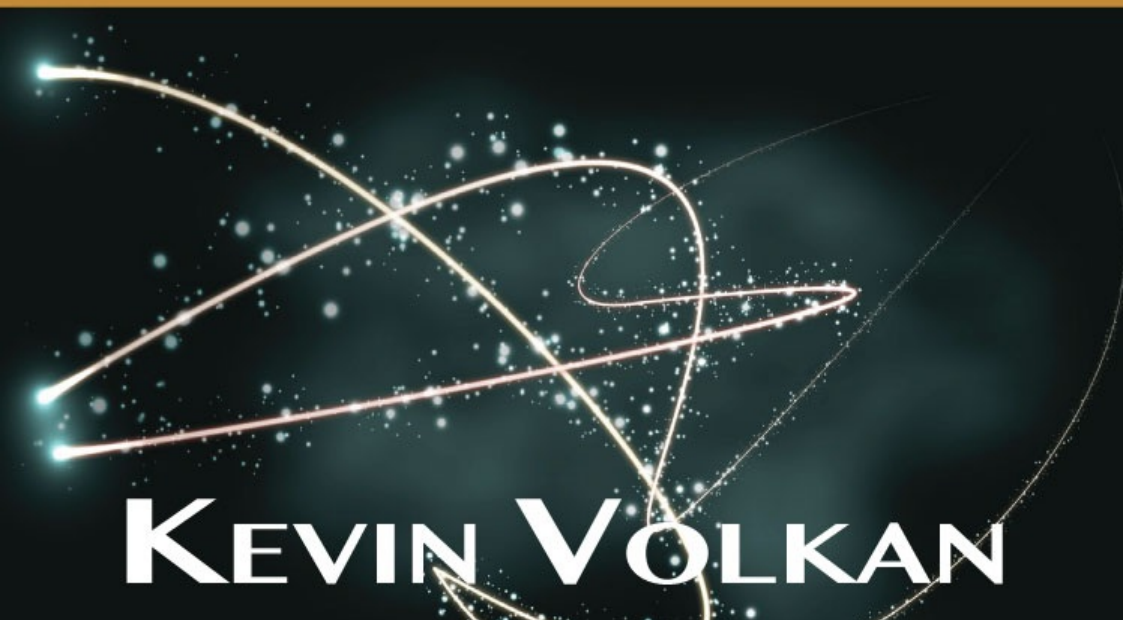
DANCING AMONG THE MAENADS

PSYCHOANALYTIC THEORIES OF DRUG USE AND ADDICTION



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Psychoanalytic Theories of Drug Use and Addiction

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Psychoanalytic Theories of Drug Use and Addiction

The area of psychology that has given close study to the endogenous factors which influence and shape the personality is psychoanalytic theory. This body of knowledge is perhaps the best tool to illuminate intrapsychic entities such as unconscious fantasies and mental representations. Included among these entities are fantasies and mental representations of drugs, i.e. what drugs mean to the user above and beyond their physiological effect.

Psychoanalytic theory also describes the course of human development and accounts for deviations in normal development due to psychological conflict and trauma in the growing child. Therefore, psychoanalytic theory is useful for elucidating the early childhood conflicts and deviations from the normal developmental course experienced by compulsive drug users.

Psychoanalytic theory has been extremely useful in understanding compulsive or addictive behaviors other than drug use. Compulsive behaviors such as obligatory sexual deviations and the use of inanimate objects other than drugs which are not taken into the body (i.e. eaten or injected) have been extensively studied in the psychoanalytic literature

(Abraham, 1910; Freud, 1927; Greenacre, 1969, 1970; V. Volkan & Kavanaugh, 1988) This research has found that some people have a compulsory need for deriving pleasure from inanimate objects like shoes, clothing, etc. In these fetishes, the visual or tactile properties of an inanimate object is used in a compulsory fashion to reach orgasm. Since psychoanalytic theory has been useful for the study of the compulsory fetishes it stands to be useful for the study of compulsive drug use.

A number of psychoanalytically-oriented studies have also tackled the problem of treating the drug user either through psychoanalysis alone or in combination with other treatment modalities (Abadi, 1984; Brill, 1977; Berthelsdorf, 1976; Clerici, 1986; Edelstein, 1975; DeAngelis, 1975; Fine, 1972; Ghaffari, 1987; Gottesfeld, Caroff & Lieberman, 1972; Grenier, 1985; Khantzian, 1987a, 1987b, 1989; Lidz, Lidz & Rubenstein, 1976; Miller, 1983; Radford, Wiseberg & Yorke, 1971; Wurmser, 1985, 1987). A few such programs have claimed some measured success with at least a partially psychoanalytic approach (Grenier, 1985; Schiffer, 1988). These treatment programs have, by and large, been derived from the psychoanalytic literature into the nature of compulsive drug use.

Classical Psychoanalytic Literature on Compulsive Drug Use

Freud (1928, 1985) conceptualized addiction as being related to

the habit of masturbation, with its pleasurable and non-pleasurable aspects. In Freud's conceptualization, drugs are substitutions for masturbation (H. Rosenfeld, 1965). The act of masturbation itself gives instinctual gratification, but is forbidden by parental authority which the individual assimilates into his own psychic system (superego system). The instinctual impulse towards masturbation is quite strong. The consequences of surrendering to this instinctual pleasure, however, are colored with feelings of guilt and self-loathing. These feelings in turn cause anxiety and frustration, which build until they require relief. The most convenient relief is to masturbate once again. According to Freud, this cycle of increase and reduction of anxiety is paralleled in all addictive behaviors. Levin (1987) explains that in Freud's view,

> ... masturbation is the 'model' addiction, upon which all later addictions are based. Substance addictions are substitutes for and re-enactment of the addiction to masturbation. (p. 75)

Abraham (1908), an early psychoanalyst, studied the relationship between sexuality and alcohol use. Abraham followed Freud's ideas on psychosexual phases and explored character formation according to fixations at different levels of psychosexual development. Thus, psychoanalytic literature contains references to oral, anal, phallic, and genital character organizations. Since the early days of psychoanalysis there have been approaches other than these for understanding

character formation. For example, the character can be understood via the defensive organization or through the level of self and object integration. Nevertheless, Abraham's classic descriptions of the oral, anal, phallic, and genital characters remain useful. The clinical evidence still validates the use of Abraham's conceptualization of character formation despite the fact that there are now other useful ways of looking at character formation and organization.

