a way out of the cycle of addiction by offering an environment where the missing psychological skills can be developed while the protective shell of compulsions is shed. Identification, education, synergy and acceptance are the key components of such a recovery process. Identification cracks the ego armour, education offers new insight and choices, synergy provides much needed support and acceptance is a skill for self-actualization. Such elements appear under one form or another in all mutual aid recovery movements for addictions. Even the most rationalistic theory of addiction as exemplified by RR (Rational Recovery) states in its "13th principle of Rational Emotive Therapy (RET)": "13- Now certain of my own human worth, I can take the risks of loving others, for loving is far better than being loved."

Ageless wisdom in all the great spiritual traditions of the world remind us that darkness or silence are pregnant spaces where humans can discover light and sound that transcend darkness and silence and therefore transcend also "desire" and "fear", the two spurs of our rational inner Don Quichote. Countless recovering addicts testify to the truth of such advice. One can even argue that "reason" itself dictates that we take into account all experiential evidence provided by those before us who claim to have found light beyond the dark night of the soul, some of whom are found in the ranks and at the pinnacle of modern science. The last word of this outlook on addiction is given to mythologist Joseph Campbell when he speaks of fear and desire and of a birth that transcends them: "Life at its source knows neither fear nor desire, it does not stop being born."

References

1. Alcoholics Anonymous, PO Box 1980, Grand Central Station, New York, NY 10163-1980
2. Beattie, M., (1987), Codependent No More, Harper Hazelden
3. Becker, E., (1973), The Denial of Death, The Free Press.
4. Bergeret, J., (1986), Toxicomanie et personnalité, Presses Universitaires de France.
5. Bufe, C., (1991), Alcoholics Anonymous, Cult or Cure, See Sharp Press, San Francisco
6. Carnes, P.,(1989), Contrary to Love, CompCare Publishers.
7. Carruth, B., Mendenhall, W., Edit. (1989), Co-dependency, Haworth Press.
8. Christopher, J., (1988), How to stay sober: Recovery without religion, Prometheus Books
9. Christopher, J., (1993), Many road, one journey, SOS International Newsletter, Vol.5, No.4
10. ICD, (1990), International Classification of Diseases, 9th Revision, Publisher: Commission on Professional and Hospital Activities
11. Edwards, B., (1989), Drawing on the Right Side of the Brain, Jeremy P. Tarcher inc., Los Angeles
12. Flores, P., (1988), Group psychotherapy with addicted populations, Haworth Press.
13. Fox, M., (1991), Creation Spirituality, Harper, San Francisco
14. Keen, S., (1991), Fire in the Belly, Bantam Books
15. Kurtz, E., (1991), Not-God, A History of Alcoholics Anonymous, Expanded Edition, Hazelden.
16. Laign, J., (1989), Co-dependency "has arrived, A special report from the first national conference on co-dependency, in Focus, Vol.12, No.6, Dec. 1989
17. Meacham, A., (1990), Co-dependency at the crossroads, Focus, Vol.13, No.6, Dec.1990
18. Miller, A., (1990), The Untouched Key, Anchor Books.
19. Sadoun, R., Lolli, G., Silverman, M., (1965), Drinking in French Culture, Monograph of the Rutgers Center of Alcohol Studies, No 5.
20. Rational Recovery Systems, Box 800, Lotus, CA 95651, USA
21. Center of Alcohol Studies, Rutgers University, P.O. Box 969, Piscataway, N.J. 08855-0969, USA
22. Schaef, A.Wilson, (1987), When Society Becomes An Addict, Harper & Row
23. SOS, PO Box 5, Buffalo, NY, 14215-0005, USA
24. WFS, PO Box 618, Quakertown, PA 18951-0618, USA
25. Wing, N., (1992), Grateful to Have Been There, Parkside Publishing