Dancing Among the Maenads

Object Relations and Compulsive Drug Use

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Object Relations and Compulsive Drug Use

Although drug use has not yet been conceptualized using a purely object relations approach, object relations phenomena are implicit in the psychoanalytic studies outlined in the previous chapter. While these studies of drug use have touched upon the macro-level psychodynamics of drug use, they stop short of explaining these dynamics in detail. The following discussion outlines the concept of object relations and its connection to drug use pathology in more detail.

Object Relations Theory

The ideas underlying object relations theory can be derived from the psychoanalytic drive/structure model, which postulates that the drive energy (libido) seeks *objects* in order to neutralize tension. This tenet is the constancy principle (Freud, 1920), which holds that the basic aim of the psychic apparatus is to maintain stimulation as close as possible to zero. This phenomena can be explained in terms of object relations. The infant is uncomfortable or in a state of tension. When the infant comes into contact with an object, his drive needs are satisfied and his tension is reduced. This tension reduction is associated with pleasure. (Symington, 1986, p. 118)

In order to reduce psychic stimulation and the tension it causes,

libido seeks for objects which will neutralize it. These objects share three important properties. First they are always reducible to the underlying drive. Second, objects may include people or things. Third, objects can undergo change.

Objects are not inherent, but are created out of the drive. When the drive is satisfied, or tension reduced, there is an opportunity for the creation of an object, or more accurately, a mental representation of the object. Repeated situations of satisfaction create an internal mental representation of an object from an external situation. In this way an object becomes distinguished from the subject. An object is something (a person or thing) outside of the subject. In psychoanalysis, the term interpersonal relationship is used to indicate the relationship between a subject and an object, while object relations theory is used to describe the relationship between internal representations of objects and the self, within the subject. In other words, object relations theory describes an internal mental representation of an interpersonal relationship. Accordingly, an object relations theory indicates that the mind includes elements taken in from the outside through a process of internalization and that there is an internal relationship between one's self representations and the representation of internalized objects.

Object relations theory is not something outside of classical

psychoanalysis. It was included in classical psychoanalysis as a separate focus or point of view. For example, when Freud (1917) described the mental mechanisms at work in the process of mourning he utilized object relations theory. He theorized that when an external object is lost (for instance when a person dies), the shadow (i.e., the mental representation of this person) falls upon the ego of the mourner. When this happens the already existing mental representation of the lost object is re-cathected. This leads to an internal interaction between the representation of the lost object and the representation of the self.

Kernberg (1976) makes a distinction between general and specific approaches to object relations theory. The general approach to object relations theory refers to an understanding of the nature of existing interpersonal relations in terms of past ones. Therefore, in general, object relations theory seeks to understand how past object relations are internalized and become psychic structures. These past object relations are seen as determining, to a great extent, the current nature of the interaction between the subject and his objects. As Kernberg (1976) says,

> Psychoanalytic object relation theory, at this level, represents a general focus or approach occupying an intermediate field between psychoanalytic metapsychology proper, on the one hand, and clinical analyses of normal ana pathological functioning on the other, (p. xiii-xiv)

The more specific view of object relations theory refers to the

building up of dyadic intrapsychic representations of self and object images. Such representations reflect the original relationship between the infant and its primary object (usually the mother or primary caretaker). These relationships are later elaborated into triadic and multiple internal and external interpersonal relationships. This way of understanding object relations theory has been greatly refined by Kernberg (1967, 1975, 1980) who synthesized the works of Bowlby, Erikson, Fairbairn, Jacobson, Klein, and Mahler.

In both the general and specific models of object relations theory there is a strong developmental thrust: The infant originally relates only to himself to satisfy his drive needs. As he ages, he begins to receive satisfaction from relationships to objects outside or external to himself. The first and primary object is usually the mother, or a part of the mother (e.g. the breast). This relationship to the primary object becomes the prototype of all relationships for the rest of the infant's life. Consequently, disturbances in this relationship have profound and far-reaching effects upon the infant's mental health.

A number of different theorists have elaborated upon the development of object relationships (Blanck & Blanck, 1986; Jacobson, 1964; Kernberg, 1975,1980; Mahler, 1975). The developmental models outlined by these authors tend to follow Freud's initial ideas about object

relations closely. Nevertheless, these modern authors emphasize different stages of the developmental path. The most common conceptualization of the stages of object relations development are as follows;

1. *Infantile Autism*—This is the beginning stage which is similar to Freud's idea of primary narcissism in which the infant has not yet developed the ability to perceive or acknowledge anything external to himself. Much psychoanalytic research has been conducted on the beginning of mentation among infants (Emde, 1985; Greenspan, 1989; Stern, 1985; Tahka, 1988). This research indicates that the infant's mind is more active than previously thought. There are potentials of mental functions, including relations to objects. Some mental function potentials get activated through more complicated relationships that exist between infant and the mother. These findings indicate that the concept of autism should be reconsidered. It may be better to talk about an undifferentiated state of self and object relations than a completely objectless state.