Abraham's conceptualization of the oral character is especially important for understanding the character of the drug user. During the first year of life, the infant's needs, perceptions, and modes of expression are mainly centered around the mouth, the lips, the tongue, the pharynx and the upper digestive system. The infant's feelings of pleasure (and aggression) originate in these bodily areas, called the oral zone, and organize the psyche. When oral expressions are blocked, oral conflicts ensue. These conflicts may manifest in excessive eating, vomiting, jaw spasms, or in mental patterns like optimism, pessimism, excessive generosity, or dependency. Abraham viewed drug use as a result of an oral conflict, conceptualizing alcoholism as an oral regressive and homoerotic tendency (Levin, 1987). Abraham arrived at this conclusion after observing that men were more openly and physically affectionate with each other when drinking in a bar. In Abraham's mind, alcohol allowed the expression of repressed homosexual urges. Hence, alcoholics

were seen to have conflicts related to homosexuality as well as problems that caused them to regress to an infantile oral state. [Socarides (1974) has also linked homosexuality to compulsive drug use, as will be discussed later).]

One of the earliest psychoanalytic papers dealing specifically with drug use pathology was written by Rado (1933). Following along an obvious psychoanalytic line of reasoning, Rado claimed that drug use represented an attempt to regress to a blissful infantile state. Drug use was conceptualized as symptom specific, with specific psychopathology underlying the use of a drugs. Drug users were said to suffer from pathological states of depression, low pain tolerance, and omnipotent narcissism. The effects of drugs were seen as essentially orgasmic. An increase in drug use, however, was thought to be accompanied by a decrease in genital potency. Involvement with drugs was also seen as an abandonment of object relations.

Glover (1939) believed that drug users were at a level of pathology that was between neurotic and psychotic. This was thought of as a new set of transitional pathologies. This new level of pathology was seen as more resistant than neuroses, but neither as a psychotic or borderline state. Glover also affirmed the importance of the aggressive drive in drug addicts, which has the effect of masking guilt. Finally, drugs were seen as

objects with the loving and hating characteristics of both parents, a point of view which will be amplified in the next chapter.

Although Fenichel does not really belong to the older psychoanalytic circle, he is included in this section because more than anyone else, he has summarized the ideas of classical psychoanalysis. Fenichel (1945) conceptualized drug use along the lines of Rado, especially with regards to the regression to early infantile oral states. According to Fenichel, these states resulted in oral dependency and depression among alcoholics. Alcoholism was seen as a defense against neurotic conflicts related to dependency and anger. Fenichel recognized that alcohol 'dissolves' inhibitions and rigid defenses (i.e., the superego). He also saw drug use as an attempt at self-medication.

Some writers maintain that many of these early psychoanalytic ideas are outmoded and of little more than anecdotal use to the practicing clinician today. This is especially true with regards to the emphasis on the regressive wish-fulfilling aspects of drugs (DeAngelis, 1975; Wurmser, 1974). However, it can be argued that the older psychoanalytic literature on drug use and addiction should be evaluated according to the history of psychoanalysis. Freud's discovery of the oedipus complex and infantile sexuality necessarily made him pay more attention to a comparison of masturbation and addiction. With the

investigation of orality and oral character formation, compulsive drug use was simply explained as a regression to, and fixation at, the oral phase of psychosexual development. These ideas still have validity today. Some of these early ideas, with some modifications, found their ways into more modern ideas about compulsive drug use. For example, Glover's bringing our attention to the aggressive drive echoes its role in the current idea that compulsive drug users function at the level of borderline personality organization. Other early ideas, especially regarding the basic depressive character of opiate addicts, narcissism and object relations deficits, also seem applicable today (Fine, 1972). For a thorough review of the early literature on drug use pathology, see H. Rosenfeld (1965) and Wurmser (1978).

Manic Depression and Compulsive Drug Use

An intriguing psychoanalytic view of drug use pathology was described by Federn (1952). In his writing Federn calls attention to the similarities between the drug addict and those who suffer from manic states. Both the manic and the addict attempt to avoid the possibility of frustration. Neither the manic nor the drug addict can tolerate frustration and both are left impotent in its presence. This frustration is the product of the inability to satisfy cravings for mental pleasure. As Federn (1952) says,

> No addict can stand his craving for satisfaction for any length of time. While the manic is able to shift his craving for mental pleasure from one object to another, the addict is chained to his specific addiction. When it is frustrated he must do everything he can to obtain satisfaction or else he succumbs to the greatest despair, and to a suicidal state of panic, (p. 276)

Addiction is also seen by Federn as an avoidance of depression, which is another by-product of the inability to tolerate frustration. This idea is supported by the fact that many addicts become depressed when their addiction is cured. In other words, a state of depression underlies addictive pathology in the same way it underlies mania. Addiction is seen as an intermediate between mania and depression. A manic person who can no longer maintain the flight of thoughts necessary for mania will lapse into a state of impulsiveness, which Federn likens to an addiction. When the impulsive addiction can no longer be maintained, depression occurs. The reverse is also true. A manic-depressive individual may seek the intermediate impulsive-addictive state to avoid swinging between mania and depression. The genesis of an addiction may, therefore, begin as an escape from the extremes of a manic-depressive illness. Once the addiction is alleviated, maintaining a balance between mania and depression becomes the central concern. This balance can only be maintained through the tolerance of "mental pain". Manics, depressives, manic-depressives and addicts suffer from a deficiency in their ability to tolerate mental pain, specifically, ego pain. In treatment, the ego's inability to tolerate mental pain needs to be confronted, or as Federn

(1952) says,

> Whoever wants to remain mentally sound should stand a good deal of the pain of frustration, or of the despair created through the loss of an object, before he begins to compensate for the loss and to master the pain. (p. 278).

For Federn, therefore, the treatment of the compulsive drug user should be geared towards helping him tolerate his mental suffering without the refuge of either a drug or manic-depressive illness. As shall later be elucidated, the loss of an early object may be one of the keys to understanding why the compulsive drug user cannot tolerate pain and frustration.

