THE CROWN

A long time ago, in a distant galaxy,
when laughter roars through the heavens,
a universal being "there" rests …

Through a Stream …

A lost region, upon the outskirts of foreign lands …
began a dance with a keeper of an eternal flame. In time was born a young son,
and to a chieftain of the noble warrior clans. Though of noblest heritage,
this young man a King of Kings could not yet he become?

By day, came visions of worlds yet to come. Of realities beyond the sands of time
warlords with power did prompt. Yet … "not on bread alone
shall one man live," said he!

Yet, in the true Middle Kingdoms where the birds sing,
where milk and honey forever flow and where the Celestial Realms began

– He at last is led to drink.

By night, in dreams … again and again hidden places deep within
come forth. As dawn approaches the darkness takes leave …

– What has been awakened is bequeathed yet to another's breath.

– Robert B. Pereira

Reflections of Dual Diagnosis

A Canadian Perspective

Also by
Robert B. Pereira, MD

Faces of Dual Diagnosis: A Canadian Perspective

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DEDICATION

To Lucia Maria for her patience, love and support.

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FOREWORD BY

JOSEPH ELIEZER

Imagine interviewing a new doctor to staff the addictions clinic you are running. From the get-go, he discloses his struggles with mental health and addiction. Would you take a chance on a doc like that? We did. And we never regretted it.

I met Dr. Robert Pereira in summer 2009 when I was the clinical director at an addictions clinic in Vancouver, BC. Our medical director had invited Robert to interview for a position. As he shared with us who he was, I was struck by Robert's candor. Admissions of personal challenges, particularly from medical professionals, as you can imagine, are extremely rare.

As I walked away from that meeting, I had mixed feelings about our decision to hire him. With time, I realized my trepidations were unwarranted. I saw that Robert's personal struggles gave him the insight into our patients' struggles that other physicians didn't possess. His extensive education, keen mind and personal experience uniquely equipped him to help his patients in a way that nobody else could.

I also learned that his openness and honesty weren't reserved only for the people he wanted to impress. It was his way of being in the world, and it extended

to everyone. When he met with patients, his intention was not only to treat but also to connect with them. With Robert, individuals who had been marginalized, abused or disregarded by family or society felt heard, safe and respected.

Dr. Pereira demonstrated uniqueness in other areas as well. Not long into his tenure at the clinic, his high level of enthusiasm for ongoing personal and professional development became apparent. When he learned the clinic had both an infectious disease specialist and a psychiatrist on staff, his immediate response was: "How soon can I meet them?" Robert knew that having close relationships with other specialists would translate into better care for his patients, and he worked hard to establish and maintain those relationships. Eager to learn from others as if he were a beginner, he approached the field of medicine with the mindset of a Buddha.

As we continued to work together, we realized we had several mutual interests. Writing was one of them. When my first book, *Simply Spirit: A Personal Guide to Spiritual Clarity, One Insight at a Time,* was released, Robert, with a very full heart, was quick to provide feedback and offer support for my manuscript. He was even more excited to see people's reactions to it.

When his first book, *Faces of Dual Diagnosis: A Canadian Perspective*, came out, I was equally excited for him. He'd finally realized his dream of sharing his insights with the world. That book, in my opinion, is a must-read for anyone in the addiction and mental health fields.

The subject of intuition, however, was what fuelled many of our conversations. Both of us recognized intuition as a vital component of mental health. We agreed that using it effectively requires an un-cluttering of the unconscious. When the mind is clearer, intuition is louder. As it puts essential, often unseen, pieces of information together, intuition transforms our experience

into a sense of inner knowing. When we follow that sense of inner knowing, we reap better, fuller results in both our personal and professional lives.

As a physician, Robert has seen the profound impact intuition can have in his medical practice. As a psychotherapist, not only do I use intuition as a tool in my practice, but I also help others to clear their minds so they can strengthen their connection to theirs. For this reason, I call my form of therapy Intuition-Enhanced Psychotherapy. And you might as well call Robert's practice Intuition-Enhanced Medicine.

The passion for the integration of empirical knowledge with intuition-based knowing led Robert to study Eastern philosophies along with Western medicine. This book is a direct result his steadfastness, never-ending curiosity and dedication to the observation of inner and outer patterns of human motivation and behaviour.

As you step into this book, you will be invited into the mind of a very schooled and complex human being, who explores the meaning of Spiritual Medicine and its role in the modern approach to helping people live healthier lives.

May you enjoy the journey.

Joseph Eliezer, MTC, MPCP

Registered Counsellor/Psychotherapist

Author of *Simply Spirit: A Personal Guide to Spiritual Clarity, One Insight at a Time*

CHAPTER 1

A NOTE FROM THE AUTHOR

Two souls reside within my breast,
And each one from the other would be parted.
The one holds fast, in sturdy lust for love,
With clutching organs, clinging to the world;
The other strongly rises from the gloom
To lofty fields of ancient heritage.