2. *Symbiosis*—In this stage, there is a dawning of external reality. There can be no symbiosis if there is no external reality. However, the external reality of the infant (consisting of its relationship with its mother) is fused with its experiences and, therefore, remains undifferentiated.

3. *Separation-Individuation*—The infant begins to develop a sense

of separateness from the mother. At first the infant can only tolerate this separation for short periods of time, but after much practice these time periods lengthen.

4. *Mature Object Relations*—At this stage the infant understands himself to be a separate person from the mother. He is able to enter into relationships with the mother and others in a way which reflects his understanding that they are separate individuals with needs different from his.

Each of the developmental stages of object relations represents a progressively more complicated dyadic relationship. Generally speaking, the time period for the unfolding of this developmental pattern is from birth to around three years of age. However, this time period varies widely. Affective states are also tied to the object relations stages. These affective states are originally derived from the biological responses of the infant to the environment and are related to the experience of satisfaction, frustration and panic. It is, therefore, not surprising to find that individuals with object relations pathology often have affective problems as well.

The outcomes of this developmental sequence are healthy psychic structures; ego, superego and id (Kernberg, 1980). The ability to enter into, and resolve triadic relationships such as the oedipal conflict is dependent upon the resolution of object relation conflicts. This is why

object relations psychopathology is usually conceptualized as being *preoedipal* in nature. It is important to distinguish preoedipal object relations conflict from other types of conflict at an oedipal level. In classical psychoanalysis oedipal level conflict is described as occurring between unconscious wishes and superego responses. Later on, this type of conflict came to be explained as being related to anxiety. This anxiety is created when expressions of libidinal and aggressive drives come into conflict with both internal and external prohibitions. This conflict is experienced as a form of anxiety which is defended against by the ego. With the systemization of object relations theory within psychoanalysis, conflicts were conceptualized in terms of conflicts among internal self and object representations. In normal development, the child slowly develops an integrated self-representation and integrated object representations. In order to achieve this integration the child needs to gain the ability to put together opposing self and object representations and their drive derivatives. This attempt at integration causes anxiety and conflict. This type of preoedipal, object relations conflict dominate until the child develops a cohesive sense of self and integrated object representations. Once this is achieved, oedipal or structural (id/ego/superego) conflicts become dominant. Dorpat (1976) succinctly describes the difference between structural (oedipal) and object relations (preoedipal) conflict:

> ...in a structural conflict, the subject experiences (or is capable of experiencing if some part of the conflict is unconscious) the opposing tendencies as aspects of himself...in the object relations conflict, the subject experiences the conflict as being between his own wishes and representations (e.g. introjects) of another person's values, prohibitions, or injunctions. (869-870).

Another way of saying this is that if an individual's psychic structure is advanced, he is able to 'own' his conflict, even if aspects of it are unconscious. If the individual's psychic structure has not developed and his internal mental representations are not integrated, he is able to own only part of the conflict while the other part is experienced as if it belongs to someone else.

Drug Use and Object Relations

Drugs have much in common with objects and their representations. They reduce libidinal and aggressive tension and, at least in the short term, give a person a feeling of wellbeing. This combination of a feeling of well-being and the neutralization of tension makes the drug experience similar to an infantile dependent state, in which the infant is symbiotically related to the primary object. The effects of drugs reduce tension, or in Khantzian's terms, provide relief from dysphoria. It follows that, in general, drug use is regressive in nature, leading the user to seek a return to the experience of this infantile dependent state (Fine, 1972; Rado, 1933). Two aspects of drug use tend

to support this idea.

The first is that the drug user tends to be helpless and dependent when he is under the influence of drugs. Although Khantzian states that drugs put the user in control of his dysphoria, it would seem more likely that the drug user alternates between being in control of his dysphoria when the drug effects wear off, and being controlled or 'taken care of', when he is under the influence of the drug.

The second aspect is that the primary model of incorporation of drugs is oral. The mouth is the earliest libidinal zone and of primary importance to drug users. (Miller, 1983, describes a case with an intravenous drug user in which the skin was the primary zone. Although in this case the libidinal zone is different, the basic dynamics of drug use retain their primitive object qualities). These aspects reinforce the idea that drug use represents a return to a state of primitive object relations. This state is characterized by symbiotic dependency on the object, which is experienced as pleasurable, and which provides pleasure primarily through the oral zone (Charles-Nicolas, Valluer & Tonnelier, 1982; Edelstein, 1975). Therefore, although drugs usually carry both good and bad aspects of the early object, individuals with good early object relations are more likely to experience drug use as pleasurable than not. Individuals who had good primary object relations will also be less likely

to crave a replay of these early object feelings, having already achieved more stable mature object relations.