Preoedipal Conditions and Compulsive Drug Use

Psychopathy

Arieti (1967) relates the characteristics of the drug addict to the simple psychopath. The drug addict, like the psychopath, experiences tension, physical discomfort, anxiety, pain and a general malaise. The drug addict "...gives the impression of mainly wanting to remove unpleasure" (Arieti, 1967, p. 263). The addict, however, differs from the psychopath in his ability to be aware of his anxiety, sense of defeat and insecurity. He is often conscious of his anxiety, hostility and lack of

impulse control, as well as his unstable childhood and dysfunctional personal history. The addict deals with all these problems by transforming them into the struggle to obtain the drug. Rather than escaping reality through a psychotic break, the drug addict deals with reality by reducing it into a search for drugs. Psychotherapy is very difficult for the drug addict because a rational treatment is self-defeating. A more constructive approach would be a therapeutic course that will help the addict tolerate anxiety so that he can receive and maintain the warm approval and deep concern of the therapist. The addict also differs from the alcoholic, who drinks in order to release inhibitions and become aggressive, vindictive and grandiose.

Sexual Deviations

Socarides (1974) has linked homosexuality with drug addiction. In his view both preoedipal-type homosexuals[1] and drug addicts suffer from similar preoedipal pathology which is related to anxiety from early childhood. Both the use of drugs and the homosexual act are reparative, providing a 'magical' external solution to the threat of self-annihilation. As Socarides (1974) says,

> The homosexual act itself may be likened to the effects of the opium alkaloids in their magical restorative powers: the optimum "fix", reinstating the body ego and sense of self against a threat of disruption, and in severe cases, imminent disintegration of the personality, (p. 301)

Both preoedipal homosexuality and drug use pathology have seemingly different clinical pictures on the surface. However, the underlying personality organizations in both seem to be the same, requiring a fix, (either a drug or the performance of a homosexual act) "...to maintain the equilibrium of a highly disturbed individual" (Socarides, 1974, p. 300). Freud (1926) spoke of anxiety as having primacy over all other affects. Socarides findings suggest that sexual deviations, which are defined as obligatory ritualized acts in order to reach orgasm, respond to the suffering produced not only by anxiety, but also the painful affect of depression. As Socarides (1985) suggests,

> The pervert attempts to regain his capacity for pleasure and the enjoyment of life by spurious means, bringing about the illusion of control through the magical powers of seduction and sensuality. His triumph lifts him to a state of intoxication, euphoria, and even elation. Elsewhere, I have termed the homosexual's reintegration through incorporation of another man's body and his phallus as the 'optimal fix' (Socarides, 1968), resembling the experience following the intake of opium derivatives, restoring body ego boundaries, and producing a sense of well-being and temporary integration, (p. 332)

Psychotic and Borderline Disorders

Based on his experience in treating nearly a thousand patients, Wurmser (1974) outlined a number of causes and psychodynamic factors related to drug use. Wurmser characterizes drug use as symptomatic of deeper psychological problems. He claims that if a drug is

removed from a user they will substitute other symptoms. These other symptoms include neurotic depression, suicide attempts, violent acts, stealing, anxiety attacks, etc. Wurmser suggests that any of these symptoms, which are found prior to the use of drugs, can reappear in a much stronger form when the use of drugs is halted. It is often the case that the reappearance of these symptoms is more dangerous than the drug use itself.

From his observations, Wurmser believes that most compulsive drug users suffer from borderline or psychotic states. " I have never yet seen a compulsive drug user who has not been emotionally deeply disturbed, who has not shown in his history the ravages of borderline, or even psychotic conflicts and defects" (p. 824). This viewpoint is in contradiction to some recent research (Blatt, Berman, et al., 1984), but is in agreement with other analytic writers (Kernberg, 1975), most notably those from France and Italy (Callea & Rubino, 1980; Charles-Nicolas, Valleur & Tonnelier, 1982).

The psychopathology of the compulsive drug user is thought to stem from massive narcissistic disturbances which arise from family pathology. As Wurmser says,

> Parents who did not provide a minimum of consistency, of reliability, of trustworthiness, of responsiveness to the child, especially during his developmental crises, are not usable as inner beacons; instead they

> become targets of rebellious rage and disdain. Parents who vacillate between temper tantrums and indulgence, who allow themselves to live out their most primitive demands...cannot impart the important combination of love and firmness...(Wurmser, 1974, p. 836)

In this view it is a narcissistic crisis which compels an individual to seek out drugs in an addictive fashion. By 'narcissistic crisis' what is meant is a loss of self-esteem and self-love which produces strong feelings of anxiety. Drugs provide a sense of control of psychic life for the user. This control relieves the anxiety caused by the narcissistic crisis and its attendant overwhelming affect. All drug use, for Wurmser, therefore, is an attempt at self-treatment. This self-treatment varies depending on the affects engendered by the narcissistic conflict. Narcotics and depressant drugs are used to calm intense feelings of rage, hostility, shame, guilt and loneliness. Psychedelic drugs, on the other hand, are understood as counteracting an emotional state of emptiness, boredom and meaninglessness. These drugs are used an antidote to a pervasive feeling of disillusionment or ennui. Stimulants such as amphetamines and cocaine are understood to be similar in effect to the psychedelics. However, Wurmser also sees the stimulants as imparting a sense of aggressive mastery, control, and grandiosity which serve as defenses against massive depression and feelings of unworthiness and weakness. Serious decompensation can occur if abstinence from these various forms of self-medication is attempted without supporting the

drug user's ego and sense of self-esteem.

Kernberg (1975) has conceptualized compulsive drug users as suffering from borderline personality organization. According to Kernberg borderline patients are not psychotic in that they do not fuse their self-representations with object representations. Psychotic individuals have diffuse, weak ego structures. Borderline individuals, on the other hand, have egos that can generally conduct reality testing in all but a few specific areas. These areas of weak ego functioning are usually related to interpersonal relationships. Although the egos of borderline individuals are reasonably cohesive, they employ primitive defensive mechanisms, which are usually not found in neurotic individuals. These defenses include *splitting, projective identification* and *denial in the service of splitting.* Narcissistic defenses such as *mirroring, idealization, omnipotence* and *devaluing* are also commonly used by the borderline individual. In Kernberg's view, borderline personality organization encompasses a wide range of pathology. The most primitive borderline individuals are characterized by hostile paranoid features combined with a high degree of impulsively and rage. Higher functioning borderline individuals display many of the characteristics of pathological narcissism.