– J.W. von Goethe in *Faust,* Part I, Scene II

"Anne" was both morbidly obese and had osteoarthritis of her knees. Over the time that I knew her – approximately 3 years – she gained a significant amount of weight. When she broke 200 lb. just prior to becoming a patient of mine, she started to complain of severe joint pain in the R knee. Her L knee had been replaced several years prior when she was not a surgical risk. An X-ray showed moderately severe osteoarthritis in the R knee. I wished to start anti-inflammatory medication but could not do so as her kidney function was impaired secondary to chronic kidney disease. I then suggested non-opiate pain relievers. She was agreeable. These worked for a time but eventually the analgesic effects of these medications wore off too due to tachyphlaxis.

When Anne's weight broke 250 lb she found the knee pain intolerable. I referred her to an orthopaedic surgeon. I was not expecting she would be told she was an ideal candidate for surgery but did expect that she be told in no uncertain terms that she needed to lose weight before any such surgery could

be seriously contemplated. She made a modest effort for a short time to lose some weight but her efforts were hampered by the fact that she was quite sedentary most of the time. At this time I also inquired as to whether she was depressed. I even took the liberty of prescribing her an antidepressant but her weight did not level off and her mood became increasingly labile.

I inquired about her sleep. She stated that it was nonrestorative for the most part. I arranged for her to have overnight oximetry which turned out to be strongly positive for a diagnosis of obstructive sleep apnea. However, she could not tolerate the CPAP machine. An overnight polysomnogram was ordered and was pending. I was hoping to get medical plan coverage for a machine if the test was strongly positive.

Anne refused to acknowledge that her weight was an issue. She believed that the denial of surgery for her was unwarranted, although she was a definite surgical risk. I told Anne repeatedly that she needed to lose weight if she wanted any kind of surgery. The fact of the matter is that she ate too much and refused to exercise. Her position was that the pain in her knees prevented her from increasing her activity level significantly. This left me in a rather precarious position.

Eventually I caved in and began prescribing her opiates. I started with weak opiates, in particular Tylenol #3 and then gradually worked up from there. Ultimately, I ended up prescribing methadone to her for her knee pain. Having considered the situation carefully I felt this was the best option for pain control in her case. It worked! The analgesic seemed to also have an antidepressant effect. Unfortunately, I made the mistake of trusting her with the medication. I did not perform pill counts and random urine screens checking for illicit substances. In medical parlance I was *opiate naïve* at that time. Fortunately, I did not prescribe more than two weeks of analgesic medication at a time but after

several months when she requested that I give her the entire allotment at once I reluctantly began doing so.

Some time later I received a call from the coroner informing me that Anne passed away during sleep. He was looking for more information. I simply stated that Anne likely passed of complications of obstructive sleep apnea. I informed him that she was also diabetic and she had had a high cholesterol level which were now both medicated appropriately and under fairly good control but her weight hovered somewhere around 270 lbs. Anne also suffered from essential hypertension which was controlled.

The shock of Anne's death prompted me to change the way I prescribe certain categories of medication and the way I practice medicine.

Was Anne clinically depressed? Clearly, Anne was narcotic dependent. I believe that giving her a free hand may have increased her tolerance to the opiate medication considerably. This may have precipitated a mild physiologic withdrawal, which unmasked an underlying depression. However, at this stage this is mere conjecture as she has passed away.

Her death was a spark needed for me to re-examine how Anne's health issues were essentially lifestyle based and caused by mental health problems. She was both addicted to self-destructive behaviours (such as refusing to address her weight issues) and to substances, and she was depressed. But why? I resolved to delve deeper into the causes of dual diagnosis [DD], and to finding diagnostic and treatment techniques that could arrest the damage and offer hope for lifelong cure.

This search has taken me into the fields of epigenetics, neuroplasticity, and quantum mechanics/consciousness. This manuscript is an extension of a previous work entitled, *Faces of Dual Diagnosis: A Canadian Perspective* [Agio

Publishing House, 2011]. There I compiled and discussed several cases of DD trying to consolidate several ideas; namely, a solid sense of self, learning to erect and maintain boundaries, the notion of a spiritual awakening and a brief introduction to Eastern studies. Though the management principles were algorithmically based, the specifics of individual management represented a departure from traditional forms of allopathic treatment for the condition of DD.

In this book, I will be furthering the concepts of sense of self, boundary setting, spiritual awakening and most importantly using the intuitive awareness of both physician and patient. I will provide a scientific/theoretical basis (routed in epigenetics, neuroplasticity, and quantum mechanics/consciousness) for recognizing intuition as a valid tool in diagnosis and treatment. Case studies will illustrate some of these concepts.

Something else that also changed my practice patterns was a peer review conducted by the College of Physicians and Surgeons of B.C. (CPSBC). Over the course of about a year a sample of patients whose Pharmanet profiles had been reviewed were subjected to scrutiny by a member of the practice review committee who then reported back to the committee with their findings. Though the procedure was anxiety-provoking, by the end of the process I was glad for the opportunity to participate in the exercise. I believe that my practice of medicine has improved considerably and I am now a safe prescriber.

Today I perform random pill counts and random urine drug screens on all patients being prescribed opiate analgesia on a continuing basis, in both my family practice and my addictions practice. I also have patients sign a narcotic contract before I agree to place them upon this kind of medication. Once patients understand that opiate analgesics are effective but carry certain risks associated with their long-term use, most are willing to comply with the rules governing their consumption.

Today nonprescription use of prescription medication (NUPM) is a growing problem. Canada is the world's #1 per capita user of Tylenol #3. Coincidentally, the US is the world's largest consumer of the drug Vicodin (a mid-potency opiate).