For those with disturbed early object relations, drug use may be an attempt to compensate for the ambivalent and frustrating aspects of the primary object, which are characterized by the expression of infantile rage, aggression and confusion. For instance, one study profiled the mothers of frequent drug users as,

> ...relatively cold, unresponsive, and under-protective. They appear to give their children little encouragement while, conjointly, they are pressuring and overly interested in their children's "performance'. The apparent net effect of this double-bind is that they turn a potentially enjoyable interaction into a grim and unpleasant one. (Shedler & Block, 1990, p. 621)

It may not only be the primary object (mother) that engenders rage, aggression and confusion in compulsive drug users. Object relations with the father and the family object relation constellation may also play important roles in the etiology of addiction. Wurmser (1978) describes the typical constellation of a family of a drug addict,

> One of the most consistent family constellations identified...was the combination of an overprotective indulgent mother with an absent or emotionally distant father. Mothers were described as having 'special" relationships with the sons and tended to be involved in their addictions. Some fathers were described as hostile and punitive rather than weak and ineffectual, but the end result seemed to be that drug addicts did not have a role figure with whom to identify in a positive way (p. 361).

These dynamics in the etiology of the drug user can be seen clearly in a number of the cases presented later in the text. Of course, the question of specificity is very difficult to address. While the family constellation presented above certainly signal future trouble, an individual with this type of family may not become a compulsive drug user. Instead, he may develop some other type of addiction, sexual perversion, borderline personality disorder, etc.

A negative experience with early or primary objects may cause an individual to crave for the good aspects of these objects throughout his life. This is readily apparent when the primary object failed to provide a sense of security, or when there was a loss of the object. The loss of the object can be real or imagined. For instance, if a mother dies, a real object is lost. If the mother is psychotic, however, there is also a loss of the object in the sense that certain interactions between mother and child will not be available. Without an object an individual may search for experiences which compensate for, or recreate the experience of the good aspects of the early object. The drug experience may play this compensatory role. The research by Blatt and his colleagues (Blatt, Berman, et al., 1984; Blatt, McDonald, et al., 1984; Blatt, Rounsaville, et al., 1984), however, indicates that compulsive drug use may be more than a search for the pleasurable primary object. Instead, it can be understood as an attempt to deal with internalized object

representations derived from the negative experience of the primary object. In other words, the harshness and cruelty of the parents, along with the frustration this experience engenders, are introjected and are established as the internal object world of the compulsive drug user. The compulsive use of drugs may be both an attempt to excise and/or control these negative internalized object representations. Therefore, it will be important to examine the object relations dynamics among drug users from the standpoint of a theory that can explain drug use both in terms of regression to the primary object and the internalization of harsh, frustrating object representations.

As noted by Khantzian (1974, 1978, 1979) and Wurmser (1974), different types of drugs may provide different types of compensation. The compensation needed for a particular personality type may be represented by the effects of a particular drug. A study by DeAngelis (1975) examined the relation of client behavior to the type of drug used within the framework of a psychoanalytic treatment milieu. This study supports the idea that personality structures related to specific patterns of object relations are symbiotically drawn to certain drugs due to the reinforcing nature of the drug's effect upon a given object configuration. Another study by Mider (1983) also gives support to this hypothesis. Although little data exists correlating the early object history of drug users with the types of drugs used, it appears likely that clear patterns

will emerge.

Drug Use, Bad Objects and Fairbairn's Theory of Object Relations

Thus far, drug use has been examined primarily as a compensation for the good aspects of the primary object. However, the relationship of drug use to the harsh, frustrating or "bad" aspects of the primary object is less clear. In order to describe this relationship it will be useful to examine the object relations theory of W. H. D. Fairbairn.

Fairbairn's major ideas were formulated in two papers, *A Revised Psychopathology of the Psychoses and Psychoneuroses,* and *The Repression and Return of the Bad Objects* (Fairbairn, 1952), both reprinted in Buckley (1986). Although Fairbairn's theories deviate from the psychoanalytic mainstream he is considered to have made important contributions to the field (Kernberg, 1980, 1984). Fairbairn's theory of object relations is helpful in the formulation of a deeper understanding of the psychodynamics of drug use. In fact, the pathology of drug dependence has been characterized in terms of Fairbairn's theories (Callea and Rubino, 1980).

Fairbairn differs from classical psychoanalytic theory in his rejection of the primacy of the drives. Fairbairn believed that objects, and hence object representations, carry libido as opposed to the classical idea

that libido seeks objects in order to reduce tension. He also believed that the ego, in at least a rudimentary form, is present from birth. Thus, he did not believe in primary narcissism, postulating instead that narcissistic states were essentially autoerotic, with the infant providing himself with the representation of an object that could not otherwise be obtained. Fairbairn viewed object representations used by the individual in this manner as "...an attempt to compensate by substitutive satisfactions for the failure of his emotional relationships with outer objects" (Fairbairn, 1952, p. 40).

In Fairbairn's view individuals undergo three stages of development. In the first stage the individual is in a state of infantile dependence or identification with the object. This stage is characterized by an attitude of 'taking' or incorporating through the oral zone. The first stage is divided into two parts: the *early oral,* in which the infant relates exclusively to part objects (the breast), and the *late oral,* in which the infant is able to relate to whole objects (the mother).