Kernberg's ideas attempt to provide a bridge between the view that holds object investment secondary to the expression of drives and that

which stresses the primacy of the infant's attachment to the object. Furthermore, Kernberg states that the borderline individual is between the level of the neurotic and the psychotic. What is meant is that the borderline individual's ego is more cohesive than the psychotic's and less cohesive than the neurotic's. A more exact way of looking at borderline personality disorder is to assess it from the view of developmental object relations. Although this foreshadows the next chapter, it will be useful to describe the borderline individual in these terms here.

Kernberg (1967,1975), V. Volkan (1976,1987) and Searles (1986) have precisely delineated borderline personality organization as a clinical entity by describing the constellation of the borderline individual's self and object representations. An object in this sense can be defined as a mental representation of another person or thing. *Good* object representations are libidinally invested and *bad* object representations are aggressively invested. Rather than just looking at an individual's level of ego organization, Kernberg (1975) examines both the individual's ability to differentiate between self and object representations, and integrate good and bad object representations. The differentiation between self and object representations is a sign of a cohesive sense of self, while the ability to integrate good and bad object representations is a crucial developmental step towards a healthy personality. Within this developmental scheme then, neurotic individuals

are seen as having a cohesive sense of self and integrated good and bad object representations. More primitive individuals, such as psychotics have neither a cohesive sense of self or integrated object representations. Borderline individuals have a coherent sense of self but are unable to integrate good and bad object representations.

The inability to integrate good and bad object, and self-representations leads to the quality of splitting which is so characteristic of the borderline individual. During the early development of the child there is a period of normal splitting between good and bad object representations which are invested with libidinal and aggressive drives. Because the growing child's ego is not fully developed, it is not yet able to integrate self and object representations. Other factors, both genetic and biological, can also influence the development of the child's ability to outgrow this stage of splitting. Of course, psychological trauma can have great negative impact on the child's ability to integrate object representations. Too much pre-genital aggression, by itself, can cause psychological trauma and prevent integration. However, the inability to integrate good and bad object representations can usually be traced to an overt trauma such as rape (Katan, 1973), contradictory parenting (Searles, 1986; V. Volkan, 1987), loss of a parent (Furman, 1986), and incest (P. Kernberg, 1989). Other, more subtle features of the family environment can also have a negative effect upon the child's ability to

integrate good and bad object representations. (V. Volkan, 1987).

When a child is unable to develop to the point where it is able to integrate good and bad object representations, the splitting of good and bad object representations becomes a dominant defense mechanism and the child's capacity for integration is stunted. Defensive splitting, along with denial, omnipotence, devaluation of self and others, idealization, introjection and projection are used to maintain opposing identifications based upon aggressively tinged bad object representations and libidinally tinged good object representations. These good and bad object representations are alternatively projected and introjected. This prevents the development of an ego identity as described by Erikson (1956). Therefore, although borderline individuals maintain relatively good reality testing, they also demonstrate many areas of ego weakness such as lack of impulse control, acting out, poor tolerance of frustration, etc.

There are many similarities between borderline individuals and compulsive drug users. Like borderline individuals, compulsive drug users often have relatively good reality testing and ego strength. Indeed, it would be very difficult for a drug addict to obtain drugs (a complex interaction with his external reality) without some good localized reality testing. Compulsive drug users, like borderline individuals, also tend to

have severe deficits in the ability to participate in interpersonal relationships. The etiology of both borderline and compulsive drug use pathology points to early object trauma. (This will be more fully elucidated in the next chapter.) In general, it is possible to conclude that both borderline individuals and compulsive drug users seek to experience a relationship with a good parent. They also seek to compensate for the experience of bad parenting, or the trauma caused by a parent. In Kernberg's view, compulsive drug use can be thought of as another defensive tactic of the borderline individual. Drug use, in this sense, serves to keep the good and bad object representations apart, preserving the all-good object representation by splitting it off from the all-bad object representation. For Kernberg, the prognosis of treatment with borderline drug users is-related to the presence of narcissistic personality structures, impulse control, the ability to use an external structure to suppress addiction, and antisocial behavior. While the ability to control impulses, ask for help and avoid antisocial behavior are indicative of a positive prognosis, the presence of narcissistic structures is indicative of a negative outcome.

A narcissistic personality structure is similar to that of the borderline except that there is a pathological formation of the self-representation called a *grandiose self.* Narcissistic individuals, like borderline individuals, may have had a traumatic childhood. However,

their parent or caretaker sees an element in the child which is supported or reinforced in order to compensate for the psychological deficiency of the parent. For example, the mother may think that the developing child will grow up and assure the family's fame or fortune. The parent's unconscious grandiose fantasy about the child becomes part and parcel of the developing child's self-system. A typical narcissistic individual is capable of carrying on their life by pumping his grandiose self from day to day. In narcissistic individuals drug use supports the grandiose self. According to Kernberg the presence of narcissistic personality structures are indicative of a negative prognosis as the drug "...may constitute a mechanism to 'refuel' the pathological grandiose self and assure its omnipotence and protection against a potentially frustrating and hostile environment in which gratification and admiration are not forthcoming" (Kernberg, 1975, p. 222).

According to Kernberg, it is important to set strict rules before treatment can proceed. For suicidal and drug-using borderline patients, Kernberg asks that they control and assume responsibility for their impulses. If the impulse towards suicide, drug use, or other antisocial behavior cannot be controlled, the patient must be able to get external help (from someone besides the analyst or psychoanalytic therapist) if the treatment is to continue. This external help allows the therapist to maintain his analytic stance so that he or she does not have to provide a

more supportive approach to therapy.

D. Rosenfeld (1976, 1992, 1993) also understands compulsive drug use as a borderline-level phenomenon, although he tends to conceptualize the addict more toward the psychotic end of the borderline spectrum. In Rosenfeld's view (which follows the theories of Melanie Klein), Good and bad objects are split in order to protect the good object representation from the primitive envy embodied in the bad object representation. This splitting arises from the infant's experience with his mother or primary caretaker who has fantasies about the child which are inconsistent with her ability to tolerate his needs. This leads to the existence of 'bad' and 'good' mother object representations. The primitive envy of the bad mother object representation threatens to destroy the good mother object representation. By keeping these object representations split, the good mother object representation is protected. Drugs help to maintain this split by alternatively (and never simultaneously) representing both the negative aspects of the bad mother and the positive sensations of the good mother, without integration.

Rosenfeld describes five stages in the psychoanalytic treatment of compulsive drug users. In the first stage the drug using patient takes drugs indiscriminately and acts out in perverse and promiscuous ways.

The patient may become suicidal and paranoid. It is important during the first stage for any interpretations to elucidate the distinctiveness between therapist and patient. In the second stage the patient begins to use one type of drug to the exclusion of all others. The patient often divides drugs into 'good' and 'bad', with the bad drugs having a persecutory tinge. During the third stage the patient becomes increasingly dependent upon the therapist and the therapy hour. The patient has an especially difficult time when the therapist is not available, for instance on the weekends. At the fourth stage the patient may tentatively stop using the drug. The patient may also begin to use other material objects, such as cultural or artistic objects as a substitute for the drug. These objects are treated almost like fetishes and can often be used in a compulsive fashion. The patient may also become depressed and suicidal during this stage. In the fifth stage the patient is clinically more neurotic. He can tolerate both the good and bad aspects of the therapy and even internalize some of the good aspects. The patient becomes less grandiose and his life plans become more realistic. The therapist is increasingly seen as a separate individual.

Rosenfeld points out that these stages are not fixed. Often positive changes in the patient's psychopathology will be followed by periods of regression and entrenchment. Therapeutic evolution and regression can occur simultaneously.

Rosenfeld also comments that drug use, especially the intravenous variety, serves to remind the addict that their body exists and that it is filled with fluids, viscera, etc. This type of drug use may be indicative of a psychotic body image, in which the addict feels that his or her body is empty. As Rosenfeld explains,

> Neither the idea of the erogenous zone nor that of the skin as a body limit exists in these patients, but only the notion of a body full or empty of such liquids, hence their need to inject themselves. (1992, p. 236)

The idea of the addict lacking a skin or a body boundary is also important in understanding the addict who,

> ...is attempting to achieve unity through a very precarious organizer, that is, a drug that functions as a poor-quality paste or glue but represents a real striving to find something which will provide a structure. (1992, p. 241)

In his later work Rosenfeld (1992) conceptualizes three categories of drug users, Category A, most easily identifiable in the above discussion, is a person who needs to use a drug to create a container for the body like a skin. These drugs users usually have suffered some type of object loss. If they are treated early and accept the treatment, they have a good prognosis for recovery. Category B drug addicts search for powerful stimuli so they can feel alive and not confuse themselves with dead objects. These addicts may overdose or act out suicidal fantasies.

The prognosis varies for these addicts, but they usually accept treatment. Nevertheless, Rosenfeld reports that this is a difficult type of addict to work with and they often drop out of treatment. Category C addicts seek to obtain very primitive body/feeling sensations, which they feel are necessary for their survival. These addicts feel that if they cannot obtain a drug they will lose their identity and disappear. The prognosis for treatment with this type of addict is poor.

Drug Use, Neurotic Pathology and Defenses

Edelstein (1975) has characterized a number of factors related to the compulsive drug user which indicate both a regressed character and a severe neurosis. These factors include early developmental defects, low stimulus barriers, object relations deficits, separation-individuation disturbances, perceptual problems, dedifferentiation of affect and the inability to anticipate or tolerate tension. These problems point to the compulsive drug user as an oral, regressed character. Nevertheless, Edelstein elaborates on the apparently neurotic adaptive mechanisms used by these drug users. These adaptive mechanisms usually consist of repetitive-compulsive behaviors which may take many forms or styles. The simplest form of repetition-compulsion is the compulsion to use drugs because of the inability to postpone satisfaction or tolerate frustration. Drug-taking induces experiences that avoid this type of

frustration. When the drug wears off, the frustration and the tension return along with the need to avoid these affects. The next level of repetition-compulsion includes an attempt to induce or change an affect which is usually passively experienced by the drug user. The induction or change of the affect in an active fashion represents control over it. In drug users this change or induction of affect is, not surprisingly, accomplished by way of a drug. The changes caused by the drug are once again temporary, so that the drug must be used again in order for the user to recapture the feelings of control and mastery. The final mechanism is somewhat more elaborate than the previous ones. This mechanism is a combination of wish-fulfilling and control mechanisms. The drug user takes a drug in response to conditions outlined in the above mechanisms. At the same time, due to the superego, the drug user is extremely self-critical and hateful to himself. This, of course, creates more intolerable affect which must be avoided or changed. The addition of further intolerable affect into the system serves to perpetuate the cycle of drug use.

In his later writings, Wurmser (1978,1985, 1987), has mediated his description of the psychodynamics of compulsive drug use. Rather than conceptualizing drug users as borderlines or psychotics, Wurmser now understands these patients to be suffering from severe neuroses, although these neurotic conflicts are different in nature than those

experienced by most neurotics. A key concept in Wurmser's reconceptualization of drug use pathology is the existence of a phobic core structure that underlies the anxiety and dysphoria seen in compulsive drug users. These phobic symptoms and characteristics are related to a defense against overbearing superego functions. Wurmser (1978, 1985) describes a typical sequence of dynamic events in the compulsive drug user. The first stage is a severe inner (superego) pressure or criticism. The second stage is a 'fantastic' feeling after some sort of success is achieved. The third stage is a 'trance' or altered state of consciousness which has a sudden unaccountable onset. This trance is accompanied by intense feelings of loneliness, being unloved, humiliated, guilt or shame and paralyzing panic. The fourth stage is an impulsive attempt to gain relief through the use of drugs. The fifth stage is a suicidal depression accompanied by calls for help, feelings of contrition and self-criticism. The sixth stage is a 'point of relaxation' accompanied by a feeling that 'all is forgiven'. The drug user tries to be good and comply, but in doing so he once again begins to submit to the inner judge of his superego, re-initializing the cycle.

At various points in this cycle, different aspects of the superego hold sway, leading to what Wurmser terms a 'split identity' or a pattern of multiple personalities. If the cycle is severe enough to cause a loss of perceptual reality, "it is as if the patient were possessed: a demon takes

over" (1987, p. 160). (This state of possession will be examined in the context of the object relations of the compulsive drug user in the next chapter.) In the severe neurosis of the compulsive drug user, defenses such as denial and splitting are prevalent. In many cases these defenses are used against conflicts which are oedipal in nature.