The value of this particular vignette is to illustrate that NUPM is a growing problem. Drugs such as heroin – specifically addiction to heroin – represent social challenges that affect marginalized populations, mostly in Vancouver and Montreal. In other areas of Canada, nonprescription use of prescription opiates is the major – and escalating – problem. [1]

I believe that self-regulation by professional governing bodies such as the CPSBC serves a vital function. Physician health and peer review of practice patterns in order to enhance physician awareness are both functions of the College that I have had the opportunity to participate in. Every year physicians burn out due to chronic stress. A minority of these cases includes physicians who have both mental health issues and addictive disorders. It is my sincere belief that, having gone through the process, what may seem to be an ordeal ultimately enables the individual physician to then impart their wisdom thereby enriching their practice of medicine for the benefit of all those concerned.

Here, I would also like to interject and state that within this manuscript I have discussed my own dual diagnosis rather candidly. Specifically, I have discussed what it was like, what happened and what it is like now having weathered what can best be described as an ordeal. My intent in documenting my life story is not to use it as a case study but to chronicle the spiritual growth which has taken place while having had to overcome horrendous odds.

I have currently being practicing medicine for close to a quarter of a century. Recently I have been inaugurated as a member of the Canadian College of

Family Practitioners by undertaking the alternative route to certification. I obtained my CCFP after being in practice for more than twenty years. Why did I wait so long? I guess the short answer is that I am a late bloomer. Most recently I have earned my diploma in Addiction Medicine from the American Board of Addiction Medicine. The Canadian Society of Addiction Medicine has also recently officially accredited me. I await fellowship in the International Society of Addiction Medicine.

Addiction imposes a tremendous social cost to society. The Canadian Centre on Substance Abuse (CCSA) released a comprehensive estimate of the health, social, and economic costs of substance abuse in Canada. [2] The study revealed that substance abuse places a significant burden on the Canadian economy. It has both a direct impact on healthcare and criminal-justice costs, and an indirect toll on productivity resulting from disability and premature death.

Based on 2002 data, the total annual cost of substance abuse in Canada is $39.8 billion. In any given year, one in five people in Canada experiences a mental health problem or illness, with a cost to the economy of well in excess of $50 billion. It is difficult to estimate both addiction-related and mental health costs together as ultimately the statistics used to assess these costs will vary depending upon the design of the studies being used to estimate prevalence. Suffice it to say approximately 37% of those with an alcohol use disorder (AUD) will have a concurrent mental illness and for those with a substance use disorder (SUD) other than alcohol approximately 53% will have a mental illness. For those with a mental illness, roughly 30% will have a concurrent SUD (twice the figure for the general population).

CHAPTER ENDNOTES

1. Rehm, J. et al. *The Costs of Substance Abuse in Canada 2002*. Ottawa, ON: Canadian Centre on Substance Abuse, 2006. ISBN 1-896323-92-8.

2. Addiction and Mental Health Collaborative Project Steering Committee. *Collaboration for addiction and mental health care: Best advice.* Ottawa, ON: Canadian Centre on Substance Abuse, 2014. ISBN 1-89632392-8.

CHAPTER 2

WHO AM I?

Once upon a time, there was Ra.
Ra took birth upon planet Eden.
There, in time, he studied the healing arts.
For twenty-six years he did study and practice the art of healing.
At the completion of his training, a master of the art of healing became he!

– Robert B. Pereira

I am rather unique in being myself both DD'd and a physician certified in the practice of Addiction Medicine. Throughout this manuscript I have interwoven intimate autobiographical episodes with fairly technical explanations. My intent is to present as detailed as is possible an explanation for my own illness and symptoms, elaborating on the scientific basis for this analysis. I have survived the illness for close to twenty-five years – which in and of itself says something. Having made this clarification, let me begin to weave the fabric of this story.

Dual Diagnosis or "DD" is the coexistence of a psychiatric condition with an addictive disorder concurrently. Both conditions may act independently of one another. However, it is not uncommon that exacerbations of one condition may predispose the individual to exacerbations in the other condition as well.

At times the symptoms of one condition may overlap or mask one another, making diagnosis and treatment all the more difficult.

My spiritual roots are Christian. Culturally I am Indo-Portuguese. My roots stretch from a place called Goa, which was a Portuguese colony from 1510 until in 1961 when, after a brief war of succession, it became a state within the Republic of India.

My father had been stationed in Hong Kong as a British ex-patriot for thirty years working as a marine engineer for a shipping conglomerate when he and my mother decided to immigrate to Canada. I was a young child at that time. The move to Canada was a big adjustment initially not only for my parents but for my younger siblings and me as well.

My father had to return to the work force having lost all of his seniority and my mother did her best to keep the household a safe and secure environment for the children to develop. The initial effect on me of being uprooted and transposed to a new continent and life situation was subtle. However, over time a fault line gradually declared itself. The cultural diversity and uprooting made my self-actualization process an arduous one. Essentially, I was unclear about "Who Am I?"

The question "Who am I?" is of particular relevance because most DD'd individuals lack a firmly entrenched belief system. Consequently, they are lost within themselves. In that regard, I started out no differently.