The next or second stage is that of transition between infantile and mature dependence. During this transition the infant's attitude turns from *taking* to one of *giving.* Objects are split into good and bad representations, with the bad object representations being internalized[1]

The third stage is that of mature dependence which is characterized by relations to differentiated objects. The attitude is one of *giving.* Both good and bad object representations are externalized.

These theories have a number of applications to drug use, but differ from the classical psychoanalytic explanation in that drugs can be seen as representing bad objects as well as good, or compensatory objects. Drugs, therefore, can represent both primal pleasurable objects and internalized frustrating objects. French analyst, Joyce McDougall (1985) expresses this dynamic eloquently,

> For the enslaved addict, the addictive object—whether it is food, tobacco, alcohol, pharmaceutical products, or opiates—is in the first instance invested as "good", in spite of its sometimes dire consequences...Yet once absorbed, the addictive substance is experienced as bad. (pp. 66-67)

Drug use takes the place of, or compensates for, a satisfying emotional relationship with an external object. This is similar to the psychoanalytic object relations notion of drug use compensating for the experience of the good object. Nevertheless, Fairbairn's theory also gives an indication of the idea that drugs can also serve as representations of bad objects. This conceptualization of drugs as bad object representations explains the underlying self-critical and hostile, introjective pathology found in opiate addicts.

In Fairbairn's theory, bad object representations carry a dual nature as enticing or seductive, and frustrating or rejecting (Cashdan, 1988). These qualities are shared by drugs and can be understood as representing both the 'loving and hating' characteristics of the parents (Glover, 1939). Drugs are exciting or seductive in that they promise to provide pleasure. They are frustrating or rejecting in that, once ingested, this pleasure is short lived and abruptly taken away. The relationship between Fairbairn's theory of object relations and drugs can be understood in the following diagram.

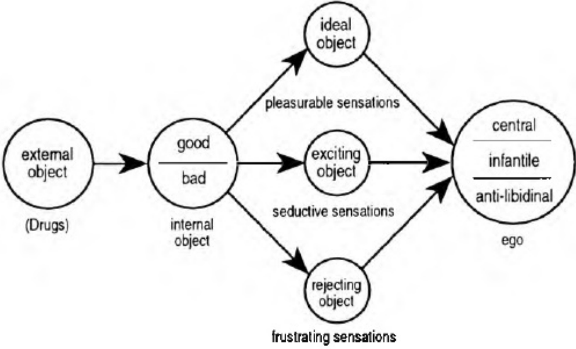

Figure 1.
Structural Representation of Fairbairn’s Theory of Object Relations with Regards to Drug Use.

In this model representations of external objects are internalized. In an internal state they are split. The good internalized object representation gives rise to the *ideal object,* which in turn becomes

integrated into the ego as the *central ego.* The ideal object represents the good and pleasing aspects of a drug.

The bad internal object representation gives rise to two aspects. The first aspect is the *exciting object* which becomes the *infantile ego.* This bad object aspect represents insatiable desire and a promised pleasure which is exciting and seductive. This characterization corresponds well with the drug user's attitude towards drugs and the drug culture in general.

The representation of the second bad object aspect is the *rejecting object,* which is characterized by negative feelings. This aspect becomes the *anti-libidinal ego* and represents the negative side of drug use. The effects of the drug wane, the pleasurable feelings end, and the user experiences frustration, helplessness, bitterness, rage and hate. The experience of the bad object representation is similar to Khantzian's (1987) description of the state of dysphoria among drug users, and Blatt's (Blatt, Berman, et al., 1984) findings of pervasive self-criticism in drug addicts.

Patterns of Object Relations Among Drug Users— Fairbairn's Theory

Using Fairbairn's theory of object relations, it is possible to hypothesize that drug addicts regulate their intrapsychic life in the

following way. Due to a deficit in early object relations and the internalization of harsh and frustrating parental objects, a person takes drugs which provide a regressive experience of a primary good object. The experience of this primary good object also masks the harsh, introjected (bad) objects and related dysphoric feelings of self-criticism and worthlessness. As the drug wears off, the affect of the bad object representations return all the stronger for being repressed[2]. Nevertheless, the bad objects and the dysphoria they produce are now linked to the drug. If more of the drug can be obtained, the dysphoria can be controlled. The search for the drug recommences and the cycle is complete.

The internalization of bad object representations allows them to be controlled while their influence is repressed. However, since the bad object representations carry tremendous aggressive energy, they threaten to surface and overpower the ego. Fairbairn characterized this as the experience of being 'possessed' (1952). In his writings, Wurmser (1987) also characterizes the drug-using patient as one who is demonically possessed. Drug users report feeling a loss of control when under the influence of a drug. This alternates with a feeling of being in control when the drug wears off. This cycle of control is very important. If the cycle of use and subsequent withdrawal from the drug is not maintained, it becomes difficult for the drug user to maintain control

over his internalized bad object representations. This type of problem can be seen among recovering drug addicts. As Blatt, Berman, et al. (1984) and Wurmser (1974) report, drug addicts who abstain from using can become intensely depressed, hostile, rageful and suicidal. The drug has served to keep their bad object representations in check. When the drug is removed, the bad object representations threaten to surface.

The bad internalized object representations are repressed with the assistance of the internalized good object representation (ideal ego). The good internal object representation acts as a conscience, passing judgment on the bad object representations to keep them in check. In the standard Freudian terminology, the internalized good object representation acts as the *superego* (although this superego is archaic). In the compulsive drug user this internalized good object representation produces a state of controlled dysphoria in the drug user. Therefore, treatment which only reinforces the superego (using moralistic or strongly didactic methods of therapy) is not likely to reduce the craving for drugs, but may instead reinforce their use. The superego of the compulsive drug user inhibits the expression of rage derived from the repressed bad object representations. The healthy expression of anger or rage concomitant with the release of the internalized bad object representations is an important step in the resolution of the split between bad and good object representations.

The good object also has an external representation which aids in the release of the internalized bad object representations in healthy individuals. This leads to mature, differentiated relations with external objects, which in Fairbairn's view is the benchmark for normalcy. Drug users have often never had a good external object (parental figure). As has been outlined, drug use compensates for this external good object. This leads the drug user to idealize the properties of a drug. Typically, drug users characterize their drugs as the “best", “rarest", etc. Freud himself demonstrated this idealizing aspect in his writings on cocaine;

> There is, moreover, in this essay a tone that never recurred in Freud's writings, a remarkable warmth as if he were in love with the content itself. He used expressions uncommon in a scientific paper, such as "the most gorgeous excitement" that animals display after the injection of cocaine, and administering an "offering" of it rather than a "dose"; he heatedly rebuffed the "slander" that had been published about this precious drug. (Jones, 1961, p. 55)

The compensatory nature of a drug is enhanced by its idealization. This idealization can only be accomplished through a separation of good and bad object representations. Bad object representations are internalized to distance them from the external good object representations. This effects a protection of the external good object representation, allowing it to exist in an idealized state. The maintenance of the good object representation in an idealized protected state is especially important when there has been a loss of the actual external

object (mother or guardian). As Fairbairn says,

> The loss of an object is thus very much more devastating in the case of an infant...He has no alternative but to accept or to reject his object—an alternative which is liable to present itself to him as a choice between life and death. (Fairbairn, 1952, p. 47)

In this case, the split of external good and internal bad object representations serves to preserve the external object representation. It is not surprising, therefore, to find that habitual drug users usually have a history of early object loss (D. Hartmann, 1969), a phenomenon which has been associated with suicide (Blatt, Rounsaville, et al., 1984; Fine, 1972; Khantzian, 1990; Wasserman & Culberg, 1989; Wurmser, 1974).

By internalizing the representation of the bad objects, the lost good aspects of the external object representation are preserved. It has been suggested that drug users have a difficult time internalizing good object representations. A . /good external object' is either not there to be seen, or it is not strong enough to overcome the negative one. It cannot be safely introjected" (Luzzatto, 1987, p. 26). The use of a drug, therefore, may represent a compensatory attempt to internalize the good object representation by internalizing its substitute. This internalization may be an attempt to introject the good object so it can control the bad object representation and hence the drug user's dysphoria. This attempt, however, backfires and does not lead to the internalization of the good

object representation. Instead, for the drug abuser, the pleasurable aspects of the drug are cathected to hostile parental introjects, causing the drug to be incorporated as both bad and good object representations. As outlined above, when the pleasant effects of the drug wear off, so too does the experience of the good object that was incorporated along with the bad. This leaves only the internalized bad object representation. Once again there is only an external good object representation and an internal bad object representation; the split remains. The state of dysphoria continues and the drug abuser will eventually repeat the use of drugs in order to attempt once more to incorporate the good object. Whether or not this leads to pathological problems depends on the extent of the internalization, the degree of badness of the object, the extent to which the ego is identified with the bad object representations, and the nature and strengths of the ego's defenses against the bad object representations.

Object Constancy

Fairbairn's theory of object relations serves as a useful backdrop for understanding patterns of compulsive drug use. Nevertheless, more modern conceptions and theories of object relations can help to delineate these patterns more clearly. One such concept is that of object constancy. Object constancy, according to H. Hartmann (1952) refers to the mental

representation of a loved object which remains internally within the mind of the infant, independent of his state of needs. In other words, when the infant reaches a state of object constancy he can maintain the mental representation of the object whether or not he has a need to be satisfied. The constant object representation is an internalized positively cathected mother image. In other words, object constancy represents the presence of a consistent and internalized representation of a good object. Mahler, Pine and Bergman (1975), however, expand the idea of object constancy to represent a consistent object representation which is a fusion of both internalized bad and good object representations.