Blatt and his colleagues (Blatt, Berman, Bloom-Feschbach, Sugarman, Wilber & Kleber, 1984; Blatt, McDonald, Sugarman & Wilber, 1984; Blatt, Rounsaville, Eyre & Wilber, 1984) have extensively studied opiate addicts and polydrug abusers from a psychoanalytic perspective. These studies have applied a rigorous quasi-experimental and statistical methodology (Campbell & Stanley, 1963; Sarnoff, 1971) to the examination of psychodynamic hypotheses.

As previously indicated, many psychoanalytic theorists believe that opiate addicts function at a very primitive level of personality organization (narcissistic, psychotic, or borderline psychology). According to Blatt,

> ...opiate addiction has been conceptualized as a regressive phenomenon in which the addict seeks immediate pleasure and satisfaction in an intense, symbiotic state either as compensation for profound early deprivation or to recapture an overindulged, infantile state, as a defense against the threat of psychotic disintegration, or as a retreat from painful neurotic affects such as depression and anxiety which result from frustrations and disappointments in interpersonal relations. (Blatt, Berman, et al., 1984, p. 157)

Using a number of standardized personality measures, Blatt and his co-workers decided to test this assumption. The *Bellack Ego Functions Interview,* the *Loevinger Sentence Completion,* and the *Rorschach* were used to evaluate the degree and nature of psychopathology among 99 opiate addicts and to compare them with normal and mentally ill groups. Results indicated that the addicts were not suffering from thought-disorder or deficient reality testing when compared to psychiatric patients. The addicts did, however, have significant impairment in their developmental level of object relations and their ability to control their affect when compared to the psychiatric patients. It was concluded that opiate addicts do not have problems in their cognitive functioning, but instead have difficulty in establishing meaningful and satisfying interpersonal relationships. This was seen as indicative that opiate addicts seeking treatment suffer from a neurotic level pathology characterized by depression and the inability to moderate their emotions. Opiate addicts were not thought of as suffering from a more primitive level of pathology as has been previously thought in psychoanalytic circles. In Blatt's concept, opiate addicts have selected "...an isolated mode for achieving the satisfactions and pleasures most people seek in interpersonal relationships" (Blatt, Berman, et al., 1984, p. 163).

In another study, Blatt, Rounsaville, et al. (1984), further elucidated

the nature of psychopathology among opiate addicts. Once again these addicts were compared to clinical and non-clinical populations. Additionally, a group of nonaddicted, polydrug abusers were included in the comparison. In this study the groups were compared using standardized measures of depression. As outlined above, a number of previous studies have indicated that opiate addicts suffer from a primitive depressive pathology.

There are two conceptualizations of depression in psychoanalytic theory, *anaclitic* and *introjective.* Anaclitic depression is derived from intense fears of abandonment and the desperate need to maintain contact with a gratifying object. Anaclitic depression was first described by Spitz (1946). The word anaclitic signifies dependence upon others. Spitz described a syndrome among infants and children consisting of apprehension, weeping, withdrawal, sadness, and refusal to eat or relate to others. The infants studied by Spitz were around nine months of age. He found that anaclitic depression resulted if the mothers of the infants were absent for at least three months.

Introjective depression refers to a lowering of self-esteem after a loss. In this situation, loss of an object is tantamount to loss of part of the self-image. Introjective depression, therefore, engenders feelings of worthlessness, self-criticism, shame, guilt and idealized parental

standards which stem from the internalization of harsh parental objects (superego). Anaclitic depression is understood as being developmentally inferior and more primitive than introjective depression. It should be mentioned that there is some controversy over the distinctions between anaclitic' and introjective depression. Some writers like Beres (1966) maintain that all depression is related to superego conflicts and that the symptoms of both anaclitic and introjective depression outlined above can be explained as a result of such conflicts. Nevertheless, the levels of personality organization for each set of symptoms— primitive for anaclitic symptoms and more advanced for introjective symptoms—still holds. Therefore, for the purpose of studying compulsive drug use, the distinctions between anaclitic and introjective depression are valid.

Because opiate addicts have been characterized as suffering from primitive psychopathology, their depression has been commonly thought of as anaclitic. After discovering that opiate addicts suffer from a neurotic level dysfunction, Blatt and his colleagues (Blatt, Rounsaville, et al., 1984; Blatt, McDonald, et al., 1984) suspected that addicts did not suffer from the more primitive anaclitic depression, but from introjective depression. As they put it,

> ...addiction is not considered as an anaclitic seeking of the immediate gratification of a mindless, trouble-free state to replace oral deprivation and feelings of neglect, but as withdrawal and isolation from human relationships because of feelings of low self-esteem and negative

> expectations in interpersonal interactions. The addict is seen as withdrawn, angry, sullen, empty, hopeless, filled with self-blame and self-loathing...(p. 343)

Using a number of depression-specific measures, including Blatt's *DEQ* scale (Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982), depression among opiate addicts was characterized in comparison to clinical and non-clinical groups. The results of the study indicated that opiate addicts are more self-critical than either clinical, non-clinical and polydrug abusing groups. Also, among polydrug abusers, there was a relationship between the amount of opiates used and the degree of depression related to self-criticism, which was indicative of introjective depression. It was thought that this may have been an indication that non-addicted drug users who are depressively self-critical are at a greater risk for opiate addiction.

Compulsive Drug Use, Self-Psychology and Narcissism

Levin (1987) has outlined an approach to the understanding and treatment of substance abuse based on Kohut's self-psychology (Kohut, 1971, 1977, 1978, 1984). Kohut was a psychoanalyst who developed a variation on both theory and treatment technique after working with patients who suffered from narcissistic personality disorders. These patients did not fit well into pre-existing psychoanalytic theory. They did

not seem to possess a sense of self or an identity, yet they were clearly not psychotic or suffering from thought disorders. These patients were also able to establish a strong relationship with their analyst. Nevertheless, the relationship that was established was far from the typical neurotic transference. Instead, these patients developed what Kohut called a "narcissistic transference". In this type of transference, the patient either relates to the analyst as if he were an extension of the patient (mirroring), or as if the patient was part of an omnipotent analyst.