Fortunately, my desire to excel scholastically enabled me to devote a large portion of my time and energy towards accomplishing goals, which were ambitious. Throughout grade school I earned a place upon the honour role consistently and while in high school I received several awards for academic proficiency.

Upon graduating from high school I received several scholarships and went straight on to university entering the Faculty of Sciences at University of British Columbia [UBC]. My intent was to work towards my MD. At this point in my life, it would be true to say I was given a head start. However, I must say in all honesty that I had yet to learn how to set meaningful boundaries for myself. It may seem rather precarious but I had no intuitive understanding of the terms "enough" and "no". It seems all I really understood was "more"!

Coming from a household where I watched both of my parents sacrificing themselves tirelessly for the sake of their children imparted the Machiavellian understanding that "more is better" from a young age. And so it was that my value system was basically that of a scientifically minded materialist.

Although raised with materialist values, as I entered university I became exposed to increasingly existential ones. What is existentialism? It is a philosophical approach that emphasizes the existence of the individual person as a free and responsible agent determining his or her own development through acts of the will. Accordingly, at this stage of my life I became increasingly self-reliant and although I did not doubt the existence of God I did not dwell upon this topic either.

How does one define the term *spiritual awakening* and place it within its appropriate context? Nuclear physics and relativity have, to a large extent, done away with materialism but they now give us a view of the universe in which there is even less room for ideas of any absolute purpose or design. Unfortunately, the modern scientist is still so naïve as to deny God because He cannot be found with a telescope, or the soul because it is not revealed by the scalpel.

The scientist has merely noted that the idea of God is logically unnecessary, and even doubts that it has meaning for to say that everything is governed and

created by God is like saying, "Everything is up" – which upon closer inspection is saying nothing at all. So with the advent of the quantum era towards the turn of the last century the "God argument" has increasingly taken on a far greater degree of sophistication if there is even to be any argument at all.

We as a society are now awakening from a Dark Age. Recent statistics would suggest that our society is in flux. The dismal consequences of transition strategies in most Eastern European countries post-WWII, the daunting economic progress of many Asian countries, the increasing income gap between the most- and least-developed societies, the distressing linkage between rising incomes, environmental depletion, and crime and violence reflect the fact that humanity is vigorously pursuing any and all directions without a clue as to how to guide and govern itself effectively.

This awakening to which I have referred is being experienced upon multiple levels. I have chosen to address this awakening at the level of the epigenome in addition to its collective sense just alluded to. Deoxyribonucleic acid [DNA] is the basis of all life upon the planet. It has evolved over eons in accordance with the biological rhythms of the tides, which are influenced by the gravitational field exerted predominantly by the moon. More than a molecule, DNA is a planetary principle.

At this point, it is perhaps germane to define the subject of *epigenetics*. This shall be a recurrent theme within this book. Epigenetics is the study of molecular mechanisms by which the environment controls gene activity. It is a new scientific field and it shows that DNA blueprints passed down through genes are not set in stone at birth. Each of us inherits our own unique variation of the genetic code. Although we can't change the hardwiring of our genetic code, epigenetic factors such as lifestyle and diet can radically change what our genes do.

Having introduced the concept of epigenetics, let us tie this subject to the term *awakening* – which herein means *a shift from one value system to another.*

Along the continuum of DD recovery, attaining a solid sense of self, maintaining firm yet flexible boundaries, and awakening represent milestones. During an awakening the individual comes to terms with what has thus far been just a shadow of reality in the concrete world and grasps the presence of an inner reality. This inner reality is demarcated by boundaries, which define, and clarify the true nature of the self. Awakening not only implies the presence of awareness but this awareness extends to the epigenome.

As a fertilized egg develops into a baby, thousands of signals received over days, weeks, and months cause incremental changes in gene expression patterns. *Epigenetic tags* record the cell's experiences on the DNA, helping to stabilize gene expression. Each signal shuts down some genes and activates others as it nudges a cell toward its final fate. Different experiences cause the epigenetic profiles of each cell type to grow increasingly different over time. In the end, hundreds of cell types form, each with a distinct identity and a specialized function. Even in differentiated cells, signals fine-tune cell functions through changes in gene expression. A flexible epigenome allows us to adjust to changes in the world around us, and to learn from our experiences. This opens the door to an entirely different range of functional possibilities for a single gene or set of genes coding for a particular trait or set of traits. So at this level of technical expertise we are learning how to unlock the hidden potential inherent within the DNA molecule.

The next issue to tackle is the lack of attainment of a solid sense of self in DD'd individuals. Neither of my parents smoked nor drank alcohol. The obvious question is why did I? Looking back now, I would state that this was entirely in keeping with the most common reasons for early onset DD, generally

perceived to include normal adolescent-specific behaviours (such as risk-taking, novelty seeking, and response to peer pressure) all of which increase the propensity to experiment with legal and illegal psychoactive substances.

These behaviours have been rationalized as being due to inadequate development of certain brain regions (e.g., myelination of frontal brain regions) that will ultimately govern appropriate levels of executive functioning and motivation. Whether psychoactive substance use or mental illness is responsible for hampering this process is unknown at this time. However, what is known is that repeated drug use undermines this process and leads to long-lasting changes in the brain.