> ...the constancy of the object implies more than the maintenance of the representation of the absent love object...It also implies the unifying of the "good" and "bad" object into one whole representation. This fosters the fusion of the aggressive and libidinal drives and tempers the hatred for the object when aggression is intense. (p. 110)

The presence of a consistent internalized object representation allows the infant to tolerate frustration, anxiety and aggression which result from the temporary loss of the external good object (mother). Along with Hoffer (1955), Mahler, Bergman and Pine (1975) believe that object constancy should be thought of as "the last stage of a mature object relationship" (p. 110). Drug users attempt to internalize a representation of a good object which is not consistent and, therefore, suffer from profound object relations pathology. The achievement of

object constancy is most likely the clearest single differentiating phenomenon between drug users and abusers. Although Blatt, Berman, et al. (1984) have characterized opiate addicts as having a neurotic level of pathology, they have also indicated severe deficits in the capacity of drug addicts to maintain gratifying object relations. Given the hostile, self-critical nature of the parental introjects of addicts and their difficulty controlling affect, it is highly unlikely that they have reached a level of mature object relations.

Patterns of Object Relations Among Drug Users—Modern Theories

When object constancy has not been achieved, good and bad object representations remain split off from one another. In pathological cases of drug use this can mean that good and bad object representations are split off to an even greater degree. To maintain this split, the compulsive drug user will increase his use of drugs. The drug serves to maintain the good object representation by providing affect related to the good object. The compulsive drug user must keep increasing his drug use to maintain the pleasurable affect as he habituates to the drug's effect. Paradoxically, this increase in the use of drugs also maintains the bad object representation by providing more negative affect as the drug wears off. Therefore, drug use can be understood energizing both good and bad object representations. When these object representations have

increased energy, it is more difficult to maintain the defensive splitting of the good and bad object representations. Therefore, in order to preserve the good object representation, the bad object representation will be projected, or externalized, with the concomitant release of rage and hostility. In this way, compulsive drug use can be seen as a projection-introjection cycle similar to the dynamic found in borderline personality syndrome (Kernberg, 1967, 1975). The major difference is that the introjective aspect of the cycle is externally controlled through the ingestion of drugs, while the projective aspect of the cycle is internally controlled by a habituation to the drug's effects. This cycle of projection and introjection maintains the split necessary to maintain ego functioning. Nevertheless, due to the physiological nature of drug use, especially the body's habituation to the effects of the drug, this cycle functions in a positive feedback loop. This means that with compulsive drug use, this cycle becomes increasingly difficult to maintain (Of course, this difficulty varies depending upon the drug used). If the split cannot be maintained, the ego may dissociate causing a psychotic break. The compulsive drug user must, therefore, perform a balancing act, constantly monitoring the introjective (ingesting of the drug) and projective (habituation to the drug's effects) sides of the cycle, regulating the libidinal and aggressive drive energy in the object/ego (self) system. This theory would seem to explain why drug users, when seen in extreme

states, alternate between states of violent agitation and profound emotional withdrawal. Interestingly enough, it is possible that those who are considered to be the most pathological drug users, i.e. opiate addicts, can best perform this balancing act. A study by McLellan, Woody and O'Brien (1979) found that users of stimulants over a period of six years showed significant increases in psychotic level pathology (including mania, paranoia and schizophrenia). Users of depressants over the same period showed an increase in general pathology, non-psychotic depression and cognitive impairment. Contrary to intuition, opiate addicts showed no change in level of pathology during the same period, except for some mild increase in depression. There was no evidence of psychotic or organic impairment among the opiate addicts.

Eventually, the ego may try and destroy the bad object representations. Unfortunately, this can lead to the literal destruction of the individual, in which the battle is won at the cost of losing the war. This may be a possible explanation for the phenomenon of apparent and non-apparent (overdoses, accidental deaths, etc.) suicides among habitual drug users.

Drugs as Transitional Objects

The significance of the object relations dynamics outlined above,

can also be understood through Winnicott's concept of the transitional object (Winnicott, 1951; 1989). Winnicott, contrary to other psychoanalysts of the British School, conceptualized object relations as an infant's relationship with its primary caretakers, especially the relationship to the mother. For other analysts, objects tend to be thought of as fantasies or projections of the infant which result from drive satisfaction. Fairbairn, a contemporary of Winnicott, postulated that these objects carried their own energy and thus freed object relations from Freudian drive theory. Winnicott very much admired the relational aspects of Fairbairn's theories of object relations and Winnicott's work can be seen as bridging the gap between the drive and relational theories of object relations.

Winnicott saw object relationships as developing from infantile fantasy or projection, but ending up as concrete human interaction, most often between a mother and her baby. Infantile fantasy and projection play important roles in object relations, but the role is to aid in the establishment of actual relationships. Winnicott's transitional object is crucial in this regard. For the infant, early development proceeds from a state of omnipotence and control over the universe to an eventual understanding that there are events and phenomena outside his sphere of control. Transitional objects bridge this developmental period and are crucial to its successful navigation.

Transitional objects are things that are familiar to the infant, such as a blanket, thumb or fingers, the mother's breast or other parts of her body, etc. The infant projects or endows these real objects with drive tension reducing qualities. The drive tension reduction of the transitional object then begins to coincide with the administering of the actual mother or caretaker. Eventually, under the modulation of the mother or caretaker, the transitional object is understood by the infant to be a separate entity. As Winnicott says,

> At first whatever object gains a relationship with the infant is created by the infant...It is like a hallucination. Some cheating takes place and an object that is ready to hand overlaps with an hallucination. Obviously the way the mother or her substitute behaves is of paramount importance here. One mother is good and another bad at letting a real object be just where the infant is hallucinating an object so that in fact the infant gains the illusion that the world can be created and what is created is the world. (Winnicott, 1989, p. 53)

After a transitional object can be experienced by the infant as existing as a separate entity, this separateness is soon extended to other objects. The infant begins to relate to the world as being outside himself. The external objects in the world can now also take on symbolic value for the infant. In normal development, the transitional object is soon left behind as the infant develops an interest in the world around him. However, in times of distress, or if the transition is not modulated correctly by the mother, a clinging (or in older individuals, a regression)

to transitional objects can occur. An infant will become very disturbed if a transitional object is removed. If the transitional object is lost, the infant will replace it with a similar object after a period of withdrawal (Greenacre, 1969).

It is quite likely that if the primary object (mother) is not available to the infant, or to use Winnicott's terminology, she is not a "good enough" mother, the infant is unable to distinguish between the primary object and an inanimate transitional object. As D. Rosenfeld says,

> The physical relation, the skin-to-skin contact with their mother is so disturbed, so vitiated, so spurious and bizarre, that the patient is indifferent to whether he is with a warm-skinned mother or with an inanimate lifeless object. (1992, p. 238)

This analogy can be extended to compulsive drug users, who cannot distinguish between the experience of the primary object and the experience of the drug. For these individuals, drugs are like inanimate transitional objects, or more accurately, the *reactivated* transitional objects described by V. Volkan (1981). These reactivated transitional objects serve to defend against object relations conflicts rather than working towards their resolution. In other words, the experience of the transitional object in later childhood or adult life is associated with a change in their original function. Originally, transitional objects served to promote healthy growth. When used in later childhood or adulthood,

however, the function of the now reactivated transitional object is to maintain a state of psychopathology. V. Volkan (1981, 1988) suggests that there are a number of different types of magical objects (all connected to the original transitional objects) that serve to maintain pathology. These include, *the childhood fetish, the childhood psychotic fetish, suitable targets for externalization, the classical fetish, substitute objects, linking objects, phobic objects* and *keepsakes, talismans,* or *ornaments.* The following is a brief description of each:

1. *The childhood fetish* is an object which functions as a pathological defense against preoedipal separation from the mother. In this type of fetish, the object replaces the gratifying aspects of the mother (e.g. the breast).

2. *The childhood psychotic fetish* is an object which is used in a bizarre way when the child breaks with reality. The child uses the object to repair a psychotic perception of body defect which stems from an incomplete separation from the mother.

3. *A suitable target for externalization* is an object which absorbs the child's unmended self and object images. These images serve to stabilize the self and object representations of the children and help them bond more closely with the group. These object images often take the form of cultural amplifiers such as flags or ethnic costumes and are shared among children in an ethnic or racial group.

4. *The classical fetish* is related to castration anxiety and is usually employed by a male to represent an imagined mother's penis.

5. *Substitute objects* are used by adult schizophrenics in the same way that children use the psychotic fetish.

6. *Phobic objects* become symbols for areas of conflict to be avoided.

7. *Linking objects* connect the mourner to a representation of a lost object. Linking objects range from being bizarre to being aesthetically pleasing.

8. *Keepsakes, talismans, or ornaments* are objects that are used to defend against separation and castration anxiety. These objects are usually invested with magical power and have cultural significance with multiple layers of meaning.

What distinguishes these reactivated transitional objects from one another are the psychodynamic processes involved in each. Drugs are probably most like childhood psychotic fetishes or substitute objects, as they are incorporated to protect the compulsive drug user's reality testing (by maintaining the split between good and bad object representations). Drugs also provide enhanced self-esteem through the experience of pleasurable affect and a sense of control over dysphoria by the user. In this way, drugs also come to have magical properties for the

user.

The above view, however, does not preclude drugs, as inanimate objects, from representing the other types of reactivated transitional objects listed above. Most of the object types listed above are related to some difficulty in early infant -mother interaction. The use of drugs as reactivated transitional objects is reminiscent of both the pleasurable and the frustrating aspects of the mother. For instance, Berman (Berman, 1972; V. Volkan, 1976) has documented a case of a young women who compulsively used amphetamines in pill form. Although he originally saw the drug as a fetish, he came to realize that it functioned as a reactivated transitional object. The amphetamine pills were seen as a representation of food. The amphetamines also gave the patient a sense of well-being and warmth which was closely associated with a transitional object. Also (in diet pill form), the amphetamines prevented eating. Therefore, the amphetamines symbolized both the good nourishing and the bad depriving mother. Drug use attempts to recreate the pleasurable aspects of the mother via the transitional object, while defending against her frustrating and anxiety provoking deficits.