Not surprisingly, Kohut understands addictive behavior as resulting from a narcissistic disturbance. Addiction in this model is seen as a "futile attempt to repair developmental deficits in the self" (Levin, 1987, p. 13). Levin (1987) has applied Kohut's ideas primarily to alcoholics, although he expands this treatment to include other addictions as well. He conceptualizes alcoholics as suffering from four types of pathology. Alcoholics are seen as self-destructive, lacking self-components responsible for self-care and self-esteem, overly self-involved, and as having a fragile sense of self or identity.

While theoretically, Levin's use of Kohut's approach is in strong agreement with psychoanalytic thought, it differs radically with regard to treatment technique. For Levin (1987), 'The therapist must diagnose,

confront and educate" (p 92). In other words, the technical neutrality of the therapist must be modified to treat substance abusers. Levin goes on to say,

> On one hand, some analytically oriented practitioners attempt to maintain a stance of "technical neutrality" when what is needed is an active stance that the patient cannot improve until the drinking stops, (p. 92)

This approach to treatment is fundamentally at odds with the classical psychoanalytic method (Fine, 1972), although psychoanalysts have been known to require that prospective patients seek detoxification or inpatient care before beginning analysis (Kernberg, 1975; H. Rosenfeld, 1965; Wurmser, 1985). Wurmser (1985), in contrast, expounds a modern analytic stance to the drug using patient,

> It has been my experience that it is better *not* to be placed into such a role of punisher and warner. A consistently analytic approach can be more effective if it remains grounded in, and compatible with a *strong emotional presence* of the therapist, an attitude of warmth, kindness, and flexibility, (p. 94).

Levin (1987) recognizes that confronting and educating the patient will be difficult for the therapist. Overcoming this difficulty relies on the ability of the therapist to establish a strong relationship (transference) with the patient before undertaking confrontational and didactic roles. This strong relationship will slowly allow the therapist to be substituted for the drug. On this point the Kohutian and psychoanalytic approaches

are in agreement. These issues will be covered in more depth in the section on treatment.

Dodes (1990) extends many of the narcissistic characteristics described above to compulsive drug users of all types. He conceptualizes the roles of power, helplessness and rage as being central to the psychodynamics of addiction. Dodes sees drug use as a mechanism which provides an omnipotent control over the drug user's affective state. This control serves to protect the drug user from being flooded by helplessness or powerlessness. Dodes also sees drug use as the expression of the aggressive drives which coexists with the maintenance of control over feelings of helplessness. The aggressive drives are "in the service of narcissistic equilibrium" and are used "to re-establish the power...which has long been known for its intensity in narcissistically impaired individuals" (p. 414). Dodes terms these drives as "narcissistic rage" which has the same compulsive, insistent qualities as addiction. Addicts use drugs to express narcissistic rage and defend against feelings of powerlessness. They do not, however, necessarily suffer from narcissistic character disorders,

> But most addicts are not narcissistic characters. The shame that may be associated with anal and separation-individuation/autonomy issues, or narcissistic injuries associated with oedipal impotence, guilt, and inhibitions, may all provide the underlying basis for vulnerability to feeling overwhelmed and helpless that is great enough for helplessness to be

experienced as a traumatic narcissistic blow. (p. 409)

Dodes' conceptualization of the compulsive drug user remains flexible. The compulsive drug user can be understood as ranging across a continuum of pathology. This flexibility is helpful with regards to the treatment of pathological drug use.

Drug Use, Self-Medication and Dysphoria

Khantzian (1990, 1989, 1987a, 1987b, 1985, 1982, 1980, 1979, 1978, 1974, 1972; Khantzian & Kates, 1978; Khantzian & Treece, 1977) has contributed voluminously to the psychoanalytic understanding of drug dependence. His work presents a number of novel ideas about the relationship of drugs to the psychic life of the individual. Khantzian believes that there is more to the addict's compulsion than a strictly biological mechanism or a psychoanalytic explanation based upon drive theory.

Much of the original psychoanalytic literature from the 1960's and '70s postulates that the first and foremost reason individuals begin to use drugs is to "self-medicate" or to protect themselves against painful or unpleasant affect. This protection also functions as a developmental crutch (Weider & Kaplan, 1969; Krystal & Raskin, 1970; Wurmser, 1974). In an intriguing argument, Khantzian (1974, 1978, 1979) postulates that

drugs do not produce euphoria for the addict, but instead provide relief from the *dysphoria* resulting from the addict's rigid, defective or overbearing defenses against affect. Following Krystal and Raskin (1970), Khantzian also believes that different types of patients will use different types of drugs, depending upon the dysphoria experienced. Khantzian proposes three types of drugs users.

The first are the users of narcotics, often described in psychoanalytic literature as attempting to return to a symbiotic, or fused state of object relations. Khantzian believes that narcotic addicts are drawn to the anti-aggressive properties of narcotics to compensate for their own powerful and uncontrollable affect arising from severely defective drive and affect defenses. The second group consists of alcohol and sedative dependent users. This group counters isolation, feelings of coldness; and emptiness through the use of drugs that soften or reduce overly rigid defense mechanisms. The third group consists of stimulant abusers, who use drugs to "...counter states of depletion, anergia, and hyperactivity..." which are associated with "...deflated ego/ego-ideal structures of depressive and narcissistic characters..." (Khantzian, 1987b, p.5).

Khantzian strongly believes that there is a is a dynamic relationship between the suffering produced by a specific drug and the suffering

relieved by that drug. He notes that the states associated with physical withdrawal from a specific drug closely resemble the pre-existing painful affect which was originally relieved by the drug. This presents an interesting paradox; that drug use "...often has dual aspects of relieving distress at the same time that the symptom causes suffering in its own right." (1987a, p. 1). From this, Khantzian believes that drug users need to control their affect as much as to relieve themselves from its pain. This control leads to a repetition-compulsion,

> ...repetition and suffering for addicts is not another example...of destructive instincts, masochism or inverted aggression, but probably represents more an attempt to control or tolerate suffering which is otherwise experienced as being beyond a person's control...They actively replace preexisting passively experienced admixtures of pain, dysphoria, and emptiness with admixtures of analgesia, relief, dysphoria and distress produced by the drug effects and after effects. (1987, p. 20)

Kernberg (1975) has also concluded that the use of specific drugs are related to specific psychopathologies. For Kernberg, patients with depressive personalities may use alcohol to achieve a feeling of well-being and euphoria. This is an attempt to regain a lost parental object whose loss has created a sense of guilt and depression. As discussed above, borderline drug users, on the other hand, may use drugs to keep good and bad objects split from one another. The feeling produced by the drugs allows for the activation of the good object and the denial of the bad object. This permits an escape from guilt and internal persecution.

