Social Class Character Formation & Persons with Co-occurring Disorders: Addiction & Mental Health Disorders

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Abstract

The paper examines the inter-relationship of social class and recovery from substance abuse addiction. It presents a related analysis of the approach of Alfred Adler to addiction, based only on his original writings. The paper concludes that clinical consideration of the social class background of a client can provide guidance for the Individual Psychology of a client. Social class emotional learnings as a child can impact the nature of a client’s Social Interest, their Fictional Goals, Life Tasks, and Private Logic. This approach can provide important clinical data in the development of a co-occurring diagnosis, and the movement of the on-going treatment plan.
# Social Class and Co-occurring Disorders

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Social Class Character Formation & Persons with Co-occurring Disorders

This is an Adler Graduate School Masters Project framed as an act of scholarly investigation with a primary clinical conception to be used to develop:

- A program of follow-up clinical and academic research
- guidance for clinical action in working with persons with substance abuse, persons in emotional crisis, and a clinically co-occurring dis-ordering of their lives.

It represents an analysis of addiction, characterological and emotional development, socio-economic class, and related psychotherapeutic/clinical interventions which is interpreted by someone with direct experience with the various subjects and objects.

This paper does not have a specific hypothesis other than that the social class background of someone impacts their character-logical and emotional, existential life experience. It applies the dual focus of the aspects of co-occurring disorders (substance abuse, and mental wellness) upon this base of living within the context of the early stages of moving away from addiction, and the related goal of dealing with emotional balance and health.

In addressing the Adlerian approach to social class, addiction, and mental health, a primary focus will be on the original writings of Alfred Adler, and the founding concepts of Individual Psychology.

The concentration of the paper will be upon the substance abuse component of dual disorders but within the framework of the background emotional structure, and life assumptions of a person of low income’s upbringing as they cope with drug rehabilitation, primarily. What are the conscious (and un-conscious) attitudes and belief systems, and possible socio-economic antecedents, which someone has that can impact their ability to move away from substance
abuse, to adapt to the demands of rehabilitation, and begin the much longer path of recovery leading to a re-formulated life-style.

An overall picture of the dominant aspects of the characterological and emotional bases of the lowest third of the social economic mix of North American society is presented. The interplay of the primary factors of what is now called Co-occurring Disorders will emerge within the focus of clinical approaches to assist clients to reconstruct their lives without the day-to-day physical, economic, and emotional bondages of substance addiction. Behavior reflecting mental health disordering is the equally important aspect but one which requires positive motion away from the behavioral cycle of addiction in order to be clearly delineated, and assessed in its importance for the individual client.

The relative shortness of this paper means that the exploration of the concept of social class impact on the treatment of the addictive component of Co-occurring Disorders will not apply in detail some important nuances of the subject. These include race, gender, rural and urban locations, and family and cultural backgrounds which are involved in a more detailed examination of the complexities of social class, addiction, and mental health. It will also not take a close look at the possible differences in addiction recovery which may arise from multi-drug addiction, or between the challenges of recovering from alcohol, judicially illegal drugs, and prescription drugs (which although “legal”) may still result in physical dependency and addiction although prescribed as part of a treatment plan.

The paper will look at the historical development of the concept of social class, of addiction (especially to the substances of alcohol, and illegal and prescription drugs), and of addiction recovery. This approach is felt to be required with the increasing application of the
concept of Co-occurring Disorders with its integration of substance abuse and mental health disorders.

Essentially the aim of the paper is to make some preliminary explorations of the ways in which the application of treatment modalities in dealing with the substance use component of co-occurring disorders as a prelude to properly diagnosing the nature of the mental health component, may be influenced by the socio-economic background of a client when the core experience is defined by being a low income child and adolescent. The conclusions reached during this process will form the basis for further explorations by researchers and practitioners.

Many persons with one or the other components of COD also have disorders within the mental health sphere. Many clients within drug treatment facilities also enter treatment with pre-existing diagnoses of depression, anxiety, schizophrenia, and bi-polar disorders which have been given to them by facilities and clinicians they have encountered both previous to, and during the active years of their substance addiction. Diagnosing and treating either, or both substance abuse and mental health disorders, has been greatly complicated for both aspects with the spread of diagnosis of mental health disorders during the last thirty years, and the concomitant spread of the prescription of drugs to serve as primary treatment methods with the mental health world. Many of the psycho-pharmaceutical drugs produce physical and emotional affects which are common to the behaviors of substance abuse addicts. This interaction complicates both diagnosis and treatment of substance abuse addicts.

This paper’s core investigation of the interaction of social class, substance abuse addiction and treatment, and mental health disorders, within the dual interactive world of Co-occurring Disorders (becoming the norm for many to most persons, with either or both areas of behavioral challenge) fits in with a developing clinical need for more complexity with therapy
and addiction treatment. The use of the term, “substance abuse addiction,” is used in this paper to focus on a specific form of addiction which has both behavioral (repeated, self-damaging actions), and is related to the ingestion/injection of substances, rather than more purely behavioral addictions such as gambling, sex, and digital/Internet obsessions which are similar but not directly comparative. Of course the intersection of both frames of addictive behavior frequently occurs also, especially with gambling addictions with alcohol, cocaine, and amphetamines.

The overall orientation of the paper places psychotherapy, mental health, and substance abuse addiction within an overall contextual analysis of social psychology, sociology, and economic history. It is about the inter-relationships of modern human life and existential expression, especially within North America. In this sense it can certainly be seen as an adapted expression of the original basis of Adlerian thought and approach. Adler was a socialist who grew into intellectual maturity during social evolution and crisis in Vienna both prior to, and after World War One. His clinical thought and psychotherapeutic practice placed the progress of personal expression within a deep social context of “gemeinschaftsgefühl,” or “social interest,” or “social feeling,” wherein a human being was part of a social milieu and on-going personal interaction (Ansbacher & Ansbacher, 1964, p. 127-154).

The establishment of Individual Psychology as a tool for social change and evolution was part of bringing psychology and psychotherapy into a primary social context of public clinics and educational demonstrations directly to the working class, and the middle class, to have direct impact on the qualitative movement of life within societies and families. Mental health and happiness in Individual Psychology is rooted in the integration of personal self in social meaning and participation.
This paper then has a dual direction of investigating the nature of clinical practice within Co-occurring Disorders, and the practice of psychotherapy as a response to social change and evolution.

As a note on the use of terminology: the term “addict” refers to alcoholics, legal and illegal drug abuser, and poly-drug use. “Social class,” “economic class,” and “class” all refer to the same concept of the socially and economically defined distributions of the population of a capitalist society on the basis of income, relation to political power, and social perception of being, and evaluation of societal worth.

As a final note on the information considered and presented, there are some significant gaps in the availability of information and research conducted with the examination of special factors based on the socio-economic background of both addiction and mental health, and psycho-therapy.

**What Is The Modern Social Class Structure?**

In this section primary attention will be paid to the development of the working class/low income socio-economic group over the last century or so. The nature of the changes allow for a more coherent understanding of the present social environment of persons who develop their selves as children, and as adults. This allows the formulation of an existential operating space of the economically and socially marginalized members of the least wealthy one third of the modern capitalist society which sets the conceptual frame of analysis for the core topic of the paper on the inter-relationship of social class, substance addiction (alcohol, and drugs), and mental health.

In the traditional Marxist conception of social class, there was a fairly rigid conception based on the largely urban employment structures of emerging capitalist society in the modern
era. From a low income standpoint there was the proletariat, and the marginal low income class group of the lumpen-proletariat. The proletariat was emerging as the producers of surplus value as they toiled in the industrial employment sector, eventually having the opportunity to achieve stable wage earning status with the development of the trade union movement. The formation of the lower middle class through the growth of the administrative sectors and functions resulted in a group of similarly paid workers, often with the industrial proletariat having higher wages than the lower segment of “white collar” administrative workers. Unskilled workers, and seasonal agricultural workers, functioned as a fluctuating labor pool, with often marginal attachment to the labor force. The spread of the distribution of consumer goods and the service oriented economic structures during the 1920’s altered socio-economic class structures. Buying more expensive consumer goods on credit expanded. The working class grew as both the industrial and service/administrative sectors transitioned from the nineteenth century into the modern era. The degree of importance of the agricultural employment sector decreased (Baran & Sweezy, 1966; Giddens, 1975; Marx, 1990, 1867).

The Great Depression reflected the gap between the old and new economic structures within the financial and governmental sectors. The resultant deadened economic environment, badly impacted the lower middle class, administrative/service sector, resulting in a growth of the lower two thirds of the income distribution scale. The consideration of the nature of social class movement in the world of the capitalist economy changed drastically with the advent of the outbreak, and progress, of World War Two. Full employment, especially in North America, altered the employment life of all persons of all classes. The role of women in the economy was transformed. This, and the loss of men into the armed forces, severely altered the nature of family life during, and after the war years. It laid groundwork for the more modern aspects of
family life, and the raising of children, which emerged in its maturity in the last decades of the Twentieth Century, including family structure, marriage resiliency, and childhood attachment patterns. (Bernstein, 1989; Temin, 2000; Turkel, 1970).

Adjustment within the administrative patterns of government, and the closer integration of finance, capitalist functioning, and governmental roles also were in a period of re-organization and re-purposing during the Depression, and continued through the development of the “total war economy” during World War Two (Marwick, 1988). It can also be argued that within the United States, that the “total war economy” has abated only slightly since then through the arms spending of the Cold War, and as a result of the Korean War, the Vietnam War, the two Iraq wars, and in Afghanistan.

The ascension of Keynesian economic interventions which began in both Canada and the United States in the 1930’s, with increased social welfare spending as income supports (direct welfare payments, and employment insurance payments), and in providing social housing, social class structure was altered. It can be said it re-oriented the nature of the unemployed “working class’ and the former “lumpen-proletariat” to create a new socio-economic class of persons who are perpetually under-employed or almost never employed, subsisting on legal income from social welfare programs, or illegal income derived from petty theft or the sale of illegal drugs (since the 1960’s). Full employment became structurally defined as 3-5% unemployment.

Arguably there have been considerable changes during the last fifty years as the global and service economies have developed. Unionization has abated and the current level of the workforce which is unionized is now approximately one third. The proportion of the adult population which depends primarily on social welfare (including disability, and old age pension) is approximately one quarter. Aging of the population, second and third generations of parents
whose primary income source was social assistance, is creating a social class with only marginal attachment to the legally defined work-force (Cynamon, & Fazzari, 2008; Stehr, 2002; Steiglitz, 2010).

The consideration of social class, and of the nature of growing up low income in North American society, has been impacted strongly by the evolution of the modern economy away from manufacturing, towards service jobs, the break-down of family structure, the influx of diverse multi-cultural populations, and the essential cessation of the provision of geared-to-income social housing. Homelessness, or marginal habitation patterns (constant mobility or short-term residencies) has increased during the last twenty five years. Increase in the market value of land, residential housing, and the re-development of structures, both residential and commercial, has resulted in the ability of persons to enter the home ownership market to proportionately decline, or to require the assumption of higher debt loads in mortgages. Rents have increased widely. There is more overall market value but it is largely distributed to a smaller proportion of the population (Newman, 1998).

The shift away from stable employment and the loss of jobs in the manufacturing sector has served to undermine both employment and income security. There have also been additional complications in the spread of digital technology and ways of personally relating which has now crossed social class boundaries. Economic class boundaries have both solidified (in terms of the ability to rise above your class with “hard-work” and “taking advantage of opportunities,” and become less rigid as the middle class world has become more fragile economically (Cynamon, & Fazzari, 2008).

Economic security is declining. The near total collapse of the financial market in 2008 has the possibility of ushering in a new stage of social class awareness of differentiation. After
six years of uneven recovery (arguably made possible only by government spending intervention, and employment resulting from the wars in Iraq and Afghanistan), overall economic health has not been achieved (Florida, 2011).

The rise in employment in the underground economy (led by the drug culture) is of marginal utility in that the length of employment is highly variable, and the distribution of income largely mirrors the steeply pyramidal nature of the more conventional economy. The shift to consumption rather than production of goods, and to selling, has lowered the ability of persons to shift from the less affluent classes to the more affluent (Wolf, 2010).

Class distinctions are becoming less obvious in cultural terms. The differing cultural definitions of meaning have become homogenized through the constant media bombardment of the ideal consumer, and definition of meaning of modern life. Development of cultural, and even social class, mental frameworks, and the growth of overall economic disparities between the top 5-10% of the population, and the increasing loss of income and employment security, is not doing away with the meaningful use of social class differences, but is making necessary a reconsideration of the conceptual and realistic existential patterns of the middle class, and the working class. One I-phone/smart phone is essentially the same as another. Almost everyone has LCD screens, and tends to watch the same programming, on a television, or on the Internet.

Higher education has traditionally been the way for movement from the lower economic class grouping. The importance of post-high school education remains, but the pay-offs are declining or delayed, and the tuition costs (and graduating debt loads) are up. John Lennon of the Beatles sang, “There is room at the top they are telling you still,” in his song Working Class Hero. But many recent graduates are learning that first you must learn to smile as you fill in orders in a fast-food restaurant (Gilbert, 2014).
The historical ranks of the working class are becoming calcified. Fears of falling within the middle class are increasing. The ability of the employed to survive longer than a few months without a pay cheque (or two pay cheques) is declining without selling a piece of property, if it is not mortgaged so high that actual returns are much diminished (Swift 1995; Sullivan, 2000).

What does the term working class mean today? Many middle class people consider themselves to be “just working people” within their office cubicles. Is an economically defined conception of social economic class of much validity now, or in the near future? It depends how you define working class. The decline of production-based employment in North America has served to hive off the elite sector of the more traditional working class. There are fewer assembly line jobs, and less employment stability. Using home ownership to increase net worth is available to fewer persons, or at the cost of large increases in the indebtedness of persons, and the concomitant necessity of stable employment (Esping-Andersen, 2013; Frieden, 2012; Trigilia, 2008).

As a social-economic class concept, large scale differences between the middle class and large segments of the more traditionally defined working class are still apparent, but arguably less fundamental. Within the “proletariat” and what used to refer to the “lumpen-proletariat,” a merging of social opportunities and levels of functional existence may be seen. Who has more to fear economically, social assistance recipient, or a full-time minimum wage earner? In terms of social prestige, the worker is more revered, and perhaps has a higher self-image. A social assistance recipient (depending on the number of children) may have less income but more real disposable income, and security of place of residence.

Middle income persons will tend to have larger residences, within neighborhoods that have a more pleasant visual and a more emotionally pleasant environment. But depending upon
the degree to which income matches “outcome,” the internal emotional world may sometimes be equal (or even “better”) within the social assistance household.

Let us assume that a “nicer” residence in a “nicer” area, is to be preferred to living in a social environment with more obvious poverty, violence, and contact with people without access to assured day-to-day needs or “luxuries,” (except for those involved in dealing drugs). Does this mean that someone who is part of a middle income background will inherently have less chance of developing mental health challenges, or in becoming a substance abuse addict? Does this mean that a child growing up with parents with higher levels of education and income will be less likely be diagnosed with having a Co-occurring Disorder (the word “diagnosed” makes this a bit of a trick question). Does this mean that the family atmosphere within the more affluent household will be more conducive to a more positive outcome in terms of the elements of Co-Occurring Disorders?