The use of drugs as a reactivated transitional object has other negative ramifications. For the normal infant the transitional object phase is important in that the ability to symbolize affective and

perceptual phenomena has its genesis during this time. If the infant is not able to successfully negotiate the transitional object stage and instead uses objects pathologically (like a fetish), his ability to symbolize and express affect will be compromised. For such individuals, affect cannot be symbolized into language and expressed. Instead it is acted out in a compulsive and impulsive fashion (Krystal, 1977). This is reminiscent of McDougall's (1984) description of disaffected patients who,

> ...were unable to contain or cope with phases of highly charged affectivity (precipitated as often as not by external events). They saw no choice but to plunge into some form of action to dispel the threatened upsurge of emotion. It might be emphasized that this could apply to exciting and agreeable affects as well as to painful ones. (p. 389)

Defects in the transitional object phase of infancy could be an explanation for the impulsivity, compulsivity and abnormal affect seen in drug users. As has been previously noted, these defects are often triggered by the real or imagined loss of a primary object in infancy. If the primary object or caretaker was not lost, then this person (mother or the father) often presented conflicting messages to her child. McDougall (1985), in her writings on what she calls the *normopath,* describes the typical object relations pattern of the compulsive drug user,

> In several personal histories among both the acting-out and the normopathic patients, one parent, usually the father, had died or left the family in the patient's early infancy. The mothers were frequently presented as over-possessive and over-attentive while at the same time

> heedless of the child's affective states. In other instances the mother seemed to have been psychologically absent because of depression or psychotic episodes. These mothers appeared to have been too close or too distant in their relationship to their babies. It seemed to me that, for whatever reasons, a truly caretaking mother-image had never been introjected into the child s inner psychic structure, there to remain as an object of identification, allowing the child to become a good parent to itself. Thus in adult life the original maternal image, essential for dealing with emotional as well as physical pain and states of overstimulation, continued to be sought unremittingly in the external world in the form of addictive substances...I have referred to these activities as pathological transitional or transitory objects, (p. 157)

In this sense, drugs also function as what V. Volkan (1981) terms linking objects. These are a variety of transitional objects which are more highly symbolic of the loss of the primary object or caretaker. In general, reactivated transitional objects recreate the pleasurable aspects of the mother while attempting to defend against her deficits. Linking objects, being related to the loss of the object, may compensate the mother's loss first and defend against her deficits second. When the drug experience is weighted more heavily on taking the mother's place, then the drug is more like a linking object. It can be hypothesized that some drugs, like opiates, function more like linking object because they produce experiences related more closely to the pleasurable aspects of the mother. These feelings, consciously or unconsciously, serve to 'link' the user to a lost object to which he has had an ambivalent relationship. Many other drugs produce an intrapsychic state which is not as directly

pleasurable and are perhaps more related to psychic defenses like splitting. Drugs, such as LSD, often induce paradoxical feelings of intense separateness and relatedness which are not always pleasurable. These drugs, when used compulsively (remember they are not addictive), therefore, function more like a psychotic fetish, in that they attempt to repair a perception of an incomplete self or body image. It is not surprising to find that this class of drugs was thought for a long time to be psychomimetic.

Summary and Conclusions

In this chapter I have outlined the basic tenets of developmental object relations theory and how it is manifested in drug use pathology. The phenomenology of compulsive drug users indicates that their object relations dynamics have aspects of the dynamics of good and bad object representations as described by Fairbairn (1952). In a more modern sense, Kernberg's (1967, 1975) conceptualization of borderline pathology, shows that the drug user is unable to integrate good and bad object representations. Instead drugs are used in an attempt to maintain the defensive splitting between good and bad object representations. This type of compulsive drug use also serves to energize a cycle of introjection and projection of object representations. Seen in light of modern object relations theories, drugs serve as transitional objects,

which reactivate a link to the good and bad aspects of the primary object. For most compulsive drug users, the transitional stage of object relations is not resolved. This has important ramifications for the treatment of drug use pathology. These ramifications are most important in the clinical setting, requiring the psychotherapist to function in the role of the transitional object, while eventually moving the drug using patient's dependence on drugs to a more healthy state.

Notes

1It is important to note that Fairbairn did not speak of object representations, but only of internalized and externalized objects. For the sake of clarity and consistency with more modem object relations theoiy, Fairbairn's theories will be explained using modern terminology. That is, objects will denote real persons or things, while object representations will denote their mental representations. It should also be remembered that although object representations are by definition, internal to the psychic system, they can be internalized, or introjected and externalized, or projected. Regardless of whether or not an object representations is external or internal, it is still a mental representation, whether or not it is projected onto someone or something outside, or internalized and made part of the self-system.

2Fairbairn spoke of the repression of bad object representations which is not to be confused with normal or neurotic repression. Fairbairn's idea of the repression of object representations is more like what would now be called splitting, or denial in the service of splitting.

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