Ultimately, what is at issue is *consciousness*, which is the state of being both awake and aware of one's surroundings. The self and boundaries are terms, more or less self-explanatory, at least within the context of DD. The term awakening is perhaps more elusive. Viewed metaphorically, awakening represents the finest flowering of a lifetime.

Ultimately awareness itself is a total, integrated state, completely devoid of such concepts as subjectivity and objectivity. Subject and object are not related; in awareness they are dissolved. Awareness begins with the process of witnessing where one silently observes the stream of consciousness or flow of one's thoughts while in the absence of any judgment. Consciousness is aware.

Witnessing is not awareness. It is simply a stepping-stone towards awareness. Once subject and object have dissolved entirely we are left with a clear awareness. I clarify my use of this term with an adjective simply because the self is virtual.

Therefore, a clarification of the term self, which is robust, requires that boundaries are in place, which are both firm and flexible. Who we truly are involves

an unmasking of the delusion that one cannot be anything other than a separate self, and that this world is anything other than what it appears to be. In actual fact, nothing could be further from the truth.

Joseph Campbell, the late scholar of comparative religion and mythology, stated that an understanding of myth is vital to attaining awareness. Campbell was an influential figure, in many ways a spiritual teacher to countless millions. Through reading his collective works I managed to find my inner voice and this I have used to guide me in my life particularly through periods of trepidation. Prior to my DD being conferred I lacked both insight and clarity into the source of my behaviours.

Clearly the anatomically based model of learning about addictions needs to be revamped to incorporate the growing body of scientific evidence. The extensive overlap of dopaminergic, noradrenergic and serotonergic nervous pathways or systems throughout the brain makes research within the field of Addiction Medicine complex. These compounds amount to the "currency" which drives our brainy economies. The behaviour of the individual creates both inflationary and deflationary pressures, which affect the overall "well being" within this micro economy.

While for many years it was thought that drug use and addiction was confined to humans, and thus attributed to the cerebral cortices only, subsequent research on animals has demonstrated that self-administration of drugs will occur in other mammalian species as well. This supports neuroanatomical findings that addiction arises in subcortical, evolutionary residual regions of the brain – that is the limbic and related areas. The significance of these findings suggests that we are now in a position to start unraveling the chemical triggers that subtend the emotional basis for the disease of addiction. This is the new frontier of Addiction Medicine in the 21st century.

The amygdala, which is part of the limbic system, is responsible for determining what memories are stored and where they are stored within the brain. It is believed that certain memories are preferentially stored when they trigger a huge emotional response within consciousness. The hippocampus sends memories out to the appropriate part of the cerebral hemisphere for long-term storage and retrieves them when necessary. Damage to this area of the brain may result in an inability to form new memories.

From an evolutionary perspective the brain may be seen as having three layers which represent evolution; first, the brainstem or reptilian brain which is responsible for autonomic functions such as breathing and body temperature. The limbic system encircles the top of the brainstem; it is the source of emotions and where trauma gets stuck. The cerebral cortex in the rostral (anterior or close to the forehead) forebrain is the place where it is believed we think and reason. The limbic system includes the amygdala, an almond-shaped structure on either side of the forebrain (about an inch into the brain from one's earlobes), the hippocampus, and limbic cortex. These Mesolimbic Reward Pathways (MRP) connect the cerebral cortices with the subcortical evolutionarily residual portions of the brain. More importantly these neural connections do not fully mature until the mid-twenties in most individuals.

Thus far I have discussed the importance of a solid sense of self and the importance of backing this up with firm boundaries. I then branched out and began discussing the topics of epigenetics and of awakenings relating the two terms by way of awareness. I shall now elaborate on the latter terms of both awakening and awareness thereby obtaining an alternate perspective upon the subject of epigenetics. In order to round out the discussion I must place these terms into their appropriate context.

I do not believe it really matters which spiritual path one follows so long as

one is disciplined and committed to the process. In my era, teenage drug experimentation typically began with tobacco and alcohol as well as pot [MJ]. In my own case, I began my substance use with occasional binging of alcohol and smoking cigarettes. Fortunately, my drug use did not escalate further during this stage of my career, as I'm sure this would have affected my academic successes. The upsurge in dopamine to 5 to 10 times over the benchmark for normal rewards (food, water and sex) is what drives socially unacceptable behaviour and perpetuates an alcohol or drug use problem.

I firmly believe that my dual diagnosis culminated from having boundaries which were repeatedly transgressed. Consequently, the boundaries I was raised having became skewed. Specifically, I was raised in a *codependent* household where there was an extensive family history of addiction on both sides. Consequently, I grew up to become an *enabler*. Though neither of my parents drank or drugged, I learned the behaviours (which subsequently led to my addiction) from members of the extended family as well as within the home to a lesser degree. The sad truth is that my parents were extremely abusive toward one another both verbally and emotionally. Though I was rarely abused directly, simply witnessing events within the home was enough to alter the internal dynamics within my psyche.

The understanding of codependency has evolved since it first came to the limelight about a decade ago after psychologists observed the interpersonal dynamics of countless numbers of alcoholic families over the preceding four decades. Codependency is excessive emotional or psychological reliance on a partner, typically a partner who requires support due to an illness or addiction. The reliance is quite obviously pathologic. Codependency is particularly linked to role-playing, which is why the person loses track of themselves and often

does not know who they are. It is precisely for this reason that codependents lack a solid sense of self and cannot maintain firm yet flexible boundaries.