All of the above queries raise the question of whether the nature of growing up in a higher income household is inherently less likely to result in substance abuse addiction and/or emotional/mental health disorders. It also has underlying possible consequences impacting the essential explorations of this paper:

- That a person of low-income socio-economic background tends to have a different set of characterological and emotional attributes than someone from a higher income background.
- That at least some of these differences are likely to have an impact on the likelihood of recovery from substance abuse addiction especially within the context of Co-occurring Disorders
• That within a treatment program for substance abuse addiction that the socio-economic class differences will impact the nature and detail of the approaches used within treatment modalities

In order to examine the questions, and the relevance to the explorations of this paper, it seems necessary to spend some considerable time firstly in discussing the nature of substance abuse addiction (in its developmental, behavioral stages), and then in the stage of the addict moving towards recovery in a treatment program.

In relation to the first conceptual area above, questions of the motivation for engaging in the use of drugs, the financial ability to purchase the needed drugs (and implications for the need to engage in illegal means of obtaining the financial resources needed once the addiction has assumed overwhelming proportions), and the contribution of the daily social environment to encourage, or at least, cast a less judgmental eye on substance abuse, will be influenced by the class-based social environment of the addict, and often impact how the addiction proceeds. In later stages of deep addiction persons with a middle-class background tend to lose at least the financial advantages of their class, and low income and middle income addicts have less obvious day to day differences (Levy 2003; Stephens, 1991)

Concerning the second conceptualization, the nature of ultimate self –image (confidence; remembrances of past successes; examples within the family social structures), access to opportunities to regain employment and social standing, and supportive emotional expectations from family, friends, and the surrounding daily social environment, will impact likelihood of continued abstinence and ultimate recovery (Keen, 1993; Pearce, 2010)

Class background can have important roles to play, but they are not necessarily dominant in recovery from drug addiction. The condition of the psyche of the recovering addict, their
detailed specific family backgrounds, the personal interpretation of their existential history, and even the nature of their “drugs of choice” can over-ride class predilections. This will be a focus of the next chapter of the paper.

What is Substance Abuse & Addiction?

The phrase “substance abuse” should be examined in its component parts. Firstly, “substance” implies something which can be seen, touched, and ingested in one way or another by a human being or other creature with a mouth and related metabolic system. When combined with the second word component, abuse, the ability to identify a meaning or explicit indication of a generally applicable reality of the two word term becomes more difficult.

Before proceeding to discuss the specific clinical definition of substance abuse used by the Diagnostic and Statistical Manual of the American Psychiatric Association, a more general examination of the term “abuse” will be done. This paper focuses on dualities of social meanings and behaviors in its social class focus, and in its consideration of drug addiction as a component of the dual nature of Co-occurring Disorders.

“Abuse” can be said to involve the “misuse” of something, based upon at least a general indication or standard of assessment of a quantity or qualitative description of the use of a substance. A social context for “abuse” involving ill-treatment, injustice, corruption is also part of examining the meaning of abuse (Webster’s Dictionary of the English Language, 1989). An added component of this interpretation of “abuse” is provided by The Online Cambridge Dictionary definition of abuse as “bad or cruel treatment of a person or animal, or the use of something in an unsuitable or wrong way” (Cambridge Dictionaries Online, 2014).

Examining imposed (within, and without the class grouping) social class connotations of “abuse” possible relationships of relevance are the self-assessment of people within low income
experiences as being someone who is “at the bottom of the ladder,” as being “in the hole,” meaning financially destitute or worse, as being “lower class,” as being persons who should be happy “with their lot.” Abuse is to be expected, and certainly quietly accepted. A question which arises is the degree to which the essential slavery represented by the addiction to substances, which provide some degree of escape from a standard life from which limits are apparent, creates an easier emotional acceptance of a life of seeking ecstasy through chemical alteration, and ultimately ending in a greater degree of being evaluated as a person worthy of disdain, even within one’s own class. It can be said a “junky,” a “drunk,” is respected by no one. Is that something “unsuitable,” “wrong,” “unjust”? Is being abused by others, judged harshly, easier to take when coming from a position with a social structure in which lack of financial affluence is a sign of failure? Substance abuse can be seen as at least a choice of self-identity at some level. These definitions of abuse provide a balancing corrective to the more neutral, medicalized definition of the condition of an addict provided by that of the Diagnostic and Statistical Manuals which follow.

The generalized terms of assessment of “unsuitable” or “wrong” themselves require the application of an interpretative frame of agreement of quality and quantity. What may be seen as “unsuitable” to some, or even perhaps a majority of persons, may be seen as “suitable” by someone else or another group. This aspect of relativity is even more at play when the second part of the definitional phrase “wrong” is considered. “Wrong” applied to a machine or technical process can tend to result in one or a limited number of applications, although even that is open to question depending on the use to which something is made once the human factor makes it entry. A screwdriver can be a weapon, or a hammer (for a small nail), or a source of profit for a merchant.
One glass of wine can be used for a series of toasts, or just the beginning of a night of drinking leading to drunkenness, or worse, a relapse from sobriety for an alcoholic. A prescribed pain pill for someone who has recently suffered an accident causing physical injury can be something which relieves pain as part of a process of return to physical health. Or it can be used as a means to get “high” if sold as a drug on the street. Or, over time, after a number of prescription renewals, it can be part of a behavioral pattern whereby someone uses the pills to get “high.” Or, the accumulated impact of the pill results in “side-effects” causing sleeplessness, or loss of libido, or inability to achieve erection, or gastric upset, or..., or... leading to another drug being prescribed to counteract either the physical or social/emotional impacts (anxiety from not having a constant supply of pills to which the body and/or mind of a person has become dependent. Or depression from the negative impact on a marriage due to sexual difficulties; extreme loss of self-esteem resulting from weight-gain, resulting in the use of diet pills) resulting in the need to treat physical symptoms which arise from the “cocktail” of prescribed drugs, or extreme impacts resulting from the patient using alcohol to “self-medicate” to try to deal with all of the above, resulting in more sickness, or an overdose.

Depending upon the society or religion of a client the determination of what may be seen as “wrong” is also not something which can be effectively determined without bringing the specific cultural context of existence of the individual into the equation of definition and assessment. Within Muslim societies, one drink is too much. Within certain aboriginal societies within North America and South America, ritual use of psychedelic substances is commonplace. Within Peru and populations within the high Andes mountain areas the chewing of coca leaves is commonplace to provide energy to replenish the draining impact of lower oxygen levels at high altitude levels.
A person may start drinking, or using, illegal drugs, in a controlled way. The person feels wonderful every time the drug is used to the point where it can be felt physically/emotionally. Over time, the level of use keeps increasing. Every day the person wants to imbibe. The person keeps increasing the amount that is needed to feel “good.” The person doesn’t seem to care anymore whether other people are present or not. The person finds themselves thinking more and more often, about getting more. When the amount of the substance in their possession is decreasing, anxiety enters and steps are taken to replenish supply. When the supply reaches zero, getting more is essentially the only thing which matters. Aspects of their life such as personal relationships, employment, and health don’t matter much anymore, and the fact that they are being clearly negatively impacted may be recognized, but the behavior of the person shows that they really don’t matter as much as imbibing. Some half-hearted attempts are made to cut-down or to stop, unsuccessfully. More and more is being consumed, with less and less pleasure, or satisfaction. Serious impacts such as hospitalization, legal consequences, loss of primary loving relationships, are not enough for the person to take effective steps to stop using. This person may be said to be a substance abuser (Feldman, 1968; Seldin, 1972; Singer, 2005; Zoja, 2000). Until this point the addict has probably not been convinced that their behavior has been “unsuitable or wrong.” The addict may not even be convinced at this point, but before the addict can begin to move towards recovery (or at least detoxification), this personal evaluative shift must be at least in its nascent stages. Fleetingly, the person may feel for a few moments that this may be case. The addict may want to gain control over the substance with some modified form of using, but often still harbors hope that after a brief period of detoxification that they might gain “control” over the objective source of their addictive behavior. Gaining “control” meaning to the addict, the ability to still partake, just without extreme consequences.
The word “objective” has been carefully chosen. There is always a “subjective” source, meaning an emotional, mind, and existential frame of their inner self which has played a major role in the progression from the initial days of using to the point of mature addiction. Objective forces such as genetic physical makeup, or aspects of brain-based chemical interactions, also have a role to play in developing the addict. However the evidence for this, especially from nosological, ontological, and aetiological viewpoints, are not yet highly developed as reliable explanatory or diagnostic tools when compared to the diagnostic specificities of standard physiologically based medicine.

The subjective frames of addiction on the experiential level of usage have just been discussed in a limited way, following the path of the addict from being a minor user to one whose life is taken over by the substance. Unsuitability or wrongness is not a static concept in the mind and feelings of the human being who progresses (regresses?) toward serious substance abuse addiction. Nor is the concept of addiction static within our society, within the moral boundaries of unsuitability or wrongness. Questions of legality, of moral approbation, of expected and urged behaviors, upon all members of modern capitalist society can be seen to impact on common behaviors such as social drinking, cigarette smoking, habitual shopping, compulsive use of digital technology, using the Internet, eating, sex, and gambling which can be seen as valid objects of addictive behavior, and/or “normal” forms of life in our society. The relativity of suitability/unsuitability and rightness/wrongness is always present.

The chapter on Adlerian psychology/psychotherapy and “Individual Psychology” will have much more to say about the “subjective”, in the essential structure of the individual, concerning a person’s characterological, and emotionally aetiological aspects affecting the causes and pre-conditions of the inner structure of a person. These aspects work to establish the
sea of possibilities which may lead to addictive behaviors, and the attainment of full-blown addiction. These analytical components will be discussed more fully also in dealing with the examination of development of a human being within, as a societal member with little money and social prestige, and within the socio-frameworks of being under privileged in the socio-economic context within following chapters.

Leaving aside the individual and philosophical realms, let us enter the psychotherapeutic/diagnostic realms in this discussion of substance abuse addiction.

**Is Addiction is a Disease?**

It is generally considered that it was the advent of Alcoholics Anonymous in 1935, and the publication of its core text, *Alcoholics Anonymous*, with its opening chapter, “The Doctor’s Opinion”, represents the beginning of the modern era in the characterization and discussion of addiction and alcoholism. However some sixty years previous to this there was a quarterly international journal founded in 1876 (The Journal of Inebriety), in the United States, with international contributors, by doctors who believed that alcoholism was a disease.

The Journal of Inebriety was published until the first quarter of 1915, with clinical and medical contributions from North American and Europe dealing with substance abuse for both alcohol and drugs. During roughly the same period, in both North America and Europe, addiction treatment facilities were founded. If this can be considered to be the beginning of the start of treatment for substance abuse addiction, the modern era of substance abuse treatment can be seen as beginning after World War Two, with the establishment of the Hazelden Foundation in Centre City, Minnesota, U.S.

Arguably the development of Hazelden, and what has come to be called the Minnesota Model of addiction and recovery, has led to the acceptance of a standard approach to substance
abuse recovery based on abstinence, and using the 12 Steps of Alcoholics Anonymous. The National Institute on Drug Abuse (NIDA) has this description of the primary aspects of the Minnesota Model (http://archives.drugabuse.gov/ADAC/ADAC11.html):

- The primary goal is lifetime abstinence from alcohol and other mood-altering chemicals and improved quality of life. This goal is achieved by applying the principles of the 12-step philosophy, which include frequent meetings with other recovering people and changes in daily behaviors. The ultimate goal is personality change or change in basic thinking, feeling, and acting in the world. Within the model, this change is referred to as a spiritual experience.

- This approach works by changing an addict's beliefs about his or her relationship to others and to self. This changed perspective occurs by attending meetings, by self-reflection, and by learning new coping skills. Through this process, the client's understanding about himself or herself in relationship to the self and to others is transformed.

- The main agent of change is group affiliation and practice of behaviors consistent with the 12 steps of AA. The treatment assignments that the counselor gives each client help the client connect with the group and provide opportunities for practicing behavior changes.

- Chemical addiction is seen as a primary, chronic, and progressive disease. It is primary because it is an entity in itself and not caused by other factors, such as intra-psyhic conflict. It is chronic because a client cannot return to "normal" drinking once an addiction is established. It is progressive because symptoms and consequences continue to occur with increasing severity as use continues.
At the beginning of the 21st century it was estimated by one researcher that over 90% of all addiction recovery treatments used the 12-Step abstinence recovery model (Lemanksi, 2001). There have been signs of some movement towards other treatment modalities, especially based on a “harm reduction” model, which have been especially driven by the increase in addiction among persons with other drug problems, including prescription drugs used to treat mental health disorders.

In the first years of the 21st Century there has also been a growing criticism of both the 12-Step and the abstinence approach, largely centered on the characterization of alcoholism, and addiction, as being a spiritual problem. This is not a false accusation. There are over five dozen references to “spirituality” in the Big Book of Alcoholics Anonymous, and four dozen references to “God,” which speak of the necessity for a spiritual solution to the problem of alcoholism. There are no specific mentions of religion (Roy, 1976). Critics of the 12-Step approach tend to see it as a “God” program more than a spiritual program, with slightly less than half of the Steps (3, 5, 6, 7, and 11), making direct mention of “God.” Mention is often made within AA of the correspondence between AA founder, Bill Wilson, and famous psychologist, Carl Jung, of his therapeutic failure with an alcoholic, and Jung’s comment that a spiritual experience may be necessary for some to prevail with alcohol addiction. The exchange of letters between the pair took place in 1961, almost thirty years after the founding of AA (see, www.silkworth.net/aahistory/carljung_billw013061.html)

There is little doubt that the overall importance of spirituality, and certainly the belief in “God” in modern society, has declined greatly during the last forty years. The overall pace of life has increased. People seem to have less patience, seeking quicker solutions to problems in general.
The spread of the consumption of prescribed medications has been steady since the 1950’s, and has only quickened during the last twenty-five years. The spread both within society, and within psychiatric practice, to have more instant solutions to life’s problems or anxieties to the middle class and upper class sectors begun through illicit drugs in the 1960’s, has expanded through the spread of the use of prescription drugs as primary tools of mental health treatment. Prior to the 1950’s drug addiction had received relatively little attention as a general social problem. So long as it was seen as being primarily an activity of non-whites, or the social deviants of that evil, weird, jazz music it was somewhat regrettable but not that crucial a societal concern.

The expansion of drug use which began in the 1960’s resulted in its spread to the “normal” world, ensnaring hundreds of thousands of middle class, white young people. It is a truth without specific numbers, and outside of the scope of this paper, since systematic collection of information on substance abuse (focused on alcohol) did not begin in a serious manner until the formation of the National Institute of Alcohol Abuse and Alcoholism (NIAAA) in 1970. Only when the Substance Abuse and Mental Health Services Administration (SAMHSA) was founded in 1992, did the modern era of collection of information on drug use make its beginning.

A longitudinal study of the University of Michigan begun in 1975 provides an overview of trends among young persons (Monitoring the Future, 2010). In 1975, when MTF began, the majority of young people (55%) had used an illicit drug by the time they left high school. This figure rose to two thirds (66%) in 1981 before a long and gradual decline to 41% in 1992—the low point. After 1992 the proportion rose considerably, reaching a recent high point of 55% in 1999; it then declined gradually to 47% in 2007 through 2009, rising to 48% in 2010).
Michigan, like much reporting of drug use, centered on illicit drug use, although tobacco and caffeine use has been monitored recently.

Increasing drug use, through prescription drugs, has been dramatic. The rise to economic power of pharmaceutical companies since the 1950’s is directly shown by the amount of money spent on psychotropic drugs growing from an estimated $2.8 billion in 1987 to nearly $18 billion in 2001 (Coffey et al. 2000, Mark et al., 2005). By 2010, $31.3 billion was spent by American consumers on antipsychotics ($16.1), anti-depressants (11.6), and attention deficit hyperactive disorder (7.2) (Wang, 2011).

The growth in prescriptive drug consumption not coincidentally mirrors the expansion in diagnostic importance and use of the various forms of the Diagnostic and Statistical Manuals of the American Psychiatric Association, especially since the 1990’s. Within the context of diagnosis of addiction and substance abuse, the analysis and prescriptive descriptions of the Diagnostic and Statistical Manual of Mental Disorders (DSM 1-5) as compiled and published by the American Psychiatric Association (APA), have become the primary “go-to” source for clinicians.

Its current overweening importance in the contexts of mental health diagnosis, payment of treatment by insurance sources, and the spread of illegal, and especially legal prescription drug usage throughout modern capitalistic society, merits a somewhat detailed consideration of its treatment of substance use as an element of societal and personal health.

In the early years of the DSM in its first two volumes its standing was largely a minor footnote in the daily practice of the mental health/addiction field confined to professionals. Each volume was small (approximately 130 pages), with a fairly brief narrative description, rather than diagnostic analysis and checklists, meant for direct usage by clinicians.
Substance abuse, addiction and alcoholism received only minor mention. In DSM-1, alcohol was matched with “Acute Brain syndrome” and in a section, “Disorders Associated with Intoxication,” being compared almost to a poison, rather than a bundle of results relating to behaviors which could be called “addiction.” This was included in Section I – 0 “Diseases of the Psychobiologic Unit”. Alcoholism was not seen as a disease itself, but a contributing factor to a “real” disease (American Psychiatric Association, 1952, pp. 1-3). It was mentioned as a “Disorder of Character, Behavior, and Intelligence,” under the classification of Alcoholism 322. Even in this section it was primarily classified as a causative behavior which could result in “Chronic Brain Syndrome,” (DSM-1, p.99). Clearly the influence of the yet to emerge Minnesota Model or the 12-Step approach of Alcoholics Anonymous was not yet a diagnostic factor.

The second version of the DSM emerged seventeen years later. Diagnostic recognition of Alcoholism (303) and Drug Dependence (304) had now been achieved, but these classifications of what is now considered to be leading to, or representative of, “addiction,” was not yet present. They were now considered to be, “Neuroses, personality disorders, and other nonphysical mental disorders (300-309), (American Psychiatric Association, 1968, p. 92). However, specific mention is made in the DSM-2 that “alcoholism and drug dependence” are no longer included in the “sociopathic personality disturbance” sub-category, but are now “listed separately in DSM-II at the same hierarchical level of organizations as the major category personality disorders (American Psychiatric Association, 1968, p.123). Clearly the DSM-II has upgraded their diagnostic consideration of substance abuse/addiction from a sociopathic manifestation, to a mere personality disorder. The Disease Concept is not a factor but a diagnostic positional shift had taken place.
It was the publication of the next edition of the DSM in 1980 which signals the beginning of the modern era of consideration of substance use (including alcohol, and drugs) from a diagnostic and clinical viewpoint. The increase in size of the DSM-III to over five hundred pages was also reflected in the increased space given to consideration of substance use disorders, with a separate section, “Psychoactive Substance Use Disorders,” covering twenty-two pages. Substance Abuse Disorders receive as much space as Schizophrenia, Sexual, and Mood Disorders, and more than Delusional, Anxiety, and Dissociative Disorders. Only Early developmental and Organic syndromes and disorders have more space (American Psychiatric Association, 1980).

By the time of publication of the DSM-III in 1980, the Minnesota Model was well established as the de facto treatment and ontological base for considering substance use disorders. Another emerging related factor within society was the beginning of maturation of the use of prescribed drugs (which began shortly after in its nascent stages at the time of release of the DSM-I). And equally important, and co-dependent, was the shift within psychiatry from “talk therapy” treatment, to the use of prescription medicines and “psychopharmacological” treatment.

When the DSM-IV-TR was published in 2000, the section on Substance-Related Disorders had become the largest in book (pp. 191-296, over one hundred pages). Substance abuse had become recognized, if not as an “illness,” at least as a behavioral “disorder,” capable of diagnosis and treatment by medical professionals. It also recognized dependence on multiple substances, laying some official groundwork for the specific consideration of co-occurring disorders with its Substance-Induced Disorders section which addressed psychotic, mood, and anxiety disorders.
Substance Related disorders continued to be the largest section of the DSM-5 released in 2013. The American Psychiatric Association outlines the changes well:

DSM-5 does not separate the diagnoses of substance abuse and dependence as in DSM-IV. Rather, criteria are provided for substance use disorder, accompanied by criteria for intoxication, withdrawal, substance/medication-induced disorders, and unspecified substance-induced disorders, where relevant. The DSM-5 substance use disorder criteria are nearly identical to the DSM-IV substance abuse and dependence criteria combined into a single list, with two exceptions. The DSM-IV recurrent legal problems criterion for substance abuse has been deleted from DSM-5, and a new criterion, craving or a strong desire or urge to use a substance, has been added. (American Psychiatric Association, 2013a, p. 16)

DSM-5 has added marijuana, caffeine, and tobacco in the section also.

If the specific words used by the various versions of the DSM is examined it can be seen that a more inclusive, less judgmental even, tone has evolved. DSM-1 had no specific section on addiction/substance abuse, placing it only under the Personality Disorders section, using “addiction” for both alcoholic and drug classifications. In DSM-2 alcoholism and drugs abuse remained a ‘personality disorder.’ Interestingly alcoholism warranted a formal use of the word addiction (classification 302.2) but section 304 Drug Dependence did not use “addiction.” By DSM-3 “addiction” had disappeared.

DSM-5 has significantly modified/expanded its description of substance related disorders in a more complex structure of measuring possible disordered usage of substances to include the use of the words, “intoxication”, and “withdrawal”, and application of specifiers for dependence. It also has directly connected substance abuse with more standard mental health disorders such
as anxiety, personality and mood disorders. At some level this can be seen as an attempt to lay some groundwork for facilitating the diagnosis of a Co-occurring Disorder condition. The examination of a socio-economic filter also has impacts which arise from this alteration in the DSM-5 approach. It is expanding its net of disordered behavior to embrace more persons, makes a socio-economic focus less important overall at some level, but also complicates consideration of applying treatment to persons with a more disadvantaged socio-economic background. More people are at least possibly subject to being diagnosed as having a professionally determined mental disorder.

The proportion of the American population which takes at least one prescription drug is now estimated to be 70%: “Researchers find that nearly 70 percent of Americans are on at least one prescription drug, and more than half receive at least two prescriptions, reports CBS Atlanta. Researchers from the Mayo Clinic, a non-profit medical and research center, report that antibiotics, antidepressants and painkiller opioids are the most common prescriptions given to Americans” (CBS News, 2013).

However, data is lacking which looks at the degree to which substance abuse recovery and mental health consumers can be identified by their socio-economic background. This lack of information is of mixed importance for this paper. It can be hypothesized that the cost of illicit drugs may have more social destruction among the family life of low income persons, as parents who are substance abusers likely pay a greater proportion of a limited income base on substances. Research which looks at the amount of substance consumption (and its attendant cost), applying a social class background interpretive focus has not been done.

In the DSM-5 section on Substance-Related and Addictive Disorders there is a closing direction that application of diagnostic rating based on the symptomology it provides should not
be applied if the symptoms apply to prescriptions supplied by doctors and psychiatrists:

“Symptoms of tolerance and withdrawal occurring during appropriate medical treatment with prescribed medications (e.g. opioid analgesics, sedatives, stimulants) are specifically not (original emphasis) counted when diagnosing a substance use disorder,” (American Psychiatric Association, 2013b, p. 484).

In examining the need to address substance abuse as a medical/psychological/sociological challenge in society, focus on illicit drugs is mis-directed at best:

According to findings from other Federal data systems, rates of drug overdose deaths—driven primarily by pain relievers—increased roughly five-fold between 1990 and 2007; the proportion of substance abuse treatment admissions reporting any pain reliever abuse increased more than four-fold between 1998 and 2008; and emergency department visits involving the misuse or abuse of pharmaceuticals increased 98 percent between 2004 and 2009 and, in 2009, exceeded the number of visits attributable to the use of illicit drugs. (Office of National Drug Control Policy, 2010, p. 1).

Looking at treatment approaches from a co-occurring point of view is made especially difficult by this limited approach of the DSM.

The DSM-5 is notable for its change from referring to substance abuse addiction as now being a “dependence.” Is there a phenomenological significance of this change? This reflects the shift away from being a “personality disorder”, to being an “addiction,” to being an “abuse,” to being now a matter of “dependence”.

Let’s look a little at the word depend and variations in the English language (from The New Lexicon Webster’s Dictionary of the English Language, 1989, p.257):

- Depend- to rely, to trust, to be contingent
• Dependable – reliable, trustworthy
• Dependent – subordinate; forced to rely

It was previously mentioned that the DSM-5 specifically excludes person who exhibit the same symptoms as someone who uses substances outside of a prescribed medical intervention, from being considered to be “dependent.” Under the Webster Dictionary definition, “depend” is characterized as being related to trust and reliability. If a substance is resulting in addictive manifestations and severely impacting one’s life, what is important in the eyes of the DSM-5 approach is the over-riding importance of the patient being subordinate, and forced to rely on the judgment of the prescribing clinician.

A question outside the scope of this paper is the current practice of diagnostic intervention, and generally resulting use of psychiatric drugs, as a mode of social control, or, even indirectly, setting the social standards for what is considered to be the socially appropriate, socially tolerated form of behavior. However there is more and more questioning of the judgment of expanding the scope of behavior to be diagnosed as a behavioral disorder exhibited in particular by the last two editions of the DSM (Breggin.2001, 2004, 2008; Caplan 1995; Francis, 2013; Glasser, 2003: Greenberg, 2013; Healey 2004, 2013; Whitaker 2010).

Class, Character Formation, and Addiction

Although human beings share some common essences, each one is different within the deep, and sometimes no so deep, corners of their Self. Expressions of sameness are impacted by the social class background each of us experiences, during childhood particularly. Freud and Adler spoke theoretically and clinically, on the lasting impacts of childhood, and family interaction. In today’s modern social and familial ebbs and flows, the specific elements of the
family can change very suddenly for a child. More and more children do not ever experience the primary presence of a mother and father whose blood and genetics flow through them.

For the sake of brevity and clarity of focus, this paper does not consider how growing up as an orphan at birth, or as a single parent child as a result of death, or as a foster child whose parents may have abandoned them before and soon after natal birth, or the impact of having parents of the same sex. The dissimilarities in character formation resulting from their experiences are certainly different in quality and force, if not in essential type.

This paper is not a sociological/demographic analysis of poverty in the U.S. or modern capitalist society. There certain facts and trends within modern capitalist society in Canada and the U.S. which relate to income and household structure. Having worked as a social planner and researcher, and as an anti-poverty community organizer in Canada, information related to household structure, and income trends, and their interaction, have been a constant part of my personal and professional experience.

Certain socio/economic generalizations can be made which are well accepted by those who have experience in social work, community work, social activism, and social planning. They apply to both Canada and the U.S. These include:

- single parent households are poorer than two parent households
- the vast majority of single parent households are female led
- the proportion of single parent households continues to grow
- it is much harder for children of a low income family background to attend college and university
- the cost of post-high school courses is increasing, and government aid is decreasing
- the average health of low income persons is lower than the middle class
This paper does not address the inter-relationship of race, or the rural/urban dynamics of poverty, the relationship between the inner city and the suburbs. There are important differences between the nature of class existence in Canada and the U.S. Easier access to health care services is perhaps primary in Canada’s favor, but a generally lower cost of living in the U.S. is to the advantage of low income people in the U.S. depending upon the state and the city. In the sense of this paper, patterns of drug use are very similar. The overall cost of housing and food is lower in the U.S. There are more addiction treatment facilities proportionately in many states in the U.S. The Canadian health care system does pay for addiction treatment access, but the waiting lists are long, due to the overall lack of such facilities, rather than a proportionately higher rate of addiction (Kessler, Frank, Edlund, Katz, Lane & Leaf, 1997; Rush, Veldhuizen & Adlaf, 2007; Luce and Strike, 2011).

This section of the paper is an exploration of hypotheses, general principles for examination, and the creation of proposals and statements designed to raise the issue whether:

- low income background affects character and assumption on self
- in approaching treatment for addiction, and for mental health treatment, how income background may affect the nature of substance abuse addiction, and recovery from co-occurring disorder
- what isn’t known to address the above issues
- what real differences might it make if the details aren’t known

A Brief Historical Overview of Low Income Culture and Psychotherapy

Sigmund Freud and Alfred Adler both believed that psychotherapy was a health tool which should be available to all persons regardless of their ability to pay. As the psychoanalytic movement, and the Adlerian Individual Psychology movement developed after World War One
there was the establishment of community-based psychotherapy clinics in Austria and Germany (Danto, 2005). Freud also felt it should be a principle that psychoanalysts should devote time each month to provide pro bono therapy. Adler’s conception of social interest was more widespread conceptually than that of Freud in that the Adlerian community services included public psychotherapy demonstrations, and actual case sessions in public settings to enable more widespread learning of the social benefits of applying the principles of Individual Psychology. He also saw that it was necessary for parents, children, and teachers to work together to begin the proper education of children to lay firmly the principles of social interest within the actions of children.

In Vienna especially there developed a system of social services, education, public housing and psychotherapeutic services, which served both the working class, and an impoverished middle class community. Within Red Vienna social service and educational experimentation occurred to a degree which has not been duplicated since (Gardner, 1992; Gruber, 1991). The coming to power by the Nazi government in 1933 in Germany, and ultimately in Austria in 1938, was the beginning of the end of this movement. By 1938 it was over.

Within the United States, the economic boom of the 1920’s resulted in the laying of the foundation of modern consumer culture in which modern conveniences such as automobiles, refrigerators, gas and electric stoves, mass-produced clothing, popular culture, telephones, and radios became things which became accessible to sectors of the working class employed in factories, as well as the lower middle class employed in the office and service sector, fueled by the advent of buying on credit (History Teaching Institute, Ohio State University, 2014).
To some extent there was a homogenization of class contexts which was building to put a new meaning to the idea of social class differences. Although the world-wide economic depression of the 1930’s helped to bring about a rise in popular consciousness of the concept of socio-economic class differences, specific application of the ways in which the psychology of classes may manifest itself was not explored. The economic situation was so threatening that basic survival issues, not class-oriented sociology or psychology, was seen as important.

Building of self-confidence, life expectations, ability to express needs, fear of social structures and groupings, capacity to address challenges and failures, and feelings of social connection, are all areas which are obvious points of reference in assessing class and social mediations of character structure. All are life issues which all human beings face.

Is there a social class mediator in the degree of ease in which someone is able to input these factors in their life? It is the contention of this paper that social class background does play a role. That is not to say that either the socio-economic destiny, or the emotional/psychological impacts on the character and life choices are pre-determined by the social/economic class frames of a childhood. Persons of any economic class will have challenges to move ahead positively in all the areas referenced above. Generally speaking though, in the sense of majority social outcomes and the experiential history of most persons within a social economic class, life realization of them are likely to be more difficult when your class background is on the lower end of the scale.

There are substance abuse addicts with all class backgrounds. Reasons for the abuse resulting in the life of someone may even be the same with two persons of a different class, even with people of opposite sexes. Substance abuse addiction is not a class disease of social and
emotional affliction. It may be possible to identify a batch of familial and social reasons which can be applied to persons of addiction, regardless of class.

But now some hypotheses of the context of social, emotional, and psychological experience of growing up as a member of the lowest economic class will be examined. Some of the following material is based on the writer’s professional experience working in urban and social planning and policy development, and as someone who for the last thirty-five years has worked as an anti-poverty activist, developing services (training low-income single parent mothers, working with public housing tenants, working with the homeless, active, and reforming alcoholics and drug addicts), and developing and delivering personal development and job training programs for persons without jobs. Of the many hundreds of low-income persons I have worked directly with, almost all had no sense of personal direction, or if they did, little idea of how to move in the desired direction, or positive expectation of being able to move into a higher class level.

There are sociological and psychotherapeutically oriented works which explicitly address the issue of the emotional frameworks of low-income persons and life (Goldstein, 1973; Hollingshead and Redlich, 1958; Reisman, Cohen, Pearl & Reisman, 1964; Rubin, 1976; Sennett & Cobb, 1972). Three works (Banuazizi, Liem, Lykes, & Morris, 1996; Colapinto, Minuchin, & Minuchin, 1998; Payne, 2001) are more recent, addressing the world of the poor, and specific psycho-service approaches.

Although the specific Adlerian examinations of addiction and relationship to co-occurring disorders for this paper has been limited to direct mention of addiction, and related psychotherapeutic contexts are restricted in this paper to the writings of Alfred Adler himself, the following are articles of other exponents of Adlerian Individual Psychotherapy which relate to
addiction and co-occurring disorders (Carlson & Sperry, 1996; Dreikurs, 1932; Linkenbach, 1993; Mosak, 1990; Mozdzierz, Greenblatt, & Murphy, 2007; Shiffron & Reysen, 2011; Stein, DeMianda & Stein, 1988).

The Psychic Experience of Being Low Income

Before turning to a discussion of the social, emotional, and psychological elements of the experience of members of the low income social class, it should be noted that the bottom economic quartile of the population is the operational definition to define low income used in this paper. As has been alluded to previously, and will be discussed again, essential elements of the psychic and emotional structure of a person who manages to rise economically out of the lower economic quartile, may not change. In this sense, the person someone becomes as a child, does not necessarily last only so long as the amount of a person’s income remains defined as being from the low income social class. As Adlerian Individual Psychology reminds us, the development of private logic and personal goals which occurs in early childhood, carries over into adult years.

The following table presents five elements of life (living space; stability; personal power; and anger; security) and characterizations of the nature of the low income experience of these elements, along with postulated results. No attempt is made to differentiate among children, adolescents, or adults. It is of most direct application to persons who spent most of their lives (childhood; adolescence; adult-hood) living within the spatial, financial, and social structures of life within the bottom quintile of economic life. It is of course possible, and not an infrequent occurrence, for persons to have brief transitions into lower economic circumstances resulting from educational sojourns, or employment transitions, especially.
The context of discussion of Table 1, is the examination of inner tendencies to feelings present within a person’s sense of self, and position, within the broader social structures of being a part of a modern capitalist society.

Table 1

**Psychic Elements of Being Low Income**

<table>
<thead>
<tr>
<th>Living Space</th>
<th>Stability</th>
<th>Personal Power</th>
<th>Anger</th>
<th>Security</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of space</td>
<td>Limited possibilities of change</td>
<td>Powerlessness</td>
<td>At others</td>
<td>Constant insecurity</td>
</tr>
<tr>
<td>Clutter</td>
<td>Repetition</td>
<td>Living with failure</td>
<td>At self</td>
<td>Degrading security</td>
</tr>
<tr>
<td>Emptiness</td>
<td>Entitlement</td>
<td>Perceived life as failure</td>
<td>At family</td>
<td>Insecure accommodations</td>
</tr>
<tr>
<td>Lack of privacy</td>
<td>Disentitlement</td>
<td>Hopelessness</td>
<td>At authority</td>
<td>Maintaining friends</td>
</tr>
<tr>
<td>Diminished aesthetics</td>
<td>Few positive expectations</td>
<td>At the lack of hopefulness</td>
<td>Having necessities of life</td>
<td></td>
</tr>
</tbody>
</table>

Source: As devised by R.G. Kellestine, 2014

Let’s consider each element in turn before constructing an overall structure of the experiential psychic result. As an infant the experience of one’s living space is limited. After entry into young childhood, the ability to make understandable comparisons of how other people live based on the size and quality of space of homes of friends and acquaintances emerges. Exposure to other spaces through television and films, and moving around an urban environment with parents, or during personal explorations with friends, results in comparisons with one’s one quarters. Occupying less space becomes apparent. The lack of space may be heightened by the abundance of objects within a small space within larger families, or a sense of emptiness may arise from a lack of furniture. A lowered sense of privacy also arises from the sharing of limited
space with family members, from having to share a bedroom and/or a bed, from having to fight for, or wait for access to bathroom space.

The question of stability within a low income life is a dual expression of unexpected change and a concurrent lack of hoped for positive change. Constant movement from one living space to another is a standard function of being for a low income household unless a government subsidized housing unit is attained. Some low income households were lucky enough to achieve some stability in housing, through ownership, prior to the modern transition of housing/property into the realm of being an exchange commodity which emerged in the later 1960’s resulted in constantly rising prices. Stability of factory employment also allowed for the upper portions of the bottom third of society to gain access to home ownership, buttressed by a more or less stable economy based on production of goods within capitalist societies. The shift to export jobs to Third World economies which began in the 1980’s has severely limited both stable employment, and the ability of lower income households to access stable housing. The negative impact of these global economic changes has been exacerbated by the extreme downturn of production of government subsidized housing (especially in North America) which began in the early 1990’s.

Any low income adult (and many children) knows the meaning of the “midnight move,” of leaving behind clothing, furniture, toys, as a parent decides that there is no choice but to leave before being evicted. When some form of housing is attained (staying with friends, shelters, another place with less immediately unaffordable rents) the expectation of staying in one place is less real with each transition. Being in unsuitable housing becomes something which must be accepted and/or endured. Repetition of moving is perhaps expected. Within the family structure, loss of a parent, a “step” parent, older siblings coming and going, is the norm. Seeing other families with two parents makes it clearer to a low income child that the stability of their
life has relevance within a context of being different, of having less. The related issues of entitlement and disentitlement, is complex. If a low income child has a greater sense of reality (especially compared to media images of family life), the question of entitlement can become moot since expectations may be so low. With multi-generation welfare households, a sense of entitlement may emerge, albeit, one within the context of low expectations. Observation of the lives of others (real or imagined), can result in feelings of dis-entitlement, perhaps largely in the mythic sense. A child/adolescent seeing others “with,” and themselves “without,” makes a feeling of being disentitled from things which everyone else seems to have, a natural feeling.

Personal power is something which a human being accepts, develops, and reconstructs, as they grow up. By early adulthood the sense of the ability to change overall personal power becomes less of an issue. Accepting one’s place becomes the easiest way to go, especially for persons who may have had dreams of ascendancy when younger and become faced with a life circumstance in which the likelihood of attaining a position of power is a painful acceptance of personal powerlessness. It may be said that the roots of various extreme negative behaviors and emotional adaptations lies in the erosion of positive expectations of the ability to gain power and success. It may also be said the roots of alcoholism and other forms of substance abuse addictions lie in the lack of stability, positive expectations, and the quest for some form of power, even if self-destructively expressed. But let’s consider the other two elements of Table 1 before returning to roots of addiction, and of emotional disorders.

Living a life based on limited living and personal space, the lack of positive stability or positive change arising from change, and low sense of personal power, results in many low income persons turning to dulled emotional effect on the outside of their expressed being, and the pushing down of anger at their circumstance, or the expression of anger against people and
things who often are not responsible for their experiential condition. Anger emerges at others, at their family members, at social institutions, at authority structures and representatives. But often their social condition results in the expression of their inner angers not being prudent. Expression of anger, if they want to keep their social assistance, their unfulfilling, hated job (if they have one), to please a landlord asking for unpaid rent, to accept the right of people to come into their home (such as it may be) unannounced, to keep their children can be challenging. This can easily result in anger being directed against themselves for being a coward, for “putting themselves” in their ugly circumstances, for having to engage in behaviors which seem necessary in order to maintain the life, as meagre and unsatisfying as it may be (Rubin, 1976; Sennett & Cobb, 1973).

A low income life may be said to be both secure in the constancy of insecurities, and insecure in the lack of constancy of being confident in the ability to have the food, shelter, clothing they need for themselves and their children. They often have constant insecurity, a security which is sometimes/often degrading. If they are in the cycle of moving to try to maintain accommodation for themselves and their family, friends come and go, for low income adults and for children.

The most logical outcome of the pictured state of existence for a low income person seems to be hopelessness, or at best low expectations of positive change, or of greatly improved personal circumstances. But some persons do “pull themselves up by their bootstraps,” or become “successful.” These generalizations of negative elements of emotional structure for persons in prolonged low income circumstance are intended to provide a valid, but not necessarily complete background, for the consideration of how life background of addicted persons, the large majority of which have emotional disorders and erratic mental health, impact
on the addiction counseling/psychotherapeutic of persons with a significant low income background (Argyle, 1994)

The psychologist, Abraham Maslow, is famous for his Hierarchy of Needs (1943) which postulates that a person requires having a series of needs met before the person can begin to look at maximizing their being. Maslow’s needs, in their order of hierarchy, were Physiological needs; Security needs; Social needs, Esteem needs, and Self-actualizing needs. When Table 1 is examined in light of Maslow’s hierarchy it can be seen that the first four needs are especially problematic for low income persons. For a low income person to move to an active, sustained quest for self-actualization seems to be unlikely.

The Mental Health Universe of the Low Income Culture

In our modern society, except for perhaps a very small proportion of its residents, (less than 10%?), people inhabit a general societal consciousness of media induced, and encouraged, desire for similar objects and activities. Just the cost and size of things tend to vary within social classes, rather than the specific objects themselves. The true variation of aspects of being for inhabitants of the bottom one quarter of the modern capitalist society lies in how a person measures, and experiences, their life expectations, and evaluation of themselves.

Within the bottom ranks (as measured by income, not quality of a person’s inner being) contrasting what they see within their families, and friends with the representations of the world seen in films, television, and advertising messages, can be said to result in an extreme cognitive dissonance when compared to their own lives. A small minority may develop the inner will to leave the world of low expectation, and generalized structural and personal looks of disdain which is most often directed towards them, behind. With public housing, the primary image of financial success which is most glaring, and seems most easily accomplished, may be becoming
part of a gang. Illegal drugs, expressions of violence and dominance, and ostentatious displays of things (cars, clothing, jewelry) may seem to be the most likely way to become a more successful member of an excessive consumer society.

But not everyone can be a success, whatever the surface measurement of success may be, or how fleeting it may be within the criminal culture for many. Escape within negativity, lack of striving, absorption of being seen as “less than,” and being a failure even with a sub-society based on low expectations, can easily lead to choosing to use drugs (alcohol included) to escape the surrounding world. This is done also to escape the personally defined world of low self-esteem, and a badly diminished sense of self. Without a healthy sense of spirit, manifestations of emotional belief, and behavior of extreme dysfunction, and separation from the primary definitions of being normal, may become the self-expression of a person without a sense of the utility of being aware and like others.

Living within depths of sadness and despair, being extremely excited by imagined achievements, escaping themselves, or easily reacting to even slight emotional discomforts, or being taken over by panic and anticipated fears, can become someone’s way of being. Being classified by peers, and representatives of the structures of social management and assessment (social workers; police; courts; doctors; teachers), as being “crazy,” “nuts,” “wacko,” “weird,” “sick,” “mentally ill,” or “mentally disordered.” Despite the professional vernaculars, each of the terms essentially means the same thing. They are terms of fear, amusement, pity, disdain, concern, and yes, even compassion sometimes, which are used by persons who see a being whose behavior is not “normal.” In the vast majority of cases, such behaviors represent conscious and unconscious choices, leavened sometimes by behavioral learning, sometimes genetic structures, which can create a personal disposition towards “mental disorder,” and
addiction, passed along within familial and social environments. The above comments can of course be applied to persons coming from a higher income social environment, but within the context of this paper, these existential choices are of particular relevance in the examination of persons coming from a lower income socio-economic background.

There are many classical Adlerian concepts which have been applied to this chapter in its discussion of the emotional and character structure of low income individuals. These include: “As If”; The Courage to be Imperfect; Embeddedness/Social Embeddedness; Existentialism; Felt Minus & Felt Fictional Plus; Inferiority Complex; Inferiority Feelings; Mistaken Goals of the Discouraged Child; Phenomenology; Private Logic/Meaning/Sense; Self-Concept; Self-Ideal (Personlichkeitsideal); Superiority Striving/Goal Striving (Griffith & Powers, 2007)

**Being Low Income and Addicted**

In all treatment programs for addiction, there is no consideration given to addressing possible differences, or need to address certain issues of addiction with regard to the socio-economic background of an addict. There has been some work to examine inter-relationships between poverty and addiction. Some studies done within the last ten years have addressed this topic.

One study (Room, 2005) makes specific note of the impact of stigmatization and marginalization on possible success in treating addicts with a low income background:

> While poverty and heavy substance use are not necessary related, poverty often increases the harm for a given level of use. Marginalization and stigma commonly add to this effect. Those in treatment for alcohol or drug problems are frequently and disproportionately marginalized. Studies of social inequality and substance use problems
need to pay attention also to processes of stigmatization and marginalization and their
effect on adverse outcomes. (p. 147)

Another study took the approach of examining the influences of socio-economic
experience which can impact the susceptibility of someone engaging in substance addiction. It
focused on five thematic areas: income disparity; transience; shift work; high incomes and
financial pressures; and expectations of entitlement arising from sustained employment. These
areas were used to discuss community fragmentation, and dysfunction within families as factors
in encouraging some persons to engage in substance addiction (Parkins & Angell, 2011).

Marginalization from the rest of society is certainly a primary aspect of living as a low
income person. Stigmatization is also something which low income people experience
constantly. Having disparate incomes has many results for low income persons which contribute
to negative feelings of being different from the society around them, from wearing old clothes,
driving old and damaged cars, patterns of speech, and living in run-down neighborhoods.

But even among low income people who may feel they are deserving of a better life, and
that they have the skills to “get ahead,” they may do so with the baggage of identifying
themselves with failure, and a fear that they will not fit in, that despite elements of personal
social striving that they may be doomed to identifying themselves are being a “low-income
loser” even when they may earn success, and leave, at least financially, the low income world.

When a person rises economically from being working class, it doesn’t necessarily
change the inner being of the person. Awareness of class background remains, although
someone may want to forget, or remembers with anger and disdain. Alfred Adler’s conception
of character formation has a person having formulated their sense of self and society by the time
they are six years old. Regardless of what directions their life may take as they become older,
the sense of self and their life expectations (their “private logic and “goals”) stay the same, without determined interventions to recognize and change them.

This is illustrated by the life of John Lennon of the Beatles. Lennon came from a working class background. His father, Alf, was a merchant sailor, who abandoned John when he was four. His mother, Julia, gave him up to her sister. Lennon spent his infant years largely as a single-parent child of two working class parents. Both had abandoned him by the time he was six years old. He grew up as part of the lower middle class. John saw his mother often but she was killed by a drunk driver when Lennon was 17. Lennon’s “adoptive” family was lower middle class, owning their home, and another cottage where he lived with his mother for a time prior to moving in with his aunt. In Lennon’s own words, “I was a nice, clean-cut suburban boy, and in the class system I was about a half an inch in a higher class than Paul, George and Ringo, who lived in subsidized government houses. We owned our own house, had our own garden. They didn't have anything like that. So, I was a bit of a fruit compared to them in a way” (Solt & Egan, 1988, p. 68).

Although designating himself as a child of the suburbs, he saw himself as only marginally higher in the social order than his fellow Beatles who came from public housing. His self-description as a “clean-cut suburban boy” was probably a sarcastic, and likely a self-deprecating comment. Calling himself a “fruit” shows that he did not see himself as better in socio-economic class terms than the other Beatles. In fact he can be said to be somewhat disdainful of accidental climbing within the English class structure.

Lennon’s 1969 song, “Working Class Hero” reveals his view of himself and his class upbringing. This song was written soon after the breakup of the Beatles, largely triggered by Lennon’s need to redefine himself, to redevelop his feeling of being an individual rather than the
being of publicity and adulation that he had become from the overwhelming success of the Beatles, and his role as an icon of the cultural changes which emerged during the 1960’s.

Despite the millions of dollars he had earned, and the societal adulation he experienced, he was not impressed with his ability to rise in the socio-economic ranks. Or with the working class which was his roots. Lennon is speaking of his own life as a child, and of himself, as someone who apparently has achieved success despite a socio-economic background from modest circumstances. The music is very simple, a strummed acoustic guitar with basic chords dominates, a melody of sparseness, with a dirge-like quality. Although the lyrics are all third person, it is also clear that Lennon is writing about himself as well as making social comment.

In the first verse Lennon talks about the development of low self-esteem based on being ignored and abandoned, physically and emotionally, resulting in numbed feelings (as a protective mechanism). All lyrics quoted in the following pages are from “Working Class Hero,” music and lyrics by John Lennon (1969).

As soon as you're born they make you feel small
By giving you no time instead of it all
'Til the pain is so big you feel nothing at all.

These reactions are not specifically grounded in a socio-economic class background. Whether working class, or middle class, or upper class, an infant/young child experiencing life on the basis of not having emotional needs met can live in these reactions. The second verse takes the infant into the social structure of school, where the motif of inflicted pain continues. Comments on cleverness and being a fool can be seen as being more strictly about someone of lower economic background caught in a system seen as structured for the student to experience negative feelings.
They hurt you at home and they hit you at school
They hate you if you're clever and they despise a fool
'Til you're so fucking crazy you can't follow their rules

The third verse veers somewhat towards middle class specificity with its mention of choosing a career. In England in the late 1950’s the working class did not choose careers. It is truer to say they took what they could get. His aunt and her husband were able to send him to the Liverpool School of Art, a lower middle class institution, after high school. The theme of confusion and fear continues in the song.

When they've tortured and scared you for 20 odd years
Then they expect you to pick a career
When you can't really function, you're so full of fear

The fourth verse is social comment in its description of life after school. By early adulthood Lennon was building his career as a musician. It is somewhat ironic that Lennon can be said to have chosen a career, but on his own terms. Interestingly his father was a musician of sorts. He speaks of life being free of the constriction of class barriers as a delusion powered by living life un-consciously with distractions. His disdain for those who feel they have escaped the class system is clear. One also has to wonder if Lennon didn’t also include himself as one of the “fucking peasants” despite his position as a cultural icon, and millionaire.

Keep you doped with religion, and sex, and T.V.
And you think you're so clever and classless and free
But you're still fucking peasants as far as I can see

The final verse can also be seen as a double-edged sword of rejection of hope to rise above the working class/middle class station without a violent cost (‘to smile as you kill.”), and a
further comment on his own “rise to success.” The adulation he experienced as a Beatle can be seen as his assumption to living with “the folks on the hill.” Did he reject further life as a “Beatle” because he had begun to feel that he was engaged in killing his Self, as his wealth and loss of being genuine as a person of his own definition.

There's room at the top they are telling you still
But first you must learn how to smile as you kill
If you want to be like the folks on the hill

His recurring ironic repetition of the chorus of, “A working class hero is something to be” is capped off by the last line of the song. It is a sarcastically-toned invitation made to anyone foolish enough to still want to be a hero given his implied description of his own life, and the demands of society, and of his own negative evaluation of his standing as a hero:

“If you want to be a hero well just follow me.”

Lennon had a socio-economic upbringing which can be seen as neither working class, nor middle class. As he says in another song (Nowhere Man), “he’s a real nowhere man, living in a nowhere land, for nobody.” Alienation and failure as a human being, within the context of both social class levels are the picture presented in “Working Class Hero.” Lennon’s story was of a child abandoned by his father, and discarded by his mother, who were both of working class background. He grew up as the “adopted” child of a lower middle class family unit. His sense of class alienation was well-rounded, being neither here, nor there, in socio-economic terms. But he seemed to see himself as being of a working class background.

The issues raised in “Working Class Hero can be seen to apply to both someone of a working class, and a middle class background. “Working Class Hero” sets the stage in this paper for a discussion of the degree to which a therapeutic analysis of someone with a Co-occurring
Disorder needs to address socio economic issues of the specific person. Before proceeding to examination of that issue, the degree to which Alfred Adler and the original conceptions of Adlerian Individual Psychology, look at the interaction of the person, social environment, addiction, and the achievement of personal balance and happiness will receive attention.

**Inner Self & the Threat of Knowing Who I am**

Adler speaks of the striving for superiority; Maslow of the fear of success, and Freud of the “wrecked by success syndrome.” All of these have some relation to a person’s evasion of inner self while at the same time trying to take action to realize inner self. The day-to-day functioning as a wage slave, the following of another’s orders just because they are in positions of authority, the blind acceptance of laws, and unquestioning faith and obedience to religious dogma are signs of adaptation to the what can be called the “Threat of Knowing.”

These adaptations can take the form of applying an external and internal ‘masking of Self” to others and your own consciousness. There can be many masks, fitted on and into, to fit a situation or encounter with someone or something. This masking is done by all people to some degree, but can be exaggerated to the point of extreme dysfunction. For the addict, the substance, and/or compulsive emotional and physical behavior can become almost a constant, rather than a momentary social adaptation. The mask can be a response to a perceived Threat of Knowing which the person has concluded they have discovered about someone, and often about themselves. The substance dulls cognitive processing, or diverts it into something else as a safety mechanism. It becomes a tool of self-care which seems permanently attached to the person. The addicted individual becomes ruled by the object, trapped in a structure they have constructed for protection. The protective element becomes destructive.
Applying a social class filter to “masking,” some thirty years of working with the disadvantaged, has shown that persons who have grown up in a cycle of welfare learn how they must act and speak in order to avoid the slings and arrows of social workers, welfare administrators, Child Protection personnel, and public housing management. These pressures of being part of the low income sector of society provide additional incentives to hide their Self so often that it becomes much easier to pursue and accept the loss of perception and feelings which result from substance abuse.

Adopting a “mask” or allowing a specific persona to emerge to fit a specific social situation, or to detach from an uncomfortable feeling, can easily lead to the loss of a sense of self that assumes involuntary aspects. The developing addict may choose to take substances to avoid facing, or considering, who they might be, or who they are. The pursuit of, and consumption of substances, can easily lead to a structural (in the sense of daily pre-occupation mentally, and primarily taking action in pursuit of maintaining supply, which results in a significant loss of sense of self, other than that resulting from taking the substance.

Pain and Weariness: Weltschmerz and Addiction

"Weltschmerz” is a German word with many nuances but essentially meaning world-pain or world-weariness:

- mental depression or apathy caused by comparison of the actual state of the world with an ideal state
- a mood of sentimental sadness

(World-weariness, 2011)
- sorrow that one feels and accepts as one's necessary portion in life; sentimental pessimism.
• sadness or melancholy at the evils of the world; world-weariness

(World-weariness, 2012)

The following are key words from the above definitions: depression, apathy, melancholy, sentimental sadness, romantic pessimism and sorrow. But in a consideration of addiction and emotional imbalance, a primary phrasal consideration has to be the simple Germanic roots of the word, Weltschmerz: welt (world); schmerz (weariness).

An addict may be considered truly to be weary of the world. In early stages of use, the chosen drug allows the addict to have a limited escape from the world around them, and from their inner world. They can feel different, they can feel not part of the world prior to being intoxicated or high, to leave the Self they normally inhabit, to become a different person in many ways, behaving differently in a contextual world outside of their daily experience.

When the chemical dream dissolves, the person who becomes the truly addicted being yearns for a return to the otherness, the ingestion of the magic potion, and its provision of the ability to escape the world around, and inside of their Self, becomes a yearning obsession. For at least a time, taking more will allow them to escape a mental, emotional weariness with the moments of being that are so unsatisfying. The drug(s) of choice may allow them to escape even a physical weariness (speed; cocaine). But eventually, especially after the deep, dark descent into daily, even hourly, need to escape, users will pass out, come down (hard). They may have left the original weltschemrz behind in their conscious times, but with greater frequency the joys of addiction become an extension of a new world weariness.

They may have forgotten the disappointments of the world of personal evil which they have fled, but are now faced with attaining at least some level of satisfaction in their chosen world based on using things which are outside of their own physical, mental, and spiritual
capabilities. Some may have allowed the overwhelming entry into true addiction to escape into a world free of sorrow, sentimentalism, and failed romanticism. Their world is limited to moments of questing for the substance, and entering into a nothingness of unreal feelings, and limited perceptions of reality. They become inhabitants of a different world of being drunk, high, stoned. It may proceed to its moments of weariness, but at least it is seemingly under their control to take what they need to regain entry to a redefined sense of Self and Otherness.

But although the escape into addiction involves creating a separation from people and circumstances, its roots of experiential dissatisfaction with the life given to them, also concerns the perceived emotional pains and regrets that concern what they were not given. The losses they feels results in the need to leave, but also to grab onto another world, even if it is primarily based on consumption of a stimulation which lies outside of themselves. They become dis-attached from one world, and attached, even if a shallow, unidimensional way, with another set of behavioral and emotional directive imperatives. This process concerns a dominant need of human beings for attachments in order to learn, feel safe, achieve comforting emotional supports, and discover who they are.

What is the connection between attachment, and addiction? Especially during the last fifteen years, there has been much academic and research work devoted to the investigation of this relationship. The results of the work agree that poor patterns of attachment during childhood results in addictive expression during adolescence and young adulthood (Burkett & Young, 2012; De Rick, Vanheule, & Verbaeghe, 2009; Flores, 2001; Hoffman & Kooyman, 1996; Thornley & Lyvers, 2006).

The Burkett and Young study (2012) is particularly unique in its combination of social attachment, and addiction, in drawing in behavioral, anatomical, and pharmacological parallels.
This kind of boundary-crossing examination seems to have possibilities for unique considerations in addressing clients with co-occurring disorders.

It is difficult to find studies which compare the quality of attachment between low income and higher income families. However a recent meta-analysis of attachment patterns in low income families (Burkett & Young, 2012) draws a conclusion which seems to validate a hypothesis that negative attachment patterns within low income families may be a serious problem with implications for the development of addiction processes in persons emerging from low income families:

Overall, these meta-analyses show the destructive impact of maltreatment for attachment security as well as disorganization, but the accumulation of socioeconomic risks appears to have a similar impact on attachment disorganization. (Burkett & Yong, abstract, p. 1)

There can be no denying that socio-economic pressures are heightened within low income families. This in itself indicates that less viable environments for healthy attachment occurs in the bottom strata of socio-economic households. Especially within Afro-American households, there is little participation by fathers of children, with some studies reporting that 54% of children in black families are without fathers (Washington Times, 2012). The figures for Hispanic children (41%), and for white children (32%) are also very high. The National Poverty Centre of the University of Michigan, using 2010 U.S. Census statistics, states that almost one third of single parent families live below the poverty line (National Poverty Center, 2015).

All of the preceding is presented to show that less than ideal patterns of attachment are very likely to be present in low income families. It may well be, that saying that addiction among children growing up in poverty is a risky proposition, is possibly an understatement. The
heightened prospects of unhealthy attachment within poverty-laded households certainly aids in persons developing an emotional weariness about the world they inhabit.

After a number of years of being in active addiction, “weltschemrz,” again emerges as a personal conceptual of Self which may have originally played a significant role in deciding to immerse oneself in the recurrent emotional and behavioral demands of substance abuse. A desire to halt usage, and the first glimmerings of the need to change their lives will be accompanied by a sense of being weary with the repetition. The obsession with getting, with consuming, with keeping psychic track of how much is left, where can I get more, the need to have stock on hand, the need to consume more to get even an approximation of previous highs and ecstatic moments becomes in a sense boring, as well as wearisome. Of course extreme negativity, even if appreciated dimly through the drunken, drugged haze, of consequences related to effects on family, loss of jobs, possible and experienced jail, works to create the need, not to use, but to hopefully find a way to stop using. In early days, addicts may also hope that they can learn how to use less, or only once in a while.

With recovery circles, and establishments, users in early, and even sometimes in later stages of recovery, talk about “boredom” as a trigger for wanting to re-enter active addiction. This expression of boredom provides a hint of providing directions for addiction counseling, and related emotional imbalances, both in terms of causes of the characterological condition, and helping a client to adopt alternate behaviors and life goals.

The addiction may have begun on the basis of the need to be free from a dualistic world weariness of both the outer and the inner worlds of being. Perhaps there is more of the desire to escape the outer world due to the lack of possessions and freedom from anxieties to attain necessities of life with the lower income addict. The middle income addict may have had more
“things,” but the destructive impact of the pressure to have more, and quest for further wealth, power and prestige can work to destroy the esteem of the more affluent addicts, including addicts coming from what may be called upper class circumstances. But what of the drives towards the escape of addiction which can be said to be emotional, and family in derivation.

In this sphere of the cosmology of addiction, each class has much in common. Table Two presents a catalogue of possibilities of emotional discomforts, clinical possibilities, and behavioral responses from which all distressed human beings, regardless of socio-economic class draw from. In itself it is not meant to be exhaustive but to provide at least a partial mapping of how all addicts can be seen as sharing many elements despite their socio-economic backgrounds. Primary influences of the generalized worlds of being within socio-economic classes will make persons more likely to contain specific elements of each classification, but also of course allowing for individual differences to make interventions.

Based on some thirty-five years of working with, and working for, low income persons to provide personal and socially beneficial services, Table 2 has been constructed to provide a basis to further the discussion of aspects of the world occupied socially and emotionally by low income persons. This will be useful in laying the groundwork even further to assess the specific relationships of living within the low income universe within a Co-occurring Disorder framework of addiction and mental disorders.
<table>
<thead>
<tr>
<th>Psyche/Self Complaints</th>
<th>Disorder Manifestations</th>
<th>Behavioral Expressions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diminished self-esteem</td>
<td>Depression-fear-avoidance- self blame</td>
<td>Forgetting</td>
</tr>
<tr>
<td>Abandonment</td>
<td>Anxiety- paranoia-freezing of self</td>
<td>Extreme anger/fighting</td>
</tr>
<tr>
<td>Lack of love</td>
<td>Addictions- anxiety &amp; fear</td>
<td>Paralyzing Fear</td>
</tr>
<tr>
<td>Shame</td>
<td>Delusions-paranoia- fear &amp; flight</td>
<td>Silence</td>
</tr>
<tr>
<td>Abuse</td>
<td>Obsession – paranoia – fear of change</td>
<td>Escape</td>
</tr>
<tr>
<td>Meaninglessness</td>
<td>Fear of change – guilt - anxiety</td>
<td>Extreme Distrust</td>
</tr>
<tr>
<td>Loneliness</td>
<td>Extremes of stability/instability</td>
<td>Debilitating Curiosity</td>
</tr>
<tr>
<td>Anxiety/nervousness</td>
<td>Disassociation of self</td>
<td>Isolation</td>
</tr>
<tr>
<td>Fear of failure</td>
<td>Loss of self</td>
<td>Hallucinations</td>
</tr>
<tr>
<td>Fear of success</td>
<td>Rejection of self</td>
<td>Repetition</td>
</tr>
<tr>
<td>Lack of affect</td>
<td>Over and under-eating</td>
<td>Avoidance</td>
</tr>
<tr>
<td>Extreme, extended excitation</td>
<td>Unacceptable conduct – school, family &amp; society</td>
<td>Extended Elation</td>
</tr>
<tr>
<td>Self-hate</td>
<td>Sexual imbalances –violence; age inappropriateness</td>
<td>Obsessing</td>
</tr>
<tr>
<td>Hatred of others</td>
<td>God Complex</td>
<td>Extreme Happiness</td>
</tr>
<tr>
<td>Guilt</td>
<td>Border line personality</td>
<td>Frequent love</td>
</tr>
<tr>
<td>Over-confidence</td>
<td>Psychopathic behavior</td>
<td>Immobility/stillness</td>
</tr>
<tr>
<td>Lack of confidence</td>
<td></td>
<td>Unsettledness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shaking/trembling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Insomnia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Excessive sleep</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Constant vivid dreaming/ Nightmares</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fits of yelling</td>
</tr>
</tbody>
</table>

Source: created by R Kellestine, 2014
All addicts can be said to share the key elements of this reformulated reality. Both the lower class addict and the middle class can share reasons for escape from their previous “welt” situated in their lack of possessing the physical things of comfort and prosperity, and the tensions of earning in order to consume. For the lower income addict it is closer to survival rather than want. And in some ways, the less affluent addict has a shorter distance to fall. But because their hold on previous things which measure wealth in our consumer society was less obvious, and more tenuous, when they lose it all, it may not seem as much of a loss as for the middle income addict. For someone coming from a higher income circumstance, it can be a different situation on the level of things, possession, prestige, longing for what is lost. But experience with 12-Step groups, allows for an understanding of the extent also of a shared emotional and psychic background of physical, emotional, and spiritual descent among all addicts.

Anyone who has spent much time with addicts/alcoholics, and/or participants in 12-Step programs, has encountered many times the following laments: “I lost track of who I was.” or, “I was doing things that were not me” or, “I decided I had to stop drinking/using, to find out who I was,” or, “I need to find out who I am.”

When someone is deep in their addictive throes, sometimes family, friends, and others may think that the behavior of addicts is totally selfish or grounded most deeply in satisfying the need of the Ego for self-pleasure, or constantly directed by the meeting of only personalist needs. The opposite is true. They have almost always lost their attachment to their real inner Self. Depending upon their childhoods, especially if it was one of abuse, trauma, and abandonment, they may never have had any real sense of Self.

The ties between addiction and trauma, (especially during childhood), have been much examined in recent years (Norman, Tate, Anderson, & Brown, 2007; Covington, 2008; Cuomo,
Gussantomio, Mancini, Roy, & Sharshaponne, 2008; Enoch, Goldman, Hodgkinson, Qiaoping, Pei-Hong, & Roy, 2010; Ford & Russo, 2006; Jacobsen, Kiston, & Southwick, 2001; Mate, 2011). Sexual, physical, and emotional experiences, and resultant perceptions of being traumatized which arise, are also often related to abandonment, which is also now considered to be a form of emotional trauma.

The reaction of a child to traumatic experiences can often result in the person drawing inward, loss of trust, expectation of needs not being met, building emotional walls around themselves, in relation to others, and in relation to themselves. Movement in adolescence to addictive behaviors is not really an unusual response. Substances provide a sense of relief, and an escape. They also allow someone with a fragile sense of Self, to adopt behaviors which allow them to be a part of others, to feel joined with their peers, to gain entry to a experiential universe where consideration of their perceived losses can be forgotten, even if only for the length of the drunk, and the high.

Development of Self as an adult is mutated into the continuation of relying upon externals for pleasure, and for escape. Combing the substances with already existing feelings of emotional pains based on sexual, physical, and emotional traumas serves to make the growth of emotional health disorders based on low self-esteem, anxiety, deep sadness, and isolation from core human contact.

In this consideration of self, and its relation to addiction, impacts based on socio-economic background have not been examined thus far. Regardless of class, the experiential circumstances outlined, and their emotional/physic outcomes are similar.

From previous material based on descriptions of the outer and inner worlds of the low income experience, it is not unusual to have issues relating to unmet needs, low self-esteem,
depression, being different, lack of respect, anxiety, constant change, unhealthy sameness of the borders of life, abandonment by parents (or lack of presence of parents) to be strong aspect of growing up. However, compared to children in middle class circumstances, it can be said that the availability of food, housing, new clothing, access to entertainment sources, lessons and training designed to enrich childhood experience and skill development, are usually missing to act as counterbalances for the more challenging and stressful pressures.

As a final section to this discussion socio-economic factors and the emotional/psychic world of the addict, the following table outlines, (only a little tongue-in-cheek), the ways in which being low income and addicted can produce “advantages” for the addict. A similar list could be constructed for the middle class, and the upper class addict. It is meant to provide an example of how socio-economic class background can be used to look at addiction, and emotional/mental behaviors through a multi-faceted lens for descriptive, diagnostic, and treatment purposes when working with clients with co-occurring disorders.
Table 3
Advantages of being low income, and addicted.

<table>
<thead>
<tr>
<th>Emotive/behavioral Statement</th>
<th>“Advantages to living the addicted life”</th>
</tr>
</thead>
<tbody>
<tr>
<td>It’s easier to do illegal things”</td>
<td>Drinking and taking drugs is costly. Sometimes/often things must be done to get the money needed to buy what you must have.</td>
</tr>
<tr>
<td>If you pass out on the street, people don’t have lower opinions of you than those to which you are accustomed</td>
<td>These things happen, especially if you are an alcoholic. At least you don’t have to worry about added disdain.</td>
</tr>
<tr>
<td>You know more about doing illegal things</td>
<td>This helps in getting the money you need to buy what you need.</td>
</tr>
<tr>
<td>If you talk weird, people will think it’s a natural condition</td>
<td>Jabbering incoherently, either from having the substances you need/want, or from consequences of not having, won’t cause you to lose respect, as you likely already don’t have much.</td>
</tr>
<tr>
<td>You are not choosy about what you get or are given</td>
<td>With low expectations, you are more easily satisfied. And it can help in pleasing people who get satisfaction from giving you something.</td>
</tr>
<tr>
<td>Being homeless is not that big of a deal</td>
<td>Since some shelters can be unhealthy, places, being on the street (at least not in winter) can be preferred. But being homeless does qualify you for some benefits you won’t get if you have a full-time job at minimum wage (which still might mean you are homeless).</td>
</tr>
<tr>
<td>You are already used to being hungry</td>
<td>Not having food is easier to endure.</td>
</tr>
<tr>
<td>You are used to not having basic needs met</td>
<td>Not having basic needs met is better, so long as your basic need for your substance of choice is met.</td>
</tr>
<tr>
<td>Being a failure is not necessarily a big thing</td>
<td>After a time, not being “successful” becomes the norm, if still somewhat uncomfortable emotionally.</td>
</tr>
<tr>
<td>You can project “tough” even when you are soft</td>
<td>Sometimes appearing tougher than you are can be a useful skill on the street. And sometimes intimidation applied at the right time, can get what you need, to get what you need.</td>
</tr>
<tr>
<td>Being considered a failure matches your own self-assessment</td>
<td>It isn’t that big a deal, if someone says you are a failure, if you have already come to that conclusion. “Tell me about it.”</td>
</tr>
<tr>
<td>You see more than you are forced to tell</td>
<td>Sometimes talking too much just gets you into trouble. And if people don’t know what you know, you may be able to gain some advantage. And being observant is free, and sometimes gives one an advantage.</td>
</tr>
</tbody>
</table>

Source: created by R. Kellestine, 2013

Social and economic factors shape risk behavior and the health of drug users. They affect health indirectly by shaping individual drug-use behavior; they affect health directly by affecting
the availability of resources, access to social welfare systems, marginalization, and compliance with medication. Minority groups experience a disproportionately high level of the social factors that adversely affect health, factors that contribute to disparities in health among drug users.

**Adlerian Techniques and Co-occurring Clients**

The final section of this paper addresses Adlerian techniques/methods/models which can be useful when dealing with COD clients. Additionally comments on potential impacts in delivering treatment to clients with an upbringing, and sustained adult experience within the lower socio-economic class will be posed.

Adlerian practice has been the subject of much research suitable for confirmation as evidence-based research related to Co-occurring Disorders. This includes research which has been done relating to bulimia and Adlerian practice (Axtel, 1991; Fassino, et al., 2006), working with criminal offenders (Daugherty, Murphy, & Paugh, 2001) with high-risk youth (Sapp, 2006), drug abuse (Steffenhagen, 1974), working with alcoholics (Carroll, 1999; Prinz, 1997), and relapse prevention and depression (Carlson, Engler-Carlson, & Waller, 2006). Specific Adlerian techniques researched in a COD context have been Early Childhood Memories, Life Tasks, Encouragement & Discouragement, Life Styles, and Birth Order. The following research studies illustrate the above techniques: early childhood memories and alcoholics (Hafner, Fakouri, & Labrenz, 1982), societal discouragement, life tasks and working with gay alcoholics (Lingle, & Suprina 2008), Adlerian life-style themes and student alcohol behavior (Lewis & Osborn, 2004), Adlerian Lifestyle analysis and ADHD (Kern et al., 1999), Adlerian Lifestyle and eating disorders (Belangee, Kern, & Sherman, 2003), Birth order and binge drinking (Laird & Shelton, 2006).
But firstly this section will explore the original comments of Adler that relate to substance abuse, and the overall context of Adler’s view of Individual Psychology in which these specific comments can be placed. It will also place Adlerian techniques and comments on neurosis and related symptoms in the context of co-occurring disorders.

**Adler on the Etiology, and Adult Outcomes of Addiction**

Adlerian theoretical foundations and practice is apparent in its name, Individual Psychology. As he wrote in 1937 in one of his last articles before his death (Ansbacher & Ansbacher, 1979, p. 24), “Everyone subordinates all experiences and problems to his own conception. This conception is usually a tacit assumption and as such unknown to the person. Yet he lives and dies for the inferences he draws from such a conception.”

Assumptions are usually based on some level of personal experiential evidence. They tend not to be purely fantastic, even if they can often be wrong-headed. And thought processes and more importantly in a psychological and therapeutic context, conclusions, are not usually a straight-line process. A and B can result in E or even S, as the next point in the psychic, personal alphabet. One person, even in the same family, can observe and live within the same occurrence and moment, and draw a conclusion unique to themselves. This makes developing a set of etiological principles with direct application to an individual with seeming similar symptoms to another person, often problematic. As Viktor Frankl (a late contemporary of Adler in Vienna) wrote, “Between stimulus and response, there is a space. In that space, is our power to choose our response,” (Pattakos, 2008, p.viii). This space is the intervention of the individual.

Adler’s use of the phrase, “he lives and dies,” (Ansbacher & Ansbacher, 1979, p. 24), is of direct application to the mode of existence of the substance abuse addict. Someone develops into being an addict by choosing to repeatedly use until the drug takes away choice with the in-
built physical need which the brain raises to a point of taking over all other aspects of life. The threat of death for a substance abuse addict (even an alcoholic) is always present, whether as a result of the effect of the drug(s) of choice on the addict’s body, or the result of the actions while drunk, or the actions engaged in to get possession of the drugs.

It relates to a person’s physical, emotional, and experiential past and present to consider a person as a whole. In contrast to the present psychotherapeutic zeitgeist as represented by the DSM, symptoms should not define, or guide the interventions of the therapist (or of the recovery by the client).

Adler wrote, “We look upon symptoms as creations, as works of art.” (Ansbacher & Ansbacher, 1964, p. 330). Symptoms may have some roots in response to a childhood illness, or congenital expression of a person. But they do not define who a person is, or what they must be. They can however provide information to assist a person in the development of a sense of Self and an individually defined personal destiny. The symptom is a creation of the person to express an inner developed aspect of character which shapes the way the person views themselves, and the world(s) around them. The value of a symptom is as an indicator of past and present inner processing, which results in the chosen outer expression of the conduct of a person as they exercise their private logic to fulfil personal goals. A symptom has a deeper significance for both the therapist and client which must become apparent to both, for therapy to have a chance of being successful. But the surface elements of a meaningful based of interpretation for a symptom must get past the surface camouflage of a behavior or feeling: “The symptoms are a big heap of rubbish on which the patient builds in order to hide himself,” (Ansbacher & Ansbacher, 1979, p. 198). To get to the Self of a client, both therapeutic parties must dig deeper.
Individual Psychology, as developed by Adler, is a “depth” psychology which combines all aspects of a person in order to develop a mutual understanding of how a person has arrived at the point in their lives which has resulted in an engagement in psychotherapy, and sometimes, to address an addiction. Addiction is a major symptom, but one which can be traced back to the inner symptomatic processes of a person’s internalization of their experience of life.

Adler is almost dismissive of therapists who feel that have explored the meaning of the actions of a client sufficiently to produce an intervention with the client, yet can’t understand why their great work has not produced the desired “eureka” moment of understanding for the client (Ansbacher & Ansbacher, 1979, p.335). It is likely that he would suspect a too easily achieved moment of emotional cognitive breakthrough. Penetrating to inner areas of meaning after a session or two may have been possible for Alfred Adler, but applied to a co-occurring client, especially when in the early stages of sobriety from a substance addiction, is much more problematic for more mortal therapists, and patients. A listing of symptoms, even based on an application of information on the surface elements of a family structure, or elucidation of early childhood memories, may be a useful shallow ditch, but not the digging of a deep psychological excavation.

One also gets the impression that when Adler talks of “depth” he is not referring so much to a quantitative measure, as to a qualitative process of weighing information, both factual, and coming from the words of a client (which may or may not be factual in the sense of displaying the objective reality possible of being seen by someone who is not the client). For an Adlerian something like an Early Childhood Recollection (ER), is not of importance as the accurate depiction of an historical event, but of a depiction of the immediate emotional response of the client within the general and specific moment of their current personal (i.e. within their
conscious and unconscious emotional) experience of their life. It is material to be explored to generate meaningful understandings within the client to make the basis of their life clearer. This understanding can then hopefully provide the basis for someone to affect a change in their sense of being, and personal goals.

In order to gain an interpretive insight into working with the volatile emotive environment of a co-occurring substance abuse addict, let us consider the validity of an ER further. Two modern Adlerians, partially in an attempt to make the use of the classical Adlerian technique more palatable to the contemporary quest for “evidence-based practice,” have a lengthy section on the reliability and validity of Early Recollections (DiPietro & Mosak, 2006, pp. 255-66). They declare that, “Reliability can be examined by determining if an ER solicited on two different occasions generated the same information, provided that no therapeutic intervention has occurred [emphasis original],” (Mosak & DiPietro, 2006, p. 256). This statement may seem obvious in its meaning, and “validity.” But perhaps not so obvious if looked at in more depth (sic). This is being done to lay some groundwork for more to come on the nature of looking at co-occurring clients in an integrative manner, and in the application of an Adlerian approach as a therapy of “individual” psychology. And to comment further on related topics addressed somewhat in the chapter on “Substance Abuse and Addiction.”

Let’s look more closely at the applied meaning of the language used to define validity. Firstly, “solicited on two different occasions.” Presumably on each occasion, both the therapist and the client would be the same. Would their moods be the same? Especially the mood, or emotional set of the client? Not likely for the client. Would it be on the same day of the week, at the same time? What would have happened in the life of the client in the interim which may impact the story’s telling, and in the reaction of the client to the story? And to the questioning of
the therapist to explore the story, even if the words used by the client were the same. Secondly, to prove relevance, Mosak and DiPietro require “the same information,” (Mosak & DiPietro, 2006, p. 256). The first comparative sameness could be using the same words. Or the client speaking about the same occurrence. Or the client describing it the same way. Or the interaction of the client and the therapist being done with the same questions, or even slightly different questions, what would be the “same” information. Then, more importantly, the degree of similarity between the resultant analytic information arising from the therapeutic questioning and response process. How much difference, in which components, would result in the ER being considered to be “invalid”?

And thirdly, the over-riding codicil, of “provided that no therapeutic intervention has occurred (Mosak & DiPietro, 2006, p. 256). There are two important issues of meaning in this statement. What is “therapeutic intervention,” and how do you define “occurred.”? Does “therapeutic intervention” refer to a formal meeting or more informal conversation between the therapist and client? Does it refer to the result of a reflection by either party about the first telling, and/or, the first analysis from the point of view of the therapist or the client? How about if either of the two involved parties had a dream which related to the ER and its possible implications, and such dream has resulted in the parties feeling different about the specific ER event, or the implications of the feelings attached to the event?

My conclusion from the preceding analysis of the assessment criteria of validity for ER’s presented by Mosak and DiPietro is that it is not of great use in making a judgment on the validity of the ER. But more important than the validity (whatever that is) of the specific ER, is making a determination of the utility of the therapeutic encounter which occurred during the relating and examination of the ER initially. Even if the second brush with the general story of
the ER was not exactly the same that does not negate the achievement of positive therapeutic movement during the initial encounter.

Focusing too excessively on the validity of the thing within itself, rather than the overall value of forward movement within the therapeutic treatment, does not seem very useful. Within the application of a co-occurring therapeutic approach, Adlerian therapy as an individual therapy would seem best applied in reference to each session, as well as in application to each client. In the early stages of recovery from substance abuse, a client can be erratic as their body, and mind, and conception of self are all fluid and under re-construction. And attempting to move ahead with a co-occurring client prior to sobriety only makes a complex situation more difficult.

Individual Psychology also expands its examination of the totality of experience of someone to the placement of the individual in relation (or lack of relation) to the people surrounding the person, or the society in which the person exists. The approach of Individual Psychology is that the life of a person does not take place in isolation from a person’s individual thoughts, feelings, and actions. In 1933 Adler wrote, “In the entire history of mankind you will find no isolated individuals” (Ansbacher & Ansbacher, 1979, p.37). Before adding considerations of social class to this question of what is appropriate when, and how, in using a co-occurring therapeutic approach lets continue more specifically with an examination of how Alfred Adler characterized alcoholics and substance abuse addicts within the context of Individual Psychology. The etiology of addiction for Adler is primarily situated in the reaction of a person to how they see their immediate others (family), and then applied as an adult, to others and other structures of society, to meet their needs.

Although there are relatively few instances where Adler referred directly with his clinical writings on substance abuse he was consistent in the tenor of his comments. The expression of
social interest within a person who becomes an addict is myopic, resulting in a “pampered”
child. His conception begins with a child who can be considered to have developed a pampered
242). But this needs to be nuanced by the understanding that the pampered child need not have
actually been pampered: “The pampered style of life as a living phenomenon is the creation of
the child, though its formation is frequently aided by others, of course. Consequently this style
of life can be found occasionally in cases where we cannot speak with any justification of
pampering, but where on the contrary, we find neglect, (Ansbacher & Ansbacher, 1964, p. 242).
In this characterization Adler directly provides inferred input relating to a consideration which
relates to a central question of this paper, the impact of social class on character development of
the substance abuse addict.

Neglect, as mentioned here by Adler, is not seen as a deterrent to the development of a
pampered life-style, and an expectation of having needs met by others, of someone feeling they
are entitled to be served. Applying a specific socio-economic lens to this issue, a pampered child
can be seen as emerging from a childhood which in dollar terms may have been one of scarcity.
Especially in the context of the presence of a developed social welfare system of minimal but
basic income, and a fairly widespread system of public housing, the childhood background of a
low income addict in a multi-generational welfare milieu may be well suited to developing a
pampered life-style (see Luthar, 1999; Payne, 2001 for discussion of the impact of multi-
genерational life within the social assistance universe).

A pampered orientation is not conducive to the development of social feeling in that
expectation of having needs met becomes a right, rather than something which requires being
worked for, in co-operation with others: “The resulting persistent deficiencies of life style lead
to failure because the problems of life are of a social nature (in society, occupation, love) and inexorably demand social interest,” (Ansbacher & Ansbacher, 1979, p. 52).

This statement of principle leads Adler to present a list of persons whose mistaken belief, largely devoid of social feeling, results in a failure to respond to the need for effort to overcome problems faced, becoming “difficult children, neurotics, psychotics, suicides, criminals, prostitutes, alcoholics, sexual perverts etc.,” (Ansbacher & Ansbacher, 1979, p. 53). The failure to develop a supportive social feeling, leading to the difficulty to effectively deal with life’s problems results in feelings of inferiority. But at the same time the person with inferiority feeling also seeks to cover up their inadequacy by seeking “to cover up the inferiority feeling with a fictive superiority complex which is no more than the exploitation of the social interest of others.” Addressing directly the addict, Adler sees the addicted assuming a cloak of indulgence by seeking a deeply individual self-pleasure to cover up a lack of self-confidence (Ansbacher & Ansbacher, 1979, p. 56).

Adler uses the term intelligence in positioning this inability to deals with the difficulties of living. He sees the pampered child, and the resulting adult character, as exhibiting a “feeble-mindedness (Ansbacher & Ansbacher, 1979, p. 45). He doesn’t mean a lack of innate or genetic ability to find out and know, but a weakness of inner will based on a feeling of inferiority, and a lack of gemeinschaftgefühl, social interest and feeling. The alcoholic (and presumably the substance abuse addict) is intelligent, but a weakness of mind leads to a mistaken fictional goal. For the alcoholic, “his action is intelligent in regard to the goal, which is to surmount difficulties in an easy, personal manner, not to solve them in the sense of the community. Anyone who agreed with this goal would act like the alcoholic” (Ansbacher & Ansbacher, 1979, p. 46).
Those who move on the “useless side of life” (including alcoholics, and suicides), in dealing with a misguided personal striving for power will “be lacking the degree of a developed social interest, and the courage which are required for the useful solutions to problems of life” (Ansbacher & Ansbacher, 1979, p. 48). Adler presents a specific characterization of alcoholics and addicts in this regard, “Alcoholics, morphine addicts etc. have brought their detouring before the difficulties of life into an intelligent system, but only by eliminating courage and reason which they render ineffective through stupor.” (Ansbacher & Ansbacher, 1979, pp. 48-49).

Many of the preceding quotes come from a paper written by Adler in 1928, “Brief Comments on Reason, Intelligence, and Feeble-Mindedness.” However, similar, and related comments are found throughout his last years of life in the 1930’s, (he died in 1937), including: “The Structure of Neurosis, (1932); “The Technique of Treatment, (1932); “Advantages and Disadvantages of the Inferiority Feeling”, (1933); “Typology of Meeting Life Problems, (1935); “The Death Problem in Neurosis,” (1936).

In many of the preceding papers, Adler groups substance abusers with suicides. All proceed from a similar position of a pampered upbringing (at least in their own minds), leading to heightened inferiority, lack of social interest, and a resultant inability to easily solve life’s problems, and to borrow a phrase prevalent in the literature and life of 12-Step programs, “accepting life on life’s terms,” (Alcoholics Anonymous, 4th Edition, 2001, p. 417).

A modern classic of French literature is Death on the Installment Plan by Louis-Ferdinand Celine (1938). This metaphor for the low destruction of life, self, and being has been taken up as a description of the result, and the intent, of persons who have been taken up many times by persons referring to substance use addiction. This theme has been adopted many times (O’Donnell & Haner, 1994; Fanaka, 1972).
As well as including alcoholism, addiction and suicide in his lists of behavior by persons without sufficient social interest, low self-esteem, and a resultant inability to solve problems of life, Alfred Adler made the connection explicitly: “Suicide, and disguised forms of it, such as insanity and addiction, are more or less active reactions against what the individual presumes to be barriers in the face of which he is no longer able to continue following the laws of life” (Ansbacher & Ansbacher, 1979, p. 241). Faced by a life situation in which the pampered individual is no longer having their needs met easily, and they feel that they are not equipped to find a positive solution themselves, the person embraces negativity and escape through addiction.

The “failure” covers up their inability to meet their needs without being given success by another by creating a “fictive superiority complex, which is no more than the exploitation of the social interest of others,” (Ansbacher & Ansbacher, 1979, p. 56). The addict covers up his inferiority complex both from himself and others by losing their self in an endless repetition of substance use. There may be a double purpose of generating or destroying both the expectation of self to achieve anything more than the next high, and hoping, and encouraging that others will do the same. If yourself, and others, have only one low expectation of achievement (i.e. getting drunk, and “high,” when that becomes your repeated action, people’s expectations are met, even if they are empty and disappointing. The addict alcoholic revels in a sense of pleasure through submergence of self, and lack of achievement, in the sense of the ways in which society measures positive results. All life becomes centered on fulfilling one single goal which benefits no one but themselves: “The addict secures of himself artificially feelings of pleasure of a self-seeking kind which is supposed to cover up his lack of self-confidence” (Ansbacher & Ansbacher, 1979, p. 56).
The use of the word, “artificially” needs comment to get a deeper understanding of the inner self of an addict deep in the throes of their personal obsession. Although the result of getting drunk or “stoned” may be artificial to someone who is not also an addict, for the addict it can seen instead as the supreme expression of reality. Their goal is to eliminate their ability to experience anything else because it may cause them to examine their own failings. What may be artificial to anyone else can represent the only reality that they wish to personally see. Adler characterizes the people without a significant development of Social Interest, “whose approach to reality shows, from early childhood through their entire lives, a more or less dominant or ‘ruling’ attitude,” (Ansbacher & Ansbacher, 1979, p. 68). He draws on a Shakespearian connection for the choice which was made, “It is as if they said with Richard III, ‘And therefore, since I cannot be a lover, I am determined to prove a villain.’” Their reaction to mistaken belief that they are incapable, is to make it a twisted positive. Suicides are proceeding from an attack on themselves, and their ability to cope with life, to a supreme act of self-destruction as a way to take control of a situation which is out of their control, and at the same time strike back against those who have not met their expectations of having their needs met. Their absorption by negativity, and a sense of failure, results in what Adler characterizes as a “lesser degree of activity”, which causes them to hurt themselves, and to “attack others indirectly,” (Ansbacher & Ansbacher, 1979, pp. 69-70). Suicide becomes the mistaken expression of a final individual proof of superiority; an act to achieve superiority which results in ultimate failure through death.

Individual Psychology may then be seen as an integrative approach to psychotherapy, and to the nature of the overall existence of a human being, within their family, their defined self, and their social self. It concerns the person, and the person in relation to other persons, and the structures of society. But how is the Adlerian approach also applicable to the provision of
treatment to persons with a substance use addiction, and at the same time, living life with the challenge of an extreme emotional and inner personal adaptation to their experience, or co-occurring disorder?

**A Co-occurring Treatment Approach using Adlerian & Existential Concepts**

Adler’s conception of an addict is developed on the basis of a person with low self-esteem, having developed the expectation of others meeting their needs, seeing them as a pampered person. The addict also tends to have a poor sense of social interest, both in relation to family members and friends, but also in relation to the society in which they live. The deterioration of the ability of addicts to take an approach of social interest also applies to their distorted sense of self.

A co-occurring therapist has the difficult task of working with a person whose inner self has become distorted by the physical and emotional impacts of sustained substance abuse, and by the re-construction and distortion of the actions and feelings of a person in extreme emotional imbalances which can be classified as a mental health disorder. It has been said in this paper, (and is at the root of most of Adlerian psychotherapeutic concepts), that the period of childhood development provides the foundation for the expression of the actions and emotions of people as they enter adolescence and adult-hood. The formation of beliefs about self and the world are a function of interaction between the inner processing of individuals, the family crucible, and social world in which human existence occurs.

Within the world of an addicted client with mental health disorders, the addiction is probably best seen as a response to the person’s view of themselves and the world. Being a substance abuse addict certainly produces strong impacts on the mental/emotional life of a person. This interaction becomes further complicated, especially in today’s psycho-
therapeutic/medical pre-dominance of the application of psycho-pharmaceutical solutions to DSM-defined mental health disorders. The prescribed drugs can result in physical and emotional behaviors which make it very difficult to determine how, and when, to treat the substance addiction, or to predict how sobriety can produce benefits to the addict. Despite the presumed intention to provide therapeutic relief and assistance, the prescribed drugs can result in behavioral and emotional affects, both during, and after a period of sobriety/abstinence by the substance abuse addict. When the impacts of socio-economic experiences are also considered, the development of a treatment plan is indeed challenging.

Although it has become accepted that providing integrated treatment for both aspects of a co-occurring client, certainly within the world of addiction recovery centres, therapeutic practice also recognizes that providing mental health treatment in any sustained manner to an addict in active addiction is indeed problematic (Arias & Kranzler, 2008; Ekleberg, 2008; Kavanagh & Connolly, 2009; Magura, 2008; Mueser & Gingerich, 2013; Wolitzky-Taylor, Craske, Operskalski, & Roy-byrne, 2011).

The core of the approach from a psychotherapeutic point of view can be seen to consist of the following principles:

1. The process of the therapist being able to work with the client to create healing and transformation begins with the therapist learning about & beginning to know the client.
2. Then there is interaction between the two persons to interpret current action and its motivations.
3. Then the use of knowledge is implemented to achieve the intention to change within the co-occurring client.
4. Then using knowledge and intention to produce changed action and feelings.
(Ronald Kellestine, unpublished manuscript, 2013)

Being able to effectively apply the above four conditions almost necessitates the co-occurring client have a significant period of sobriety of at least a few months (Brunette, Mueser, & Drake, 2004; Ekleberry, 2004; Gilmore, Griffen, Hunter, Sheehe, & Watkins, 2005; Nememzik & Straussner, 2007; SAMHSA, 2013).

In moving into co-occurring treatment of clients in the provision of cognitive/emotional treatment supports in the initial treatment phases of substance abuse rehabilitation, particular reference should be made to some specific differences between clients with low-income socio-economic background by paying special attention to the initial attitudinal mindset of a client concerning:

• effects on the likelihood of success – family history (always poor; nuclear poor; gradation of poor; welfare, working poor) ; orientation to challenge
• approach to the institutional provider of service- approach to authority, presence of a debilitative welfare mentality of entitlement and powerlessness, especially in a multi-generational context within an extended family constellation
• considering the socio-economic context can also affect the application of standard treatment modalities due to lower levels of literacy; unfamiliarity with the concept of doing “homework,” or the use of experiential modes involving role-playing, drama, art-therapy.

The following elements are presented as particular elements of assessment for possible, and already diagnosed co-occurring clients for which socio-economic analysis should be applied when developing treatment and diagnostic conclusions. These could be applied specifically to clients whose socio-economic background is known to be low income, or integrated as part of an assessment tool for clinicians: Race; Urban or rural resident; Age; Sex; Level of education;
literacy level; Married/single; Sexual Orientation; Voluntary or court-ordered; Instances of sexual/physical abuse; Psychological abuse (of special importance for lifetime low income). These factors need to be considered especially in the forms of a cross-tabulated analysis, as separate consideration may not in themselves be as indicative as when presented as inter-related factors looked at in combination with socio-economic inferences. In a sense this is suggesting a more nuanced approach to client assessment in general, and as an added context of clinical interaction and assessment for co-occurring clients, an already complex area of psychotherapeutic practice. Both for individual clinicians and for organizations, this inter-related balancing of conditions is useful, especially one’s engaged directly in providing direct services for substance abuse clients, both in-patient and out-patient related.

The emotional preparation, in general, for being an adult (whatever that may be) is far more limited for persons growing up low income. It is likely that expressions of mental/emotional health disorders may also contain aspects which are affected by the life experiences of a low income person. The following mental health disorder areas (among others) may contain specific elements in expression which should be examined by clinicians in order to effectively determine both causation and specific treatments (and inner-treatment modulations).

- Incessant low-grade to clinical depression
- Bi-polar and low income – what form does the mania take
- What are the differences between low income and other income categories of the often seemingly chaotic behaviours of schizophrenia

Two specific suggestions for considering the implications of a specific diagnosis in light of the social background of a client are as follows:
• Oppositional Defiance Disorder as forward movement, and a valid defense mechanism for low income children and adolescents

The O.D.D. diagnosis seems to have a strong possibility for considering the impacts of the social and economic background of client, co-occurring or not. Some clients, and especially low income clients, whether male or female, may have pressing reasons for having anger and distrust towards authority structure, and representatives of these structures.

• The value of functional delusion in order for low income persons to adapt to extreme financial and social pressures

Delusion, although of detriment to adapting most completely to a specific personal situation, can also produce some positive adaptations to someone who has perhaps given up to being able to change a situation but requires at least a period of release and relief from extreme anxieties which have been present for too long (as measured by the individual). Escaping from the situation, even if for only a limited time, may be beneficial. The time may also not be limited, but if not producing behavior of danger to themselves, or others, may not be completely a dysfunctional adaptation.

There is a related question of great importance in treating Co-occurring Disorders related to the socio-economic class of both the client, and of the clinician: how does the class background of the diagnostician impact the interpretation of low income symptomology? Without an understanding of the culture of being low income, a clinician or addiction counsellor may have less chance of understanding either the present or the past of a low income person, particularly in terms of:

• The quality of self-esteem as a result of constant lack of assured essential services
• A constant experiential mode of societal disdain, and “being less than”

• Possible physical impacts as a result of poor nutrition

• Quite likely abandonment traumas as a child from family break-up, family addiction, often being alone due to the lack of presence of a parent

• The lack of positive male role models

• Severely low personal expectations, either from outside and inside

At some level, the question of why is someone addicted, or depressed, on anxiety ridden, or isolated from others (and self), living apart from their surrounding world with a strong sense of delusion, becomes rather “why not,” rather than, “why.”

Psychiatrist Viktor Frankl, Holocaust survivor, and contemporary of Freud and Adler in Red Vienna, developed a form of psychotherapy (logo-therapy) based on the need for people to have a meaning in life in order to survive, and thrive. His experiences in the Auschwitz concentration camp led him to his view of human beings needing a point to their existence, beyond just basic physical needs. The conditions of Auschwitz resulted in a transformation of existence whereby persons were faced on an hourly basis with making a choice to die or to survive (Frankl, 1984). The life experienced prior to the concentration camp became a dream which caused the inmate to focus on living each ugly day at Auschwitz as the be-all of one’s present, and at the end of each day, to exclaim, “Well another day is over,” (Frankl, 1984, p. 47).

Within the 12-Step Program of Alcoholics Anonymous, and Narcotics Anonymous, the participants are often told, and say to newcomers, that the recovering addict needs to focus on “one day at a time.” This echoes Frankl’s comment.

In the low income world, the nature of existence and human striving, especially when considered in the context of the centres of modern capitalist society in North America and
Europe, becomes a matter of living the present, no matter how deprived or painful. Low income persons who see wealth around them constantly, who are barraged by media and internet images of persons achieving happiness and fulfilment through buying and consuming, through the definition of self-value being tied to what you have, rather than who you are, may have to adopt a consciousness similar to those who were at Auschwitz. See Frankl’s description of life in Auschwitz (Frankl, 1984, p. 19-117) wherein he relates persons daily deciding that ending their live was preferable to living.

I remember speaking with an adolescent in public housing in Canada, who lived in a high-rise apartment building, where drug-dealing was rampant. He said to me, “You know one day I just might decide to just jump from the roof, and fly like a bird.” He said it with a laugh, and a smile. A couple of weeks later there was just such a suicide. It wasn’t him, but it well could have been.

How does growing up within this constant situation of being apart from, of being incapable of full participation, of being told they are “less than,” or disdainfully excluded, manifest itself within the developmental perceptions of personal worth and being, within the emotional interpretation of the world for some (many, most?) low income persons? What kinds and levels of human deformation takes place, situationally, and of a more lasting nature, or even permanence, within (and without) our modern society?

What is the impact of drug addiction on this deformation? The initial stages of using drugs is provide escape, and an ease of discomfort, to allow the user to be more than what their inner definitions of being tell them they may be. As the substance abuse continues, any conscious sense of personal being disappears as the accumulated chemical impact on the body and brain become dominant, over any “therapeutic” impact of using the drug. An addict
becomes a deformed version of a human being, wherein the substance becomes their personal life-meaning. The human being of flesh and blood, becomes an irritating object whose primary reason for being a part of anything, is to get and consume the drug. The addict gives all existential meaning to something which is outside of their Self, rather than give meaning to something with a human existence that is meaningful to them (and others).

Within Auschwitz for many (or for most?) inmates of the camp, they themselves had no meaning, other than acting as an object to be consumed by processes of destruction and death of the camps. They provided a justification to the Nazi’s emotive need to create a better world by destroying those who were the root of evil, deforming the wished for ideal Aryan society, one free of Jews, gypsies, homosexuals, the physically and mental deformed, and communists, the active human expression of societal deformation. Low income persons (and substance abuse addicts) within the modern capitalist consuming society perform a similar function. They have a primary place as an example of what not to become, providing a demonic example of failure, to be an object of fear and threat, for persons who can fulfil their human being by buying and consuming. They also provide a way for other “caring, helping, empathetic,” people and professions to gain emotional satisfaction from working with the lower circles of existence to improve their lot, usually very marginally. These activities help to salve the conscience of many who can accumulate the products of a wealthy society, and feel that they are giving as they consume.

The drug addict becomes a variant of the concentration camp inmate, a variant of the dependent low income person, taking but not giving to the betterment of a society defined by things. If there is an advantage to being a low income addict (in addition to the sardonic benefits outlined in Table 3), it is that, in the evaluation of general society, that they are doing no more
than what is expected, even if they are despised for the limited nature of their achievement. A middle income addict also experiences disdain, but also disappointment. How could they do this to themselves? Their mother, father, siblings, wife, must be so embarrassed!

The impact of defining self-worth by consumption and purchase of things which is very prevalent in our modern society can be seen as encouraging addiction and escape. Although the focus of this paper is substance abuse, there are many forms of addiction resulting from the emphasis on encouraging persons to look outward for stimulation, and interaction (celebrity worship; reality television; social communication through digital means; isolation from nature). Much of this tends to transcend social class, and be a shared context of existence. The ability to engage in some escapes from the day-to-day environment through vacations, owning of country property, attending sporting events, eating meals in restaurants, as opposed to the quick consumption of fast food, access to training and educational pursuits, is however closely impacted by the income of a household.

The individual lives within their own psychic/soulful positioning, but also within their interactions with other people, and their society. Adler's Individual Psychology made some steps in this direction originally, but the modern interpretation and practice has not furthered the idea of Social interest/feeling much. And remember both Adler and Freud were social activists, albeit within a psycho-therapeutic context in Red Vienna and Germany until the Nazis, applying aspects of class analysis to psychotherapy. In today's society, the labelling of people with severe emotional and societal adaptations as being sick, or a danger to "normal" society who have to be controlled and monitored may be seen as the ruling orientation behind many diagnoses in the DSM, and the widespread application of psycho-pharmaceutical drugs.
The Adlerian approach especially puts human behavior, thought and feelings within a context of the necessity of persons to see themselves as part of, and to adopt an obligation to contribute to their social surroundings. Substance abuse addiction is perhaps the most selfish manner of maintaining existence for a human being, at the cost of losing contact with society, family and friends, and of course with their own being. The addition and need for substantive integration, of the mental health aspect, produces almost a new field of psychotherapeutic endeavor.

**Concluding Comments and Next Steps**

The co-occurring clinician must be aware of the substance, the emotional/mental result of the past life of the client, their related, and unrelated influences on the client, and, as proposed by this paper, the interaction of the socio-economic background of the client. Not a simple set of tasks, with very little likelihood of having a simple, repetitive set of answers. The Adlerian approach of Individual Psychology has the potential to assist the integration of the individual, and of social interaction, to address the many faceted aspects of Co-occurring Disorders.

It is the tendency of governmental and social services to build structures which apply a few solutions as possible in order to save money, to make the provision of solutions as simple as possible, to be able to be accomplished (or at least allow for the adoption of beliefs, and accepted assessments) in a short period of time. Therapeutic applications requiring time or much work on the part of the counselor/therapist, and even effort by the client, has been in decline for at least the last thirty years. The adoption of the use of psycho-pharmaceutical approaches has been widely embraced by psychiatry, general medical practice, and by the general population looking for a “quick-fix” without obvious pain or effort.
Co-occurring disorders are by their very nature of the interaction of substance abuse, and mental health disturbances, a very complex process. This is further complicated by the inherent difficulty of working with the motives and feelings of human beings whom a therapist/counselor sees within a limited amount of time, and defined social roles, both for the therapist and the client.

This paper suggests the need to add more nuances to the diagnostic, and therapeutic equation by applying the overlay of the influences of the socio-economic background of a person. Although attempts have been made to examine social class, social class learning styles, from the point of view of sociology in the United States (often with an extreme racial focus), and in Great Britain, there has been little clinical research or in-depth analysis applied from the point of view of co-occurring afflictions. The use of the word affliction is meant to keep the focus on the examination of human difficulties which have especially a causation of both inside, and outside factors of the true subject of the topic, how a human being both chooses to live, and in an individual and social sense, “forced” to live.

The current paper has focused exclusively on the psychological field of human meaning, although in both the areas of substance abuse, and mental health, the physical impacts leading to further physical impacts on behavior is of much importance. It should be considered, but not in the contexts of this paper which is a relatively short exposition of complex matters. Traditional Adlerian consideration of the impact of physical health on emotional development was an important aspect of the very beginning of Adlerian Individual Psychology. As physical health factors, nutrition, stress, access to proper housing, and clothing, are important aspects of the growth of a human being, and the ability to cope with the varied stresses of living, particularly living with low income in a capitalist society.
Much clinical, and sociological research is needed which apply socio-economic filters to the area of substance addiction, behavioral addictions, and emotional adaptations to aspects of existing (and “living”) in our modern world. Applying a social class analysis to an emerging field of physical and emotional important, neurology, and brain development has important contributions to make in the consideration of both etiological, and therapeutic approaches to co-occurring disorders.
Tables

Table 1: Psychic Elements of Being Low Income  p. 37

Table 2: Psychic Complaints, Disorder Manifestations, and Behavioral Expressions  p.56

Table 3: Advantages of being low income, and addicted  p.60
References


SAMHSA (Substance Abuse and Mental Health Services Administration. (2013). *Substance Abuse Treatment For Persons with Co-Occurring Disorders, A Treatment Improvement Protocol, TIP 42*.


