

APPLYING RELATIONAL THEORY

TO ADDICTION TREATMENT

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Many people at the end of the 20th century are isolated, contradicting our innate need for connection and community. Models of development which stress the need for individuation, differentiation, and autonomy are increasingly being recognized as inappropriate and unfulfilling for women, and to some extent also for men. In spite of numerous cultural messages attempting to convince women that autonomy and individuation are the highest states of development, women consistently turn to relationships for their sense of self. Although often not stressed in male models of development, the ability to form and sustain a variety of interpersonal relationships is considered to be a major component of healthy human development, and newer developmental theories are beginning to balance this component alongside that of autonomy. Relational, or self-in-relation, theory focuses on the importance of relationships, particularly for women, and examines how these are enacted throughout women's lives.

The importance of relationships in addiction, especially for women, has only recently begun to be explored. Relational theory can be extended to support the hypothesis that addiction represents, at least in part, a misplaced striving for connection. This chapter examines the various relational aspects of addictions for women, reviews relational theory and applies it to women and addictions, and suggests treatment interventions based on the relational approach.

WOMEN, RELATIONSHIPS, AND ADDICTION

Interpersonal relationships are always problematic when accompanied by addiction. It is difficult, however, to determine a direction of causality to this association. It may be impossible to unravel which comes first. The following six points, although not comprehensive, illustrate how integral relationships are in women's addictions.

1. Women are often introduced to alcohol and drugs through a close romantic relationship. Initially, many women become involved with drugs in service to an interpersonal relationship (Waldorf et al., 1991). In other words, they care less about the drug than about pleasing the person with whom they are romantically involved. Consequently, in order to recover, or remain drug free, women may have to terminate the romantic relationship.

2. Addicted women are more likely than men to be diagnosed with underlying emotional problems, and both problems may be associated with difficult relationships. The most frequent mental health diagnosis for addicted women is depression (Turnbull and Gomberg, 1988), which has been found to be closely associated with isolation (Belle, 1982). In addition, Straussner and colleagues (1980) have shown that alcoholic housewives exhibit distinctive MMPI profiles as compared with non-alcoholic women, indicating that alcoholic women attribute their drinking to the behavior of their loved ones.

3. Women's addiction is often associated with prior or current relationship violence or boundary violation. Research studies of women in treatment for addiction find alarmingly high rates of childhood sexual abuse (Rohsenow et al., 1988), as well as higher rates of sexual assault (Klassen and Wilsnack, 1986) and family violence (Gorney, 1989) compared to men or non-addicted women.

4. Addictions and parenting are closely and conflictually associated for women. Many women seek treatment or at least attempt to reduce their drug intake when they are pregnant (Rosenbaum and Murphy, 1990). Moreover, since children of addicted mothers are often removed from their custody, the potential of regaining custody is a strong motivator toward recovery. On the other hand, addicted mothers are constantly confronted with their guilt for not being perfect, pushing them further into their addiction (Black and Mayer, 1980; Corrigan, 1980).

5. Women are the fastest-growing group to be diagnosed with HIV/AIDS, and this is closely associated with relationships.

Women are more likely to be infected with HIV through sexual relationships with infected men than from sharing needles (Kelly, 1994). Moreover, women with few economic options may trade sex for drugs or may be reluctant to insist that their sex partner wear a condom (Fullilove et al., 1990). Furthermore, women are more likely to take care of other family members with the disease and neglect their own care, resulting in quicker AIDS-related death rates than those found in men (Amaro, 1995).

6. Women receive less social support than men for recovery. Women are less likely to be emotionally supported and encouraged during their recovery process by their families than men. For example, although most wives remain married to alcoholic men, most husbands divorce alcoholic women (Johnson et al., 1990; Schilit and Gomberg, 1987).

RELATIONAL THEORY

Relational, or self-in-relation, theory was originally developed by theorists at the Stone Center of Wellesley College in the 1980s. Its primary assumption is that connecting with others is a basic human need, and that this need is particularly strong in women (Jordan et al., 1991). The developmental framework for the theoretical model is based on the work of Miller (1976), Gilligan (1982), and Chodorow (1978), among others. Briefly, it states that all people have a need for connection with others as well as for differentiation from others and that these are enacted differently by gender, with females being much more attuned to connection than males.

Theoretically, girls perceive themselves to be more similar than different to their earliest maternal caretakers, so they do not have to differentiate from their mothers in order to continue to develop their identities. This is in contrast to boys, who must develop an identity that is different from the mother's in order to continue their development. Thus, women's psychological growth and development occur through adding to rather than separating from relationships. Consequently, defining themselves as similar to others through relationships is fundamental to women's identities.

One component of relationships is achieving a sense of connection with others. **A connection can be regarded as an interaction that engenders a sense of being in tune with self and others, of being understood and valued.** Growth-enhancing relationships facilitate more and stronger connections as they develop. Of course, relationships also involve disconnections, when the people involved feel their separateness and distance from each other. Growth-enhancing relationships have the ability to allow disconnections which, with effort on everyone's part, may be turned into connections.

Relationships are defined here as interactions over time that can be assumed to occur with some regularity. All interactions are not assumed to be connections, and all relationships are certainly not growth-enhancing. At least two kinds of interpersonal relationships can be distinguished, close and functional, although others may also exist (Gilmour and Duck, 1986). **Close** relationships (Kelley et al., 1983) are ongoing interactions between people who care about and mutually influence each other, while **functional** relationships are oriented to achieving a certain goal.

We have close relationships with, for example, our families, friends, and romantic partners. We have functional relationships with our hair stylists, teachers, and so on. We may have both types of relationships with people with whom we work; the relationship may be considered close while we are working together, but may actually be based on function and not continue after one person leaves the work environment.

APPLICATION OF RELATIONAL THEORY TO ADDICTIONS

It has been suggested (Byington, 1993) that people not only have relationships with other people but that they may also have a relationship with an object or experience. Addiction develops when a relationship with a drug, including alcohol, food, gambling, or another person treated as an object, is pursued and believed by the individual to be essential to her/his life despite continuing negative consequences and is considered to be at least as important as

relationships with other people. For example, many smokers deny the health hazards of cigarettes in spite of hacking coughs or other physical problems, and may even curtail relationships with family members or friends who object to their smoking. The relationship with the cigarettes is at least as important to the smoker as relationships with other people and continues despite numerous negative consequences.

The essence of addiction, in this model, lies in troubled relationships rather than in internal or disease processes. The relationship with the drug is presumed by the individual to be a close one, as with "best friends," but is actually functional, providing to the person a feeling of well-being or a "high". However, addiction is only associated with, not caused by, the drug involved. The person is addicted to the consciousness changing experience, or "high" that is achieved through the drug (Weil, 1986.) Although the addicted person believes that this experience can only be achieved through the drug, in actuality it can be generated through a variety of methods and comes from within the person rather than outside. This reality is extremely difficult to accept if it has only been experienced in association with drugs. After physical addiction (tolerance) develops, continued drug use may be more associated with fear of withdrawal than the desire to maintain the "high," which has become elusive. The person at some level realizes that she/he is not in control of the relationship with the drug but, rather, acts in service to it.

Healthy interpersonal relationships involve some degree of mutuality, with both people contributing to the interactions and building of the relationship. Relationships with drugs are not mutual, no matter how much the drug is anthropomorphized or valued. The drug cannot "give back" to the individual, although this is not recognized by the addicted person, who regards the drug as essential to her/his well-being and even existence. It is the nature of addictive relationships to increase in importance until they eventually usurp most of a person's relationship time and energy.

Not everyone who uses drugs becomes addicted. Why some people develop an addictive

relationship with a drug and others do not is probably more reflective of the characteristics of the person (including her/his genetics) and the setting than the nature of the drug (Bratter and Forrest, 1985). The relational approach suggests that individuals are most vulnerable to developing an addiction when a problem or gap exists in one or more areas of interpersonal relationships, which is then filled by the relationship with the drug. The problem or gap may take many forms. For example, it could be associated with a lack of experience with fulfilling interpersonal relationships, loss of a significant other, ongoing problems in close relationships, negative past experiences that lead to mistrust in current relationships, or an environment in which relationships with drugs are "safer" emotionally than investing in people.

The mix of relationships for any woman is called her relational field. One way of depicting a person's overall relational field is through the use of relational maps (McAuliffe and McAuliffe, 1992). Relationships that are more important are depicted as larger and closer to the person than those that are less important. Healthy, nonaddicted people have a variety of growth-enhancing interpersonal relationships, whereas addicted individuals have their strongest relationship with their drug of choice and weaker relationships with other people.

First, every woman has a relationship with herself, whether or not she is involved in any other relationship. For healthy individuals, this relationship is positive and involves self-care and self-empathy; addicted people have a shame-filled, negative relationship with themselves (Mason, 1991). Healthy women also have relationships with family, friends, romantic partners, co-workers, and others. They may have a spiritual relationship with a Higher Power, as well as significant relationships with special pets or plants. Many people have relationships with objects, such as a house or car, or with experiences, such as running, gambling, or work. All of these relationships, however, are balanced, with each receiving relatively equal energy and attention over a period of time. Healthy people's relational maps include a variety of relationships, but the strongest ones are interpersonal relationships. If one relationship drops out, others are available to fill the gap.

The relational map for a typical healthy woman, such as Ann, is exemplified in Figure A (place Figure A here). Ann has numerous relationships, and these are all nicely balanced. Figure B (place Figure B here) reflects Ann's restricted range of relationships after she has developed an addiction to alcohol. She has a limited number of interpersonal relationships, and her closest relationship is with the bottle. Note that the former relationship with John, her husband, is no longer in her relational field after addiction.

Relationships are extremely important for women, and relationships with drugs are initially seductive and less stressful than interpersonal relationships, which may be troubled. Unfortunately, as the drug relationship becomes addictive, the initial pleasant connections become more difficult to attain and more effort goes into regaining them. Other types of relationships weaken as the relationship with the drug strengthens. The addicted person is searching for connections, albeit in an ultimately self-destructive fashion.

ROLE OF RELATIONSHIPS IN HEALING

Since relationships are important for women, and addictions are bound up with relationships, they can be an important motivator for healing. Women have major but usually unacknowledged strengths in regard to relationships that can be drawn upon in treatment.

First, women are dedicated and tenacious in maintaining relationships. For example, many women will stay with abusive men and, in spite of all evidence to the contrary, hope and believe that the relationship will change. Some of them even develop a relationship with drugs in order to remain in the abusive interpersonal relationship. That innate optimism and tenacity are major strengths that can be used to help women turn their self-destructive addictive relationships into healthy interpersonal ones.

Second, women's sense of identity is largely derived and defined through relationships. Rather than viewing this as a deficit and attempting to eliminate it, we can draw upon this relational self for healing. Addicted women have substituted a relationship with a drug

for healthy interpersonal relationships, and this reflects an underlying but misdirected need for connection. This need can be acknowledged and rechanneled for healing.

Relationships with children and significant others can be used to support healing.

Women want to be good mothers. Since addicted women usually have difficulty with their mothering role, this results in guilt, which reinforces their sense of unworthiness and leads them to lean even more heavily on the relationship with the drug. Such desire to be a good parent can be invoked to help women succeed in treatment. In the best of conditions, women would have a strong sense of self and feel worthy of succeeding for themselves, but until that confidence develops, healing can be motivated by the desire to do things for other people that women might not initially do for themselves.

TREATMENT APPROACHES

Treatment techniques can be devised that are focused on developing healthy relationships. These techniques may be used as adjuncts to more traditional forms of treatment. Suggestions for treatment are in four general areas.

Ending the relationship with the drug. First and foremost, the **relationship with the drug must end**. It is theoretically possible for a relationship with a drug to decrease in importance for an individual, just as some interpersonal love relationships evolve from lovers to friends, but probably not without a lengthy transition time in which no relationship exists. Ending an addictive relationship is an incredibly difficult task, especially given women's dedication to relationships in general, and may take quite a while to complete, but the relationship must be ended in order for healing to commence.

It may be helpful to initiate this process by assisting clients in making two relational maps, one representing the time before the addictive relationship and the second depicting the time just before entering treatment. As seen in the case of Ann, these will probably show a restriction of other relationships as the relationship with the drug increased in importance.

If addiction is explained in relational terms rather than as a disease, the message that is transmitted is that change can occur. Women need to believe that they can be in control of their lives, because they have traditionally been so much out of control. Assuring them that they are sick and not responsible for their behavior does not help women to feel and be more in control; it merely reinforces their belief that someone or something else has more control over their lives than they. Women are used to feeling responsible for everything around them while at the same time feeling unable to control any of it. The relational model of addiction is simple to understand and to explain, and through it women can reframe their experiences away from badness or sickness to understand them as misplaced efforts to connect.

In addition, women need to understand the general process of how relationships end. Ending an addictive relationship with a drug is at least as difficult and painful as ending any other love relationship. It can be a slow process with much ambivalence until and even after the final decision is reached and action taken.

Any time a relationship ends, it must be grieved. Humans have a need to understand why and how events occur, especially endings. In the process of making meaning out of painful situations or transitions, we naturally move through the stages of grief. The first stage of grief is denial (Kubler-Ross, 1969), and we know that addicts deny the strength of their addiction in the face of overwhelming evidence to the contrary. Denial will probably need to be addressed in treatment for quite a while, especially if the client relapses in an attempt to continue the drug relationship. When relapses occur, explaining them through the relational approach might make them more understandable and less shame producing. Conceptualizing relapse as an unsuccessful attempt to deny the strength of an addictive relationship honors the woman's efforts to control her life and encourages more productive attempts at developing relationships.

Grief is an all-consuming experience and must not be trivialized. After a woman has ended an addictive relationship, she can expect to experience the physical effects of withdrawal as well as the physical and emotional effects of grief. These are normal stages of recovery. Grief

takes time and a great deal of energy, but it does abate in time and the person can and will recover.

Two Gestalt-type therapeutic techniques to assist grieving have been suggested by Duffy (1992). Since the relationship with the drug substituted for interpersonal relationships, the suggestion might be made to the woman to give the drug a name and talk to it. In addition, she might write or compose some sort of eulogy to the addictive relationship in deference to the finality of its ending.

Building healthy relationships. As the grief begins to subside, the client can be supported in developing new, healthy relationships to fill the gap left by the addictive relationship. Relational maps can be drawn and examined on a regular basis as part of the healing process to examine where gaps continue to exist and where progress has been made. Women with a variety of roles are less prone to developing addictions (Wilsnack and Cheloha, 1987), and this translates in the relational model into having a variety of interpersonal relationships. Clients can draw a best-case scenario relational map and plan for how to get from where they are to where they want to be.

People who are involved in addictive relationships are assumed to have other problematic relationships, and most have very few relationships of any kind by the time they enter treatment. Addicts frequently refer to their drug of choice as their "best friend." Addictions are so disastrous to interpersonal relationships that the drug may indeed be the addict's only remaining "friend," or source of companionship. Since women define themselves primarily in terms of their relationships, they are likely to accept even poor relationships in lieu of no relationships at all. Relationship training can be very helpful in helping women to understand why they choose the relationships they do and how to recognize and foster healthy relationships. Women who have been involved in exploitive relationships throughout their lives have "de-selfed" themselves (Lerner, 1985), or given more of themselves away than they would prefer. They need to learn how to recognize when a relationship is not mutual and be supported in even minimal efforts to

make positive changes.

Supportive relationships among women in treatment can be facilitated by involving them in women-only groups. These groups can explore commonalities in experiences and help women put a voice to their experiences. Since many women have been sexually or physically abused by men, women-only groups can provide a safe haven to explore their experiences away from potential abusers. One of the results of victimization is a difficulty in establishing trust (Russell and Wilsnack, 1991), and many women have never developed trusting relationships with other women. Building healthy relationships with group members is another possible outcome of the group. Women can also be encouraged to attend self-help groups. Although the value of 12-step programs for women has been criticized (see Kasl, 1992, and Coker's chapter in this book), women's meetings of 12-step programs or Women for Sobriety may be especially helpful.

Of course, women will continue with their lives while they are in treatment. This may include romantic involvements. Most treatment programs, for good reasons, discourage romantic involvements until clients have been drug-free for some lengthy period of time in the interest of supporting their own self-care. Many of these involvements are not healthy for either party and retard recovery. If these can be reframed, however, as attempts to establish connections in a positive manner, these relationships can be discussed openly in treatment, rather than hidden, and can be considered to be relationship practice.

Practicing relationship skills. Recovering women need practice in all types of relationships. This includes developing friends of both sexes, possibly rethinking or reconstructing a romantic involvement, attempting to repair disconnections with family and friends, and practice in self-empathy and valuing self. Significant others can be brought into the treatment process by including them in relationship training sessions, couples and family counseling, and education groups on the relational model. Parent education can be offered to women who are pregnant or already parents, and children can be taught to understand their mother's experiences.

Women's relationship to creativity and productivity should also be explored. Vocational testing and training can help women find meaningful work to provide them a decent standard of living as well as foster pride in achievement. A focus on encouraging creativity in all of its many aspects can balance an extreme dependence on relationships for life's rewards (Bepko and Krestan, 1993). Social action may be a satisfying experience for women who have previously felt incapable of making changes in their lives and in the outer world.

Relationship practice can include visualization of successful recovery and healing of relationships. Visualization can be used to identify potential blocks and areas of anxiety before they must be confronted in reality. Staff should model positive relationships, both in their relationships with clients and with each other. Disagreements between staff are not necessarily negative, because staff can model remaining with a disconnection until it is resolved and turned into a connection.

The client-counselor relationship is an extremely important area for relationship practice. Many issues can be resolved through a corrective therapeutic relationship in which the client gains experience in trusting, being valued, and feeling understood.

Strengthening relationship with self, society, and universe. Finally, and possibly most important, women need to be encouraged to examine their relationship with themselves. Addicted people have major disconnections between the parts of themselves that need to be discovered and reconnections made. However, they need to be allowed to choose the extent of this exploration and the timing, especially if sexual abuse is involved (Barrett and Trepper, 1991). Regardless of the form or extent of this exploration, some level of insight into feelings and behavior should be encouraged.

Women may also benefit by an understanding of feminism and the overall negative effects of patriarchy and sexism on both women and men and society in general (Bepko, 1989). An exploration of these issues can empower women to initiate more balanced, equal relationships in their own relational fields and in the larger society. Similarly, understanding how sexism

interacts with racism, homophobia, and other attempts to discriminate against particular groups can assist women in understanding the larger context of addictions and in taking action against prejudice and discrimination.

Finally, clients should be encouraged to explore their understanding of their place in the universe and to formulate their own spirituality. Whether or not clients are interested in organized religion, they can learn to accept, to quote from *Desiderata*, the anonymous stonecarving found in Old Saint Paul's Church in Baltimore and dated 1692, that "you are a child of the universe, no less than the trees and the stars; you have a right to be here."

CONCLUSION

It is an extremely sad situation when a woman's "best friend" is her drug of choice. Addiction is, at least in part, associated with isolation and poor interpersonal relationships, which can result in a person developing a primary relationship with a drug that gives temporary relief from pain and loneliness. Relationships are only one aspect of addiction, but they are very important, especially for women, and have largely been ignored in traditional forms of treatment.

The relational model recognizes the need for connection that is common to all humanity and utilizes it in the service of healing from addiction. The need to feel connected to others is universal, and assisting addicted women to connect in healthy ways with other people can enhance their overall treatment process. A focus on relationships can offer a positive direction to the healing effort that may continue to provide benefits throughout a recovering person's lifetime.

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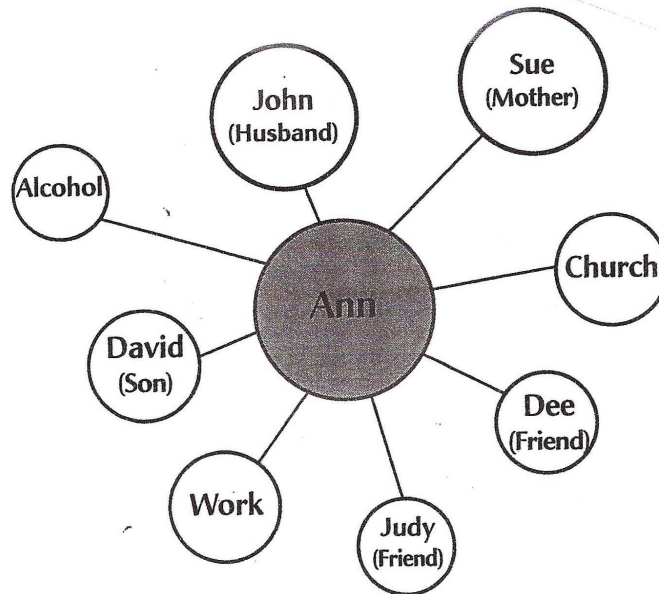


FIGURE 2-1: Relational Map: Healthy Person

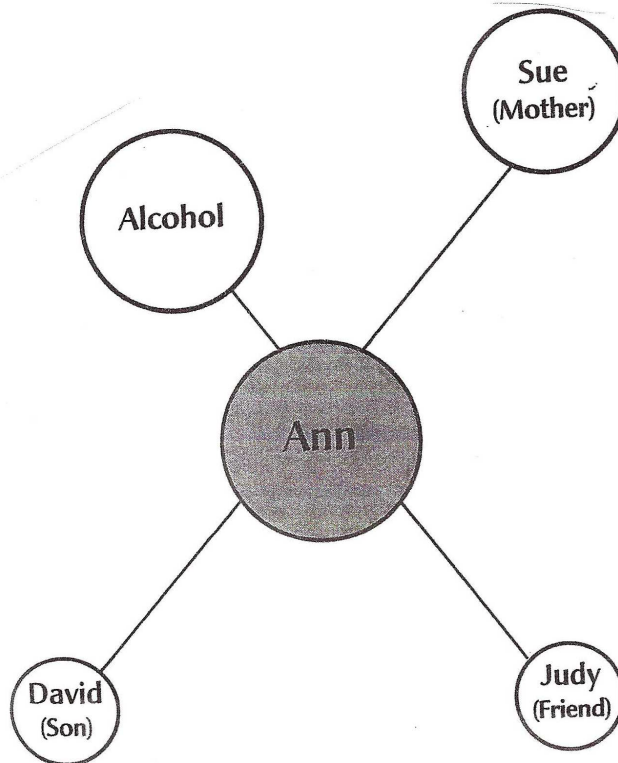


FIGURE 2-2: Relational Map: Addicted Person