Shadow work (as pioneered by the late eminent psychotherapist Carl G. Jung) has revealed that I have had a tendency to take on the emotional pain of others and somehow rectify the situation subconsciously. Let's look at the psychodynamics of this situation in more detail. The conspicuous absence of a physical boundary between the fetus and its environment changes irrevocably with birth. It is generally accepted that in early infancy, the child remains enmeshed with its parental figures, meaning that it does not yet perceive any boundaries. The infant's sense of "right" from "wrong" is much intertwined with its sense of "self" and "other". At each successive stage of the developmental process, the libidinal ego progressively differentiates itself from its attachment figures (usually the parents); then as a child begins to explore how it is indeed separate from its parents, the idea of self is consolidated. In families where boundary distortions are the rule, parents continue to project, negatively, upon each other and upon the child.

Had I the benefit of firm boundaries I would have been able to perhaps shield my younger siblings from the emotional deluge at home. Given the nature of the preponderance of research evidence – namely, that DD is a neurobiological disorder – why then such an emphasis upon belief systems and spirituality? Today we understand that only about fifty percent of the risk for a brain disorder is related to the genome. Therefore, the remainder of the risk is due to psychosocial factors, which are transmitted culturally. Hence the term epigenome is now in vogue.

In summary, having discussed the importance of having a solid sense of self and firm yet flexible boundaries, I shall now focus in on awakenings. In his

book, *On Self-Knowledge*, the late Jiddu Krishnamurti wrote the following, which to me has become a rite of passage:

> "… What is in the future – the future being uncertain – that projects its own creation as a certainty? That is, the mind moves from the known to the known, it cannot move to the unknown, therefore it wants an assurance of the next known, and when the next known is questioned, we become anxious.
>
> "So, while physical security is necessary, there is no such thing as permanent psychological security, and the moment you have that security, which is self-projected, you become lazy, contented and stagnant. But when there is no security, then you must have a mind that is living from moment to moment, therefore living in uncertainty; and the mind that is uncertain, the mind that does not know, that is not seeking gratification, is creative.
>
> "That creative state of being comes about only when the mind is completely silent, when it is not seeking, when it is not looking for a reward. Then, there is abiding peace; and because we do not know how to arrive at that state, we seek gratification and hold it, and that gratification becomes the incentive for action. But gratification, however refined, entails endless fear, anxiety, doubt, violence, and all the rest. But if the mind understands itself and thereby finds that state in which there is complete tranquility, then creation takes place, and that creation is itself the total end of all existence …"

I would now like to round out the discussion with a clinical case. My purpose in discussing this case here is to introduce and illustrate the concept of

boundaries as they are often observed in clinical practice. As we move into subsequent chapters the relevance of this case and others like it will become apparent particularly as I relate them to my own case history, as and where appropriate. Accordingly, one will note similarities between my own case history and the case histories of other subjects. At these times it is best to think of a mirror, which reflects equality in difference, and difference in equality. This is the characteristic of eyes that have experienced the reality of DD.

"Larry" is opioid dependent. He also suffers from an anxiety disorder, for which he is on an anti-depressant medication for. Larry has been on methadone replacement therapy for about six months. He is on a moderate dose. Unfortunately, Larry's progress has been halted simply because he refuses to go "up" on his methadone despite the fact that his urine is consistently positive for opiates in addition to methadone metabolites. Larry admits to using heroin regularly.

Larry states he wants to quit both methadone and heroin at the same time! Given the pharmacokinetics of the medication (in particular its large volume of distribution and its long elimination half life) this is an impossible situation. Pharmacokinetics is the study of how the body acts upon a drug whereas the related concept of pharmacodynamics is the study of how a drug affects the body. Essentially, one must titrate the methadone to a dose where cravings for illicit opiates have all but abated. This happens once all of the mu opiate receptors have been saturated. It is the mu opiate receptors that are responsible for the rewarding effects of these drugs of abuse.

Larry cannot understand this for his own reasons. In support of my contention, Larry states that he feels "sick" on his current dose of methadone and the heroin makes him feel somewhat better. I then explained to Larry that the reason he is "sick" is that he is experiencing minor opiate withdrawal and an

increase in the methadone will take away his dope sickness and circumvent the need to take additional doses of heroin throughout the day or night.

So, Larry will not budge! I simply asked Larry if he plans to be on heroin six months to a year down the road? He simply said, "No!" I then asked him point blank how does he plan to accomplish this given the fact that he will not comply with the principles of the program. He stated he was thinking of quitting the program, as methadone was not for him.

This was a pivotal point in Larry's recovery. Prior to this point we were playing a game where he either exhibited avoidant behaviour or missed his scheduled appointments or else he would use heroin or finally would simply refuse to agree to a higher dose of the methadone. I then enlisted my persuasiveness and his zeal to get off heroin in order to encourage him to accept an increase his dose of methadone, if only temporarily. I simply told him that I saw through his charade. It worked! This strategy proved somewhat effective but not definitively. Yes, there is more to this case.

As it turns out Larry's use of heroin coincided with his ex-partner's use of the drug. More importantly, his rocky relationship with her was the cause of much of his anxiety. Once he understood the dynamics of the relationship and the fact that she was enabling him he was able to consciously distance himself from "Susie's" influence on his drug use and upon him. This led to further improvement in his urine drug profile [UDS] with time.

As just stated, much of Larry's anxiety was the result of his relationship. Though he knew he was being manipulated by Susie and he had a genuine desire to end the relationship on several fronts he was unable to do so as he lacked firm boundaries and did not have a solid sense of self. Susie's response was to use Larry's weakness for heroin as a bargaining ploy to keep his interest

in the relationship going. Needless to say the relationship was highly dysfunctional. When all else fails with DD'd individuals, trying some hard-core honesty usually does the trick.

I recall a conversation I had with Larry where I asked him point blank if he had genuine feelings for Susie. He stated he like the drugs more than anything else. In actual fact, I think the anxiety he was experiencing was surmounted by this fact. I think he knew he was with the wrong person doing the wrong things. He has still a way to go but we are trying.

CHAPTER 3

AM I?

Ra was so greatly moved by those whom he helped,
He rarely took rest or sleep.
But Ra was half god and half man,
Some said he had special powers.
In his heart burned the eternal flame of compassion
tempered by a veritable ocean of knowledge.

– Robert B. Pereira

After my third year of undergraduate studies at university I applied for early admission to the Faculty of Medicine. However, I was placed on a waiting list and did not ultimately gain admission to the faculty that year. I was heart broken! Yes, I suppose medicine has always been my first love. Though I made the grade academically I was, in all fairness, very young and impressionable and this may have been what held me back during the formal admissions process. I say this retrospectively. I did not take this minor set back adversely but began working even more diligently the subsequent year and excelled scholastically to the extent that I was offered a place within the graduating class of 1990.

Cutting to the chase, there was no in-between stage for me as far as alcohol went. I went from being a social drinker to a blackout drinker within a matter of a few short years. This final transformation took place during the final year

of medical school and my internship year, which followed. During this period my tolerance for alcohol increased accordingly. However, at this stage there was little if any remorse associated with drinking. I can honestly say that at this stage, the thought never crossed my mind as to why I could not drink like other people could; that is to say with extended periods of abstinence or alternatively in moderation. I suppose I had yet to acquire the definitive mind-set of an alcoholic. At this stage I lacked awareness about my drinking.

To my mind at least, drinking was mostly an innocent, jovial and gregarious activity generally enjoyed by all who participated though it was always to excess, at least in my case. These times occurred after exams in medical school particularly. I had little understanding of "consequence" and so I drank with an attitude of impunity. Though I had not yet developed a full alcoholic mind-set, I certainly had an alcoholic temperament. This means that I was restless, irritable and discontent most of the time. Being so highly strung, it seems the only thing I could do was to use some sort of psychotropic agent to placate my nervous system thereby rendering it somewhat more placid. Alcohol was this panacea.

At this stage of my life I would have been loath to admit that I had even the slightest flaw. I was quite unaware of the subtle changes in my mood which preceded my flirtatiousness with alcohol. However, my younger siblings and the remainder of my family were quite aware that I was "moody" at even the best of times. However, given that my mother in particular was indomitably moody, my disposition at least upon the surface did not appear to be pathologic. As for my father, he was stoic and did not usually express his emotions. Yet, at times he too could be like a volcano particularly once my mother got him going. After moving to Canada particularly, the bulk of my childhood

memories consisted of my parents arguing with one another. The way I had coped was by immersing myself in my studies.

Ultimately, there is a limit to what one can tolerate. Facing a barrage on all fronts my only recourse was to isolate myself and take to activities which were predominantly antisocial. To this extent I enjoyed smoking cigarettes and took to the occasional drink of alcohol under the table. Perhaps this is where I developed the tendency to want to drink excessively if not surreptitiously. I did not drink in front of my parents for as a general rule this would have been forbidden. It was not until I graduated from university with a baccalaureate degree that my parents condoned consumption of alcohol in moderation.

I led a cloistered lifestyle in medical school characterized by what seemed like endless hours of study and many sleepless nights particularly prior to exams. Had I taken the time to socialize and forge solid relationships with my colleagues while in medical school the entire experience may have been more memorable. Even if this had not been the case, it would have at least taught me the value of setting appropriate limits. However, my moodiness pushed away most who were interested in genuine friendship away. My seemingly childish behaviour upset me during moments of clarity but I did not understand that a biological process governed the vacillation of my moods, which were definitively pathologic by this stage.

As an adolescent I had a dry wit and a perverse mind. Perhaps it is no wonder that I most enjoyed gross anatomy in first year medical school where we dissected a cadaver. In second year I enjoyed neuroanatomy most where we dissected the human brain. However, for me at least, medicine came to life when we began clinical teaching and the study of clinical pharmacology in third year. This is when all of the concepts, which had appeared unrelated, all suddenly

came together. This is also where I learned that medicine is a 24/7 proposition. This was something I looked forward to with some degree of trepidation.

The first two years of medical school were academic. There was a brief exposure to clinical teaching in the third year, which was magnified with each successive stage of educational attainment, but the final year was entirely a clinical year. Here, the days began with rounds early in the morning where each student would present a progress report about the clinical course of their respective patient loads. This was followed by lectures in the afternoon after rounds and finally dispersal for on-call responsibilities of that day.

The days were long and the nights seemed even longer. The on-call schedule varied anywhere from every third or fourth day to every alternate day depending upon how busy a clinical rotation was, as well as the nature of the clinical rotation. On-call responsibilities during medical school were not overly taxing, as still there was a large degree of back-up supervision. Individual merit had more to do with personal initiative as concerns the workload one ultimately endeavored to become responsible for.

As luck of the draw would have it I excelled clinically though academically I was merely an above average student. However, as I advanced on-call responsibilities became increasingly grueling. There was little if any opportunity to sleep during regular hours. The complexity of one's caseload also increased in tandem. Slowly but surely I was being indoctrinated into the process of working longer and longer hours and feeling overworked and under paid relatively speaking.

I was paid a stipend in the final year of medical school but it was just enough to cover the cost of tuition and related amenities such as books and equipment. By this stage, I was beginning to feel as if I was being taken for granted. I had

always thought that doctors were those who were part of a privileged few. My experience taught me that medical education is more about summarily separating the wheat from the chaff for progressively more cutthroat odds.

The morning after being on-call, most medical student interns rounded with both the senior staff person on duty and junior residents in house, and then it was straight home to bed after tying up odds and ends on the previous night's roster. At least that was the pattern for the usual bunch. My experiences told an entirely different story.

In my case, after having refreshed myself with merely a nap, the day subsequent to call was a time to burn off some steam by downing several glasses of ale at the local pub. For some reason, I did not require sleep to the same degree that many of my colleagues did. This was when my self-medicating began in earnest. It was during this period that I recall building up a formidable tolerance to alcohol, so much so that by the end of this stage of my drinking career I began to drink alcohol no longer for fun but out of necessity. Let me dissect this paragraph for the benefit of the reader.

At this stage I was not dependent on alcohol but an increasing amount of my time and energy was put into activities that revolved around the consumption of alcohol. My acquaintances were more or less drinking buddies whom I fraternized with in the pub. Though I was too naïve to see it I became attached to these individuals though there was no justification for this sentiment.

This is where I first experienced the lack of a solid sense of self and an inability to erect and maintain firm yet flexible boundaries. What I am basically saying is that here I began having difficulty saying "no" to alcohol. Here I began buying rounds for my drinking buddies and saying "yes" to rounds bought for me.

Once I began to drink alcohol I drank to the point of mild intoxication most

times. Having reached this point I felt relieved. I now realize I was drinking alcohol to relieve a pathological condition which I suffered from. This was my DD. In the vernacular the drive state of my neurobiological illness was steadily increasing. As it turns out what preempted the escalation in my pattern of consumption was psychological trauma. Here I was experiencing an awakening of sorts.

With respect to my gradual stepwise increase in consumption of alcohol during medical school, I believe this all stemmed from a liaison with an older woman, "Meryl", who was a member of a graduating class ahead of me. In the aftermath of our break-up I was left devastated. Rather than seeking counseling or medical attention as I became increasingly depressed, I coped by increasing my consumption of alcohol precipitously.

The relationship triggered something within my subconscious which had more or less been lurking there up until this point. I believe what was triggered was the psychological and emotional abuse I experienced as a child. With no other perceived avenue to choose, I turned to alcohol to obviate the discord I was experiencing.

By my final year of medical school, I became a "man about town". This is an individual who, having developed some antisocial personality traits, indulges the senses at every conceivable opportunity. In my case these antisocial traits were unmasked by tobacco in association with the consumption of excessive amounts of alcohol. The thoroughfare always began after a few drinks, with more alcohol eventually tipping the scales.

The issue is why the powerlessness within the relationship with Meryl? Well, the simple answer is that she refused to entertain my genuine advances offering affection but was enamored instead by my innuendos. Consequently, the

relationship lacked depth and genuine caring, but given a choice would I have done it all again … ? The lack of depth is perhaps understandable given the difference in age.

Our mutual lack of genuine caring for one another stemmed from the fact that the relationship was basically platonic. In the vernacular, we were friends with fringe benefits. However, at the time, I could not understand how such a relationship could exist as my world was entirely "black" and "white" then. In time, I would understand very clearly the nuances of this relationship. In time I would look back and realize this drama to be but a flea bite.

At this stage of my life, I had absolutely no intention of settling down. All I desired was a steady partner, yet I had no understanding as to how to frame this clearly. Essentially I had difficulty being honest with either myself or others when it came down to stating in no certain terms what my expectations were. Speaking from the heart is indeed liberating and nothing should be easier. However, for codependents this is a laborious chore. In this regard, I was no different.

Little did I realize that I was beginning to treat my duties frivolously wherever I was allowed such a privilege. Yet little did I care at the time as I had other priorities. Paramount amongst these was socializing and making up for what seemed like too many years of lost time. In my heart of hearts I felt that I had grown old before my time. Albeit so, I possessed little if any true wisdom at this age. And so ultimately there existed a fundamental dichotomy between my personal and professional life. The way I responded to this situation was to drink even more as it placated the anxiety I felt.

I would have been better off if I had just said what I felt. The real problem was that my heart and my head were entirely separate places. Upon one level I had