Narcissistic borderline patients, as previously mentioned, use drugs to fuel their sense of grandiosity as a protective response to a hostile and frustrating environment.

Schiffer (1988) studied the case histories of nine compulsive cocaine users in a framework similar to Khantzian's. These patients were treated with long-term, in-depth, psychodynamic therapy. The treatment outcome, as reported by the patients, was successful, with little relapse one year after the completion of therapy. All of the nine subjects suffered from disturbed interpersonal and work relationships at the time of intake and all patients were found to have unrecognized psychological trauma stemming from childhood. Cocaine addiction was seen as a form of self-medication and as a repetition-compulsion. The use of cocaine, according to Schiffer, is "...an unconscious, symbolic repetition of the early trauma in which old psychological injuries would be re-inflicted by the drug abuser" (1988, p. 133). This re-experience of the early trauma serves to give the drug user a sense of control over the drug. Hence, cocaine, is important as a medicine for relieving the unpleasant affect from the original trauma and is subsequently invested with a great deal of energy. The use of drugs to re-experience past trauma is also seen by Schiffer not only as an attempt at self-medication, but also as a self-destructive repetition-compulsion which includes aspects of denial, reaction-formation, and identification with the aggressor.

Summary and Conclusions from the Psychoanalytic Literature

Overall, the above studies indicate that there are many different ways to understand drug use pathology. The modern viewpoints presented in this chapter may be summarized into four categories. The first category includes the writings of Arieti, Federn, Kernberg, D. Rosenfeld, Socarides and Wurmser (1974) and conceptualizes drug use pathology as primitive and preoedipal. Among these authors, the compulsive drug user is seen as manic/depressive, psychopathic, borderline or psychotic. The second category, represented by the writing of Levin and to some degree Dodes, expresses the pathology of the compulsive drug user in terms of narcissistic disturbances as they are understood by Kohut and others. The third category is represented by the work of Khantzian, Edelstein, Schiffer and to some degree Arieti and Dodes. These writers conceptualize the drug user as engaging in an attempt to medicate himself in order to avoid intolerable affect or rage. This self-medication is understood to be a form of repetition-compulsion. Compulsive drug use is also as seen as ranging across a continuum of psychopathology. The fourth category encompasses the work of Wurmser (1978, 1985, 1987) and Blatt in which the compulsive drug user is seen as a severe neurotic who utilizes primitive defense mechanisms and who suffers from phobic and dissociative personality structures or introjective depression.

These apparently contradictory conceptualizations of drug use pathology all contain valid and useful points of view. However, despite the seeming disparity of these points of view, they lead a number of shared conclusions. My first conclusion is that drug use fits into a wide range of psychopathology, although this pathology is circumscribed at the extreme ends of the range. For instance, compulsive drug users do not seem to be psychotic. Although compulsive drug users may be subject to brief reactive psychoses, they do not often present themselves, nor do they permanently regress into, overtly psychotic states. On the other hand, compulsive drug users also do not seem to suffer from simple neuroses, although on first glance their defenses (e.g. denial) may seem to indicate neurotic repression of traumatic material. There is, however, a paradox contained in this conclusion. Although opiate addiction is generally considered the ultimate level of drug use pathology, Blatt's studies indicate that opiate addicts suffer from less primitive pathology than polydrug abusers. Other studies (McLellan, Woody & O'Brien, 1979) have also shown that stimulant and depressive drug abusers are more likely to decompensate into a more primitive level of psychopathology than opiate addicts. Additional work is needed to clarify the range of pathology among opiate addicts and other types of drug abusers. Blatt's studies of opiate addicts may have been misleading in this regard, given that his examination was limited to those addicts who sought help. This

group of opiate addicts may be functioning at a much higher level than the addict who remains on the street.

It is possible to see compulsive drug use in any type of personality organization. If a drug user is neurotic the drug will be symbolized at a high level. Compulsive use of drugs at higher levels of personality functioning may be attempts to patch up neurotic conflicts. Nevertheless, it is possible to say that most compulsive drug use pathology falls into the range of what would today be labeled as a borderline pathology, including higher level borderline pathology which presents more like a severe neurosis, borderline pathology with narcissistic features, and more primitive borderline pathology which presents with more psychotic features. In general, it is possible to say that most compulsive drug use would seem to appear in those individuals who have unintegrated self and object representations. In these individuals, drug use helps maintain primitive defense mechanisms like splitting which defend against a psychotic regression. This leads to my second conclusion, that the etiology of the compulsive drug user is based upon early object relations pathology. Another idea, which is present in many of the studies reviewed above, is also related to object relations pathology. This is the presence of hostile, self-critical rage among compulsive drug users. This rage appears to be mitigated or obscured by the effects of drugs.

Indeed, the presence of object relations pathology seems to be the major point on which the studies cited above agree. It is, however, difficult to tell from the above studies whether or not compulsive drug users suffer from an object relations deficit (Kohut), the development of a pathological object relations structure (Kernberg), or both. Part of the confusion here originates in the differing conceptualization of pathological narcissism and borderline personality organization by Kernberg and Kohut. A thorough comparison of these two viewpoints is outlined elsewhere (Adler, 1986) and I will not pursue it here.

Given that compulsive drug users suffer from some sort of preoedipal disturbance and that object relations play an important role in this pathology, it will be useful to examine the relationships of drugs and drug use to object relations. It is quite possible that further study and conceptualization of the constellation of object relations among drug abusers and addicts may resolve some of the different aspects represented in the psychoanalytic literature on drug abuse.

Notes

1 It is important to distinguish between homosexuality as a lifestyle choice and a compulsive homosexuality related to a psychopathological condition. Socarides is referring to the latter, which he terms preoedipal. The comments made here are not meant as a negative description of homosexuals in general. Instead this text seeks to address the problems of individuals who must compulsively engage in certain behaviors. Many different behaviors can become destructive or pathological. These behaviors

include eating, heterosexual acts, homosexual acts, etc. Society does not pronounce that eating is bad because of the existence of anorexics. Likewise, homosexuality should not be negatively judged because some homosexual behavior derives from a psychopathological condition.

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