DYNAMIC THERAPIES FOR PSYCHIATRIC DISORDERS

Psychodynamic *Treatment* of Alcohol *Abuse*

Jerome D. Levin

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e-Book 2015 International Psychotherapy Institute

From *Dynamic Therapies for Psychiatric Disorders (Axis I)* edited by Jacques P. Barber & Paul Crits-Christoph

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Alcohol abuse cannot be viewed solely in psychodynamic terms. Ethanol, the "active" constituent of all beverage alcohol, is a drug that profoundly affects the nervous system, altering cognition, affect, perception, and motor functioning. Ethanol is toxic, and its small molecule gains ready access to all body tissues, where it can inflict a wide variety of damage. It is an addictive drug in the sense that it induces tolerance and withdrawal symptoms. Abrupt cessation of prolonged, heavy drinking can be life-threatening. The *DSM-III-R* and the *DSM-IV* make a distinction between alcohol abuse and alcohol dependency (alcoholism) that parallels but is not identical to the distinction between problem drinking and alcoholism. Alcohol abuse and problem drinking are usually viewed as more psychodynamically and socioculturally determined, while alcoholism is usually viewed as more biologically determined. There is considerable evidence (Cloninger, 1983; Goodwin, Schulsinger, Hermanson, Gaze, & Winokur, 1973; Propping, Kruger, & Mark, 1981; Schuckit & Gold, 1988) for the existence of a genetically transmitted biological predisposition to alcoholism. Alcoholism typically has a progressive, downward course.

Although the distinction between alcohol abuse and alcoholism is an

important one, theoretically and clinically their psychodynamics, whether antecedent and etiological or consequent and resultant, are essentially similar. Accordingly, the distinction between them will not be emphasized here. I view alcohol abuse as emergent from the interaction of four factors: the pharmacology of alcohol, genetic predisposition, environment, and psychodynamics. The weight of each factor in etiology varies from case to case. There is a continuum from alcoholism that is powerfully, if not uniquely, determined biologically to alcohol abuse that is driven by a futile attempt to ameliorate intrapsychic conflict. Alcohol abuse is best conceptualized as a biopsychosocial disorder. Patients presenting with alcohol problems demonstrate considerable commonality, and even if that commonality is the product of their drinking rather than its cause, the clinician must deal with it. The nature of that commonality has been variously understood over the history of psychoanalysis.

HISTORY AND DEVELOPMENT

Until recently, analysis has paid little attention to addiction. Yet alcohol abuse and other chemical dependencies have played an important role in the history of analysis. Freud's involvement with cocaine is well known. A lifelong depressive, his attraction to an "up" drug is not surprising. Part of Freud's obsession with cocaine was narcissistically determined by his drive for fame. The extent of his obsession with it comes through in the myriad associations

and references to cocaine in *The Interpretation of Dreams* (1900/1953). His other addiction, to cigars, killed him. Freud's physician, Max Schur, pleaded with him to stop smoking. Sounding like any addict rationalizing his addiction, Freud refused, saying, "I can't be creative without smoking."

The earliest psychoanalytic insight into addiction is contained in a letter from Sigmund Freud to his friend Wilhelm Fleiss: "It has occurred to me that masturbation is the one great habit that is a 'primary addiction,' and that the other addictions, for alcohol, morphine, etc., only enter into life as a substitute and replacement for it" (1897/1985, p. 287). In Freud's view, infantile masturbation is both compelling and guilt-inducing. Often forbidden by parents, children internalize that prohibition, and a struggle ensues between the wish for instinctual gratification and the internalized prohibition. The struggle not to masturbate is almost always lost. However, the return to masturbation is accompanied by guilt, anxiety, and the fall in self-esteem that accompanies failure to carry through a resolution. Masturbation can then be used as a way of assuaging that guilt and anxiety. A vicious cycle ensues. Later addictions are not only displacements and reenactments of the original addiction to masturbation; they are also attempts to master, through repetition, the traumatic loss of self-esteem that follows the failure to live up to the resolution not to masturbate. It is now believed that infantile masturbation plays an important role in the process of separation-inpiduation, and that it is a vehicle through which the child establishes

autonomy, learns to soothe him- or herself, and establishes a sense of efficacy. If this is the case, and later addictions are symbolic reenactments of the first addiction, then addiction must serve the same purposes.

Freud returned to his theory of addiction in "Dostoyevsky and Parricide" (1928/1961). Playing on the word *play,* Freud traces Dostoyevsky's compulsive gambling back to his addiction to masturbation, emphasizing that addiction serves as a means of self-punishment for the original, forbidden wish. Oedipal wishes are similarly and simultaneously punished. Freud (1926/1959) said that the resistance from the superego—the need for punishment and the patient's feeling that he or she does not deserve to be well—is the most difficult resistance to overcome. This is true in alcohol abuse: the drinker often continues to drink to punish him- or herself for drinking.

Freud's insight has more than a little validity. Alcohol addiction is indeed a dead-end path, as is masturbation as an exclusive form of sexual activity. Freud's theory has the additional merit of highlighting the narcissistic nature of addiction. The love object of the alcohol abuser becomes alcohol itself, which is experienced either as an extension of the self or as an omnipotent substance with which the drinker merges. Freud's theory also highlights another aspect of the narcissistic pathology inherent in alcohol abuse: the loss of self-esteem that alcohol addicts experience when they

drink.

Freud's (1920/1962) theory of the "repetition compulsion" also sheds light on alcoholism. In fact, the addictions were one evidence he gave for the existence of a repetition compulsion. For Freud, such compulsion was a derivative of the death instinct. One need not be an adherent of the death instinct theory to agree that the mobilization and adaptive externalization of aggression are salient in breaking the circle of alcohol abuse.

Karl Abraham (1908/1979) published the first psychoanalytic paper on alcoholism. In it he viewed alcoholism as a nervous and sexual perversion. He was referring to oral-regressive and homoerotic tendencies when he spoke of perversion. Abraham based his theory on analysis of male alcoholics and on his observation that men become openly affectionate in the camaraderie of the beer hall. He inferred that heavy drinking allows expression of forbidden homosexual wishes and postulated that alcohol addicts have especially intense conflicts around repressed homosexuality. Abraham, as one would expect in an era of id psychology, emphasized instinctual regression in alcohol abuse. The capacity for sublimation is lost. Abraham's paper is also prescient in its amalgamation of the sociological and the psychodynamic.

Edward Glover (1928) emphasized the aggression in alcoholism. Writing from the viewpoint of classical analysis, he spoke of "oral rage" and

"anal sadism." He was talking about drinking at someone, using alcoholism as a weapon. Although a primitive, ineffectual, and self-punitive way of expressing rage, this mechanism underlies much abusive drinking. The twin hook of expressing rage and being punished for expressing it is extraordinarily powerful. What Glover did not pick up is the extent to which the rage externalized by drinking is projected self-hatred.

Sandor Rado (1933) was the first to point out the similarity between alcoholism and manic-depressive psychosis, with the alcoholic elation during the high and depression during the hangover paralleling the manic-depressive cycle. Rado related both the mood alterations of manic-depressive illness and the alcoholic pattern of highs and lows to the cycle of infantile hunger and satiation. He saw the key issue in alcohol abuse as a disturbance in the regulation of self-esteem. Abusive drinking is a futile attempt to raise self-esteem.

Robert Knight (1937) distinguished between "essential alcoholics" and "reactive alcoholics." The essentials are patients who never established themselves in life. They are financially and emotionally dependent and have spotty educational and work histories. Their object relations are at the need-gratifying level. Knight described them as oral characters who have not reached the "mastery of the object" characteristic of the anal stage of psychosexual development. Essential alcoholics had trouble with alcohol from

the first drink. Knight pioneered the study of borderline personality disorder, and his essential alcoholics had borderline character structure. He believed that they could never drink safely. Knight's essentials may have suffered from a strong biological vulnerability to alcoholism.

The reactive alcoholics had managed some life successes. They had achieved economic independence and often had considerable educational and vocational attainments. They generally succeeded in marrying and establishing families. The quality of their object relations was once fairly adequate but is now gravely impaired by their drinking. Most had a period of social drinking before crossing what Alcoholics Anonymous (AA) calls the "invisible line." Knight thought that reactives could return to normal drinking once their psychological conflicts had been resolved. This is doubtful.

Knight emphasized the depressive aspects of the alcoholic personality. The fathers of his reactive patients were powerful, unavailable, and erratically punitive. One suspects that many were themselves alcohol abusers. The mothers, dominated by their husbands, were passive and ineffectual. The alcoholic sons were overwhelmed by their fathers and unable to achieve a satisfactory masculine identification. They wanted oral supplies from both father and mother, were enraged at not receiving them, and were afraid to express their rage directly. Their alcoholism, which humiliated their families, was an expression of their rage, but mostly they turned their rage against

themselves—hence their depression. If Knight's essentials are borderline, his reactives are narcissistic personality disorders.

Otto Fenichel (1945) also thought that oral dependence and frustration result in chronic depression in the alcoholic. He saw alcoholism as a maladaptive defense mechanism used to resolve neurotic conflicts, especially conflict between dependence and expression of anger. It is to Fenichel that we owe the observation that "the superego is that part of the mind which is soluble in alcohol" (p. 379). Therefore, forbidden impulses can be indulged and id-superego conflicts resolved by the use of alcohol. Fenichel was the first to explicitly refer to narcissistic regression in alcoholism. He highlighted the deepening self-involvement that accompanies alcoholic regression.

Karl Menninger (1938) put great emphasis on the self-destructiveness of alcoholism. He called alcoholism a form of chronic suicide. It is an aggression against the self as punishment for hostile, aggressive feelings. Alcohol makes the conflict between passive, erotic dependence on the father and resentment of him manageable.

Ernst Simmel (1948) was the first analyst to recognize the usefulness of AA in the treatment of alcoholism. He had founded the first alcohol rehab in the 1920s. In it, he used splitting adaptively; the nursing staff was trained to encourage regression and provide gratification while the analyst represented

the constraints of reality. Simmel emphasized the social pathology created by World War II, which trained men to kill and enjoy it, predicting that this would lead to an increase in all kinds of acting out, including alcohol abuse. On the psychodynