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Psychoanalytic Approach to Addictive Disorders

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EARLY ROOTS

Early in the history of psychoanalytic thinking, addictions were considered to represent a regressive expression of instinctual strivings that took the form of habitual pleasure-seeking behavior. The symptoms described as the behavioral pattern of the addicted individual are organized at the unconscious level to replace the threat of instinctual; these are pleasure-pain mechanisms (Freud, 1905, 1960; Abraham, 1926; Fenichel, 1945). This chapter reviews roots and contemporary psychoanalytic models of addiction. The focus is on advances in the discipline of concern to clinicians. It explores the foundations of Freudian thinking, examines components of treatment, and presents a case illustration of an alcoholic and compulsive eater from a psychoanalytic perspective.

Addictive behavior was understood as a fixation at stages of development, such as oral for eating disorders and compulsive drug and alcohol use and phallic for compulsive sexual behavior. The psychotherapeutic work with patients followed the standard procedure for the treatment of the general neurotic population manifesting a compulsive symptom picture. The early work stressed the importance of viewing compulsive symptoms as an important piece of a larger defense system organized to ward off unpleasant affect unsuccessfully managed any other way. Psychoanalysts today continue to accept and build upon these theories regarding addictions as a symptom/defense (Silber, 1974; Vaillant, 1983; Wurmser, 1984).

With the introduction of "self" psychology, there has been a shift from viewing compulsive behavior not as a defense resulting from conflict but rather

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as a deficient formation of the self, lacking cohesion and unable to provide its own comfort. This early deficit leads to narcissistic disturbance in later life, thus creating a need for an artificial self-soothing agent. This process ultimately develops into a maladaption, which can assume the form of an addiction (Kohut, 1971, 1977; Kernberg, 1975). Both the conflict and deficit approaches offer a correct and compatible understanding of the psychological underpinnings of addiction.

Probably the most valid criticism of early analytic treatment was the inflexibility of early analysts in approaching addictive problems. The reluctance of early analysts to deviate from a classical psychoanalytic posture, which emphasized a totally nondirective environment for the patient, made treatment difficult and often frustrating for both doctor and patient. Psychoanalytic work does not involve directing the individual toward making specific choices in his life, and this holds true across all schools of psychoanalytic thought; however, in current practice, certain therapeutic interventions of a direct nature are made solely for the purpose of preserving the integrity of the treatment. If, for example, an individual is preventing the analytic process, then it is necessary for detoxification before treatment can start (Jaffe, 1983). Other interventions can be employed to set the stage for a successful psychoanalytic treatment, such as inpatient hospitalization and behavior modification.

Both the traditional conflict model and the more recent self-deficit model should be considered in the successful treatment of an addicted individual. Rather than being viewed as incompatible, they should be considered in tandem; early childhood deficits and poor internalization of soothing mechanisms cause the creation of neurotic defenses, which must then be analyzed and properly worked through to achieve a healthy adjustment.

THE WORKING ALLIANCE

A good working alliance is the foundation of any successful psychoanalytic treatment. In the therapeutic setting, the working alliance describes the strength of the relationship between the analyst and the patient. Through this collaborative effort, both can effectively allow the unconscious material to be expressed in their structured therapeutic relationship. Many therapists fail to appreciate the amount of special attention and deliberation involved in creating and maintaining a strong alliance. The working alliance determines the ability of the analyst-patient relationship to tolerate struggle; that is, it describes the level of trust the patient experiences for the therapist. This grows out of several responses on the part of the therapist to respect the subjective reality of the patient. Emphasis is on the subjective because it is essential the patient trust the analyst to see and tolerate the patient's experience of self in the world as he sees it:

> From the vantage point of the patient's unconscious neurotic processes and psychological organization, they represent his attempts at maintenance of the status quo. They protect the patient against conscious awareness of unacknowledged and unpleasurable elements within his own psychic life, and they promote and sustain the continuing search for fulfillment of inappropriate drives, fantasies and relationships. (Dewald, 1982, p. 48)

By the time the addicted patient reaches the analyst's office, he has developed a long history with people in the world at large who are incapable of understanding (and therefore untrustworthy and critical of) the patient's defenses (drug use, overeating, purging, or any other compulsion). The analyst is in the unique position of creating an alliance with the patient based on a true appreciation of the patient's defenses as seen in an adaptive context, even though they are wholly inadequate:

> Even at times when the patient himself recognizes that his behavior may be in opposition to the vowed wish for psychological maturation and change, the unconscious adaptive and anxiety-reducing functions of behavior may take precedence over the wish for maturation and growth. (Dewald, 1982, p. 48)

Let us consider an example of alliance building in the early treatment of an alcoholic. A husband initially reports that his reason for treatment is that his wife has threatened separation if he does not seek help. His presenting problem is not that he has a drinking problem because at his level of defensive functioning (denial), he does not experience it that way. What he is perceiving is a family that does not understand him and, in particular, a wife who nags him too much about his drinking. No one in his family is able to accept his version of reality or validate his perceptions of what is happening in their home environment because they are experiencing it quite differently.

During the course of history taking, it may be abundantly clear to the analyst that the patient in fact does have a serious drinking or drug problem. Patients commonly minimize and misrepresent the amount of drinking, drug use, and other addictive behaviors during an initial interview (Gedney, 1984). The analyst is appropriately more concerned about first validating the perceptions of the patient as a way of building the alliance in what will lead to longer-term growth. The assumption is this: The analyst-patient relationship will follow the same futile pattern as other relationships in the patient's life if the analyst makes the mistake of attacking the patient's defense structure (like so many others who have been unable to reach him). Before the patient's defenses can tolerate letting the analyst assume a trusted position in his life, that trust must be earned over time. The first way to accomplish this is for the analyst to demonstrate that he is not an agent of the defense-attacking outside world but rather someone whose primary task is to see the world through the eyes of the patient. Threatening the patient's autonomous expression could ultimately lead him into a negative therapeutic reaction (Jaffe, 1981). The result of proper validation is that the patient feels understood and capable of a working therapeutic alliance with a trusted analyst.

ANXIETY AND DEFENSE

Great care is taken in psychoanalytic treatment to be sensitive to the patient's defensive functioning. These ego defenses, although they appear primitive at times, serve an important adaptive purpose: protecting the conscious portion of the psyche from becoming overwhelmed by thoughts and accompanying feelings that are difficult to integrate and threaten effective living. The analyst's responsibility is to be acutely aware of the nature and purpose of the defenses at all times and to work around them until the alliance is sufficiently strong to sustain an interpretation of them. This approach is especially necessary in the treatment of addicted individuals, whose defenses are particularly brittle. To tamper with the defense too quickly will cause the patient to flee from treatment or leave him flooded with anxiety, unable to achieve insight into himself, and all the more eager to resurrect defenses of the past. That is why, in psychoanalytic treatment, the patient determines the content and pace with which treatment proceeds:

> The patient determines the subject matter of the analytic hour. This rule is a corollary of that other one, that we must always work with "living reality." What does not interest the patient cannot be forced upon him . . . for who must operate at that point where the affect is actually situated at the moment. (Fenichel, 1941, p. 44)

There must be respect of the patient's resistance to breaking down his defenses and an appreciation that the defenses will not be relaxed before the patient is ready. To increase anxiety is to exacerbate the addictive symptom, as Slochower (1987) demonstrated in her research on overeating. The addicted individual utilizes addiction as an adjunct to his defense structure. His ego defenses along with the addictive behavior provide a strong affect defense against experiencing the signal anxiety and the subsequent thoughts and feelings that lie beneath the repression barrier. Wurmser (1984–85) suggests this defense is largely to ward off superego conflicts in addition to a "return of repressed."

When the addictive behavior is removed, the result is a significant increase in two kinds of anxiety. The first, *withdrawal anxiety*, is unique to the physiologically addicted person who undergoes biochemical changes during withdrawal of a substance. In psychoanalytic thinking this is also considered objective anxiety because it represents a real threat to the individual's survival. The second form of anxiety, *neurotic anxiety*, results from a perceived threat of a breakdown of ego defenses, allowing for repressed ideas and affects to enter into conscious awareness. Although psychiatric nomenclature is often lacking in specificity (Eysenck, Wakefield & Friedman 1983), there are psychometric data to support the linkage of addictive behavior, neuroticism, and accompanying anxiety. For example, the Minnesota Multiphasic Personality Inventory, a frequently researched objective personality inventory, has been used to establish that certain personality types, particularly those with neurotic traits, are

frequently associated with addictive symptom patterns (Friedman, Webb & Lewak, 1989).

ANALYZING THE TRANSFERENCE

Children come into the world without expectations on how they will be treated by others. Their phylogenetic structure causes them to engage in certain reflexive responses. They arrive as strangers to a new world without any interactive history. They do not know whether the world is friendly, hostile, fair, rational, arbitrary, reasonable, or cruel. Only through interactions with others do they arrive at a developed set of expectations of self and others. Their interaction with the world and their evolving expectations begin to develop at the moment they arrive on the scene. It is not necessary for any verbal exchange to take place for children to begin to learn about the world.

The following example illustrates how easily expectations are formed. Imagine two girls, Rachel and Leah, born to two sets of parents in the same hospital on the same day. Although constitutionally different, both share a limited interactive history by virtue of their limited experience with the outside world. From the moment they are born, however, their ontogenetic history begins. Let us examine how transference develops as a result of differences in child rearing by looking first at the relationship between Leah and her mother.

Leah's mother is overly concerned that her baby be properly fed and healthy. She believes that her baby does not know instinctually what is best for her and must rely entirely on parental discretion to provide the necessary nourishment. This is reflected in her feeding style, force feeding Leah every two hours whether or not Leah expresses any interest in eating. She keeps the nipple in Leah's mouth until she consumes the amount that the mother predetermined. At times when Leah is either satiated or uncomfortable and wishes to pull her mouth away from the nipple, the mother forcibly pushes the nipple back into place. Even when Leah cries, her mother insists that she continue feeding and forces the nipple back until the child passively submits.

Rachel's mother behaved in quite a different way toward feeding. Rachel's mother fed her on demand. This mother came to the feeding situation with no preconceived ideas about how much her child should eat. Instead, she waited for natural cues that her daughter was hungry (such as rooting and crying) and then provided nourishment. When Rachel fussed during a feeding, her mother withdrew the nipple and attempted to comfort her. If Rachel was no longer eating, her mother would not force her to continue.

Two babies are offered different approaches to feeding, and the beginnings of disparate worldviews immediately develop. Let us imagine that these babies were visitors from another planet sent to spend one month on earth and then called back to report their findings. Granted, their breadth of experience is limited mostly to interaction with the nipple (mother), but this forms the basis of their understanding of the world as they know it. Leah would describe the

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world as a place where one is expected to accommodate the demands of unsympathetic external forces. It is a world that is experienced as basically hostile because one is immediately placed in an adversarial position with the environment. It is a place where one feels helpless to reduce comfort and is expected to submit passively to an insensitive and all-powerful authority. Leah's experiences are generally characterized as helpless, overwhelming, frustrating, and resigned to insensitivity.

Rachel's report is quite different. She describes the world as a pleasant place where needs are quickly gratified and discomfort is promptly remedied by powerful benevolent forces. She finds it to be exceptionally responsive and eager to accommodate her wishes. This creates in her feelings of effectiveness and competence in a world where people are reliable and basically kind.

These examples illustrate the early development of worldview (the child's expectations of others and general philosophical outlook on the basic nature of humanity). It is well known and appreciated in pyschoanalytic study that these early and persistent encounters with primary caregivers give form to interaction patterns that continue throughout life. These patterns continue even though an individual will come in contact with others (e.g., teachers, relatives, and neighbors). The reason is explained by the principles that govern ego organization and accompanying personality development. Once organized, the ego defines the world in a way that is consistent with its initial impressions of it. It is highly resistant to the integration of information that contradicts its original worldview. The ego continues to assign a perception based on original conclusions drawn about the nature of human interaction. What makes this such a fascinating process to observe is not only the ego's prepotent disposition toward experiencing people in a particular way but the relentless quest to seek out and associate with others who by their actions support this original worldview position. This makes the position airtight and serves to reduce anxiety in the conscious portion of the ego by maintaining predictability.

Transference is the continuation of early expectations, perceptions, and behavioral patterns that an individual brings to every relationship. In psychoanalysis, the transference emerges in the context of the therapeutic relationship and can be analyzed so that the patient can discover the origins and nature of his early conflicts. Because a person's worldview pervades every idea, verbalization, and action, it is impossible to conceal it in any relationship. It is common for people to seek out others who will reinforce their general outlook and the interactive patterns that follow. Early conflicts continue to be expressed in the transference with others who make up the individual's world. This becomes especially noticeable in the life-styles of alcohol and drug addicts, who surround themselves with those who behave similarly.

Transference plays a central role in treatment. It offers an opportunity to engage in a relationship that serves as a type of human laboratory within which the transference is illuminated and analyzed. The patient agrees to become a subject of study in an educational pursuit designed to uncover the underpinnings of the subject's personality development. The transference derives from the core of the individual's psychic structure and is activated in a therapeutic (or any) relationship. Transference is virtually indistinguishable to the patient. Observing one's own transference is analogous to seeing the forest from the trees. It is virtually impossible to achieve awareness of it independently, without benefit of an objective person capable of maintaining an alliance and providing the proper interpretation at the critical time, which aids the person in becoming aware of the transference phenomena:

> This new fact which we thus recognize . . . is known by us as *transference*. We mean a transference of feelings on to the person of the doctor, since we do not believe that the situation in the treatment could justify the development of such feelings. We suspect, on the contrary, that the whole readiness for these feelings is derived from elsewhere, that they were already prepared in the patient and, upon the opportunity offered by the analytic treatment, are transferred on to the person of the doctor. (Freud, 1977, p. 442)

The degree to which the patient rejects or resists the analyst's attempt to analyze the transference is termed *transference resistance*.

The first awareness of transference usually occurs as a revelation that one's parents do not represent the paradigm for all adults. For example, it is common for a patient to report, "I never realized that all fathers didn't drink," or "I never thought that any parents took an interest in the details of their children's social life." That type of realization opens up the individual to a greater understanding of the causal relationship that exists between early childhood experiences and addictive patterns formed later in life. Helping a patient to become aware of transference phenomena usually ensures continued motivation, self-wonderment, and confidence in the analytic method. At this point in the treatment, the entire process begins (perhaps for the first time) to make perfect sense to the patient. Until this time, the patient's commitment to treatment may be maintained by blind faith or the immediate comfort that the patient experiences by the soothing presence of the analyst.

SELF: FROM SYMPTOM TO OBJECT

In psychoanalytic treatment, the therapist, once engaged in an active working alliance, can assume the position of an idealized object for the patient; that is, the patient can assign certain defensive powers to the analyst to help soothe the patient in the face of anxiety. Since the threat of anxiety is so great (most addicted individuals believe they cannot live without their symptom of choice), the working alliance must be quite strong, and the analyst must be perceived as someone who begins to approximate strength, reliability, and the defensive power of the patient's addition:

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The nature of the object relations of the drug-dependent patient is such that he craves to be unified with an ideal object, but at the same time dreads it. He thus becomes addicted to acting out the drama of fantasy introjection and separation from the drug. There is a corresponding intrapsychic defect; certain essential functions related to nurturance are reserved for the object-representation. The objective of therapy is to permit the patient to extend this conscious self-recognition to all of himself, thereby freeing him from the need of the placebo effect of the drug as a means of gaining access to his alienated parts and functions. (Krystal, 1977, p. 98)

The analyst must engage the patient in a relationship that serves to be uniquely accepting and empathic. Through this encounter, the patient may develop a greater sense of trust in his ability to acquire emotional nourishment from others in exchange for the temporary and ultimately destructive soothing that is derived from an addictive symptom. The natural process of growth and development that occurs when an individual is actively registering, processing, and integrating his world becomes seriously arrested during the addictive process. This process must be set into motion again through the work of the analysis. At first, the patient exhibits little trust in this process since it was originally found to be inadequate and abandoned in favor of an addictive defense. It must be assumed that the patient is psychically overwhelmed during the initial period of abstinence from the addictive symptoms.

The ego functions necessary to accomplish the negotiations of impulses have been effectively operating artificially prior to abstinence from the symptom. Demands on the ego are to mediate, integrate, organize, and defend against impulses. The flooding of anxiety, fears, and feelings of being overwhelmed comes about as a signal that the ego verges on losing equilibrium. Previously the addiction fortified the ego defenses and created an artificial homeostasis; during abstinence, the analyst must provide the external fortification of ego defense to allow the patient to make a transition from symptom to object (person).

At this point in the treatment, the patient resumes an approximation of the early parental relationship that empathically failed him. Without the use of the addictive symptom, the patient experiences the reawakening of childhood's overwhelming emotions, anxiety and vulnerability. It is through the mastery of a manageable frustration and anxiety that the infant and child develop a sense of inner resourcefulness for providing adequate self-soothing and frustration tolerance. Early in life, this is achieved through repetitive contact with parents (particularly the mother) in which actual soothing is provided physically and verbally. The child learns that he possesses the ability to withstand unpleasant sensations by utilizing the parents' methods and strategies (defenses), which eventually become his own. This process is known as *transmuting internalization* (Kohut, 1977). Transmuting internalization (self-soothing) is accomplished only when the child is forced to cope with the manageable frustrations that will inevitably occur. "What are the wholesome self-object processes that build up the healthy self? We see them as occurring in two steps. First, a basic intuneness must exist between the self and its self objects (parents). Second, self object failures of a non-traumatic degree must occur. We refer to the results of such failure of self objects of childhood as 'optimal frustrations' " (Kohut, 1984, p. 70).

When frustrations are overwhelming for the child and result in a faulty connection between mother and child because of neglect or inconsistent communications (especially during the time of the child's discomfort), several problems occur. First, the child learns that the world is unresponsive and unreliable and cannot be counted upon for soothing.

Second, since the individual recognizes that he has not accomplished the necessary internalization of self-soothing capacity, he continues unconsciously to seek something in his external world that can be taken into himself to satisfy the previously unsuccessful internalization. This is not the case in which one or both parents were addicted during the child's development. In that situation, the child actually introjects the parents' methods (addiction) for managing discomfort. This accounts for why such a high incidence of addiction follows family lines.

Third, the child and subsequent developed adult is limited in his ability to register, analyze, and integrate his world through meaningful contact with others. Instead, the child, and later the adult, compulsively turns to his symptoms of choice. In other words, the individual is limited in his capacity for object relatedness.

Finally, the individual is resistant to giving up an addictive symptom for the promise of personal growth that never before had been realized by way of a dependent relationship (parent-child).

It should be apparent why the recapitulation of the early parent relationship in the context of analysis has its challenges. The analyst must constructively deal with the patient's resistance until the patient can view his world more accurately by working through the unresolved issues in the analytic relationship. The analytic relationship offers the patient an opportunity to repeat an earlier time in his psychological development and correct the maladaptive defensive organization that has produced the addiction. This successful transition from addiction to improved human relatedness with the analyst becomes generalized to the world at large.

MAKING THE UNCONSCIOUS CONSCIOUS

In order to understand analytic work, it is necessary to appreciate the role that the unconscious plays in maintaining the maladaption of the addictive process. The defenses fortified by the addictive behavior exist in order to ward off anxiety, which is the signal that unpleasant ideas and accompanying affect are pushing their way into consciousness. This push upward is motivated by the psyche to free up countercathected energy required to allow the repressed ma-

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terial to continue to reside in the unconscious domain. This energy used to hold on to the repressed material at the unconscious level is not available to the psyche for application in other more constructive activities, such as working, creating, and loving. As long as these threatening ideas reside at the unconscious level, they drain energy, seek symbolic expression, and control the individual. The work of the analysis is to help the patient loosen up and free the unconscious material into consciousness so that he can exert greater control over his life.

Psychotherapists observe how the addict's defense of denial prevents the individual from becoming aware of disturbing realities concerning the nature of his self-destructive behavior and other painful realities that predate the onset of the addiction. Although the realities of this patient's life may be more than apparent to an objective observer, the patient is unable to see it. That which the patient cannot integrate into his conscious awareness is termed *unconscious*. The inexperienced or overly zealous therapist is likely early in treatment to insist the patient see what is so obvious to the therapist (and the patient's family). This is often attempted through the use of confrontation. Unfortunately, this method serves to mobilize the defenses against the therapist and the unconscious material that he is seeking to illuminate. The defenses will break down and allow the protected unconscious material to emerge only as the patient can tolerate integrating these ideas with a manageable amount of anxiety. The analyst's job is to monitor and, to the extent that he can, modulate an improvement in the patient's general outlook on life, because for the first time he can trust the process of growth itself. This is what is often referred to as a spiritual awakening in twelve-step programs. The patient's existence is directed away from simply maintaining a habitual pattern of behavior to avoid the ensuing anxiety, instead learning to confront and understand the historical basis for anxiety, thereby freeing himself from the chains of his past.

The analyst always attempts to be aware of the patient's level of anxiety. Too much anxiety causes the patient's defenses to form an impasse, or the patient discontinues treatment. When there exists too little tension or anxiety, especially early in treatment, the patient can lose motivation for continuing in therapy.

INTERPRETATION

Interpretation involves helping the patient to understand his current behavior as a product of past and current relationships and situations. It is the tool that the analyst uses to help loosen unconscious material to make it available to the patient's conscious mind. The reason it is termed "interpretation" is that the unconscious thought process is inaccessible unless there is an effective ambassador serving as translator between the unconscious and the conscious domains. To be a successful translator, the analyst must be familiar with the particular conscious thought process of the individual and be especially knowledgeable

of the unique ways in which the individual conceptualizes himself and the world. It is a process analogous to an ambassador's serving as liaison between two countries that differ in philosophical and cultural traditions and practices. Unless the ambassador is well acquainted with the customs of a foreign country, it is too easy for him accidentally to commit a social faux pas or fail to communicate an important message.

Analysts in training commonly make interpretations that are either too early or too deep based on a limited understanding of the patient's concept of self (Fenichel, 1941). These interpretations are not only rejected out of hand but create a rift between analyst and patient that may prove to be insurmountable and impossible to repair. It is not unusual to hear psychotherapists who practice outside the analytic schools of thought to complain that psychoanalysis is a modality of treatment that takes too long to achieve its goals. But responsible and conscientious psychoanalysts do not risk the patient's progress by making assumptions about his internal life before understanding how the patient views his world and himself in it.

Most effective interpretations are offered to the patient in a spirit of honest inquiry, stressing the collaborative effort between patient and analyst to explore and uncover hidden truths that lie below the surface of the patient's repression barrier. Therefore, the patient is always offered the opportunity to express his separateness by rejecting an interpretation (Jaffe, 1981). The seasoned analyst will make the analytic setting a comfortable place for the patient to take issue with any interpretation if the patient is inclined to do so. In keeping with this position, it is desirable that interpretations be made tentatively or in the form of a question—for example, "Could it be that . . . ," "Perhaps . . . ," or "I wonder if . . . ." These qualifiers permit the patient to respond at his level of comfort with the timing and depth of the interpretation. It is important that the analyst assess the patient's tolerance to accept a particular form of an interpretation. Selecting the correct form of an interpretation should not be underestimated; the key to a successful analysis usually lies in the analyst's ability to be exquisitely sensitive to the limits of the patient's tolerance for interpretive intervention at any time. "When one makes an impact, they do so not because we are so omniscient or omnipotent, but most likely because we have had the good sense to read the patient's signals correctly and tell him what he is ready to hear" (Basch, 1980, p. 145). If the interpretations are accurate, they provide the substance from which the patient is able to achieve independent insight into the forgotten and hidden secrets of his own being by someone who has been listening carefully.

The pitfalls that are unique to the addicted patient tend to be associated with the anxiety level the patient is experiencing in treatment. An accurate interpretation is experienced not only as an "aha" event for the patient but is also taken as empathic soothing by the analyst of the patient. When the anxiety level is not maintained at a manageable level, either because there is an insufficient amount of soothing or because of other internal facts, the individual is

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more likely to resort to his earlier defense against the anxiety, the addiction. With nonaddicted patients, this concern is not as immediately threatening to the well-being of the patient and the treatment. In all cases, it is necessary to be in tune with the patient's anxiety level at all times before attempting an interpretation.

CASE STUDY

This brief case study concerns an alcoholic and compulsive eater from a psychoanalytic perspective.

The Beginning of Treatment

Mr. A. made an appointment for an evaluation because his drinking, eating, and depression had increased over the previous two years. Just prior to coming in, he could not find the motivation to go to work and sat drinking and overeating in his house for almost a week. At the suggestion of his wife, he made an appointment to see if something could be done to help him out of his condition. He had no prior history of treatment.

During the initial appointment, Mr. A. reported being unable to control his eating and drinking; he felt desperate and stated that if he were permitted to return home, he would continue to drink and become more depressed. Hospitalization was offered to help him detoxify from the alcohol and provide a safe holding environment. He readily accepted and was taken to the hospital, where he was evaluated and admitted to an open substance abuse unit for three weeks. Mr. A. began seeing me for individual psychoanalytic psychotherapy twice weekly while in the hospital and then three times per week after discharge.

During the initial sessions of psychoanalysis, Mr. A. expressed an urge to resume drinking and asked for help in abstaining. At first, I asked if he would be willing to attend Alcoholics Anonymous (AA) meetings, but he flatly refused, saying that he would consider virtually all measures except AA. When inquiry was made as to why he refused to attend AA, he said he was unaware of any specific reason, only that he did not like "those kind of people," whom he described as being "religious fanatics who are critical and judgmental." Although it appeared to the staff that his contact with them was positive on the inpatient unit. It appeared to me that this perception involving religious fanaticism was transference laden and defensive, so I avoided confronting it at that time.

Patient History

Mr. A. was born in Canada in 1930. His father, a minister by profession, was 38 years old at the time of his birth; his mother, a housewife, was 26. The family moved to southern California two years after his birth. An only child, Mr. A. grew up in a semirural area of California and attended public schools.

The patient's father, who died when Mr. A. was 23 years old, was described as a strict disciplinarian. He was remembered as being "moralistic and critical" and although very concerned about punishing Mr. A. for misbehaving, rarely, if ever, physically controlled him. Instead, he would discuss with his son the sinful nature of his son's behavior. Consequently, the patient developed a strong sense of morality and accompanying guilt. Active as the community church leader, his father spent a great deal of time with other people and away from the house. Mr. A. was taught to be the man of the house in his father's absence, and it was stressed that he (like his father) must be an example to the community.

The mother, who died when the patient was 34 years old, was described as being emotionally volatile and unpredictable. Mr. A. recalled being unable to know from one hour to the next how his mother was feeling and thus how she would behave. Mr. A. recalled that his parents argued constantly as he grew up. In particular, his father frequently complained about his wife's appearance and the general upkeep of the house. Mr. A. vividly remembered the mother's screaming at the top of her voice in response to his father's criticisms.

Mr. A.'s first memory dates back to when he was 8 years old. In school, a liquid wax candy broke in his pocket, but before asking for an explanation, his teacher publicly accused him of having urinated in his pants. He recalls feeling humiliated, which was followed by ridicule from his classmates.

Mr. A. was quite tall and large (obese) for his age but experienced a great dilemma when physically confronted by peers. Although fighting was commonplace in grade school, he was always afraid that he would be punished by his father or that because of his great size he would seriously injure his challenger. Denying ever provoking a physical fight, he remembers almost always walking away from them. However, one day when he was 10 years old, a smaller boy cajoled him into fighting back. The boy suffered a broken jaw and had to be taken to the hospital. When Mr. A. was taken home he was severely punished with a belt by his father. He does not ever remember fighting again after that episode.

Mr. A. always excelled academically. He was an A student and described himself as always well behaved. Throughout elementary school, he never had more than one friend at a time and did not participate in any team sports. At the age of 14, his father caught him smoking a cigarette behind the house. Mr. A. remembers that at first his father began to lecture him but began to sob uncontrollably and could not finish talking. Mr. A. continued to smoke cigarettes thereafter but felt guilty for years.

After attending college for a short time, his only friend joined the army to go to Korea, and he followed. After basic training, he requested placement in a technical job, which served to isolate him significantly. It was during the time Mr. A. was in the army that he began to binge drink. Always responsible

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his drinking took place during his time off, and it was often necessary for someone to bail him out of jail on the weekend.

When he returned home, he met a woman 18 years old and married her within a month. This woman was part Indian, and Mr. A's father strongly objected to the marriage. It lasted for less than a year, with his wife's running off with another man. Two years later, his father died, and shortly after Mr. A. left California for a job in Chicago, against his mother's wishes and requests.

After living in Chicago for a few years, he met and married his second wife, in a marriage that lasted seven years. The separation occurred for unknown or vague reasons, according to Mr. A., except that they began "drifting apart." At the end of the marriage, they had a son, who is now 23 years old. Eight years later, Mr. A. was married again to his current wife, twelve years his senior.

Dynamic Formulation

Impulsivity was always a problem for Mr. A., and he continued to be concerned that he would "lose control of his anger and hit someone." This especially created concern for him when he was frustrated, criticized, or humiliated by another person. To deal with the threatening impulses to express his aggression in destructive ways, he drank alcohol, ate compulsively, and utilized the defense of intellectualization. In this way, he was able to intellectually minimize or rationalize conflictual situations to avoid having to experience his aggressive and rageful impulses, wishes, and accompanying fears.

Intellectually defensive in his approach to people and problems, Mr. A. was overly controlled and lacking spontaneity. His intonation was often void of affect, his emotional experience of the world virtually unavailable to him. He attempted to maintain distance from intimacy but was left feeling alienated and socially isolated. It was difficult for him to get close to another person, including me.

Mr. A. grew up in a family that provided a distorted and impoverished view of reality. His father was critical, moralistic, and verbally punitive. As a result, he incorporated a strict and overbearing superego, which prohibited the expression of aggressive impulses because to do so was considered primitive and subsequently was punished. AA was experienced early on as a paternal transference object easily associated with his father's church in Mr. A.'s childhood. In the transference, AA was perceived as possessing all of the negative attributes of his father. Eventually this was interpreted, and Mr. A. was able to understand it. However, this is a case that clearly demonstrates that to have insisted Mr. A. attend AA would have been contraindicated and would have destroyed the therapeutic relationship. All treatment modalities, including AA, must be evaluated on an individual basis and assigned relative value according to dynamic issues at hand. Anxiety associated with the expression of impulses was compounded when, as the result of his anger, Mr. A. sent a fellow classmate to the hospital. From early on, he repressed any aggressive wish, impulse, or fantasy. In order to manage these impulses, he developed a keen intellect that helped him to circumvent his overwhelming emotional experience. This defensive strategy did not sufficiently inhibit the impulses' expression into his consciousness because it appeared as signal anxiety. Finally, he attempted to eliminate the anxiety by using alcohol.

The patient's identification was with his father, but he experienced intense feelings and ambivalence toward him. On the one hand, the father was seen as strong, worthy of respect, and emotionally stable (at least more than the mother); on the other hand, he was critical, arbitrary, and punitive. Unable to resolve the ambivalence, the patient felt guilty and afraid of his own strength and afraid that the expression of his own impulses would be followed by moral condemnation and disastrous consequences. His admiration of his father was mixed with rage for having been so frequently criticized by him. This led to Mr. A.'s attempt to avoid awareness of his own human shortcomings and rationalize away mistakes that he made.

Early in the treatment Mr. A. demonstrated difficulty forming a working alliance because of all the negative paternal transference aroused by the therapy situation. He was unable to tolerate even the most shallow interpretation, taking it to be criticism. In general, he has had difficulty accepting caring from others, and he prefers to be alone. Caring relationships ultimately come to be perceived as critical and hurtful, and so to maintain distance, he drank. He ate excessively to make himself less attractive to others.

Despite the difficulty he experienced with his father, Mr. A. did rely on this parent to provide a fair amount of consistency and stability. His mother was apparently disturbed in this area. She was unable to provide basic mothering because she was emotionally unstable, labile, and generally erratic in her treatment of her son. Mr. A. remembered when he was a boy that his mother cried uncontrolled for long periods of time without stopping while intermittently screaming and cursing at him. He recalled being frightened and confused during these periods. He became frightened and overwhelmed by intense feelings in general. Although he could not recall the source of this information, Mr. A. reported hearing that his mother was "terrified" of giving birth. It can be reasonably assumed that the responsibility of taking care of an infant was overwhelming for his mother and that she was unable to soothe him properly. In the absence of necessary nuturance and soothing from his mother early in his life, the patient never achieved the transmuting internalization necessary for adequate self-soothing.

Mr. A. remained deeply frustrated by ungratified dependency needs. In his relationships with women, he has assumed a passive-aggressive position. He appears very needy and yet unable to accept caring from them (reenacting his

relationship with his mother). During treatment, it was revealed that his maternal transference caused him to view women as objects who take from him, and he denied that they have anything to offer him except instability.

As an only child, Mr. A. remembered feeling isolated during much of his childhood. Although he did have one friend most of the time, he always felt alienated from the social mainstream in school. He felt envious of children who were more comfortably involved but compensated by participating more actively in solitary kinds of sports. This mode of relating to others persisted over time. Before treatment, he did not identify with the group (his current contemporaries) and referred to himself as an outsider. In therapy, he became aware of how this position served to maintain distance so as not to risk getting closer to the old disappointments and rage so typical of his childhood. He joined two social organizations and made new friends.

Mr. A.'s size also affected the way in which he perceived himself. Much larger than all of his classmates, he recalled being treated with ridicule by his peers and expected to behave more like an adult to the point that friends of the family commented how being in his presence was like being with an adult. He assumed the behavior of a much older person but secretly resented being inhibited from expressing himself as a child. This strengthened his intellectualized defense against his true feelings, offering no opportunity to understand and integrate more primitive impulses typical of his true age.

Earlier in the treatment Mr. A. would perceive much of what I had to say as being disapproving, even though it was neutral. His apparent perception (transference) of me changed quite frequently during the first year from being critical to kind, demanding to uncaring, from wanting to control me and cause me to feel guilty and ashamed to being totally disinterested in me. It took almost two years before he was able to acknowledge that he was in a meaningful therapeutic relationship and was able to recognize that many of his perceptions of me were the result of transference derived from earlier experiences in his life. At the end of four years he was still sober, at the fiftieth percentile for weight, in his own business, more aware of the emotional dimension of his existence, and significantly less conflicted in life. It was at that time that we mutually agreed to terminate treatment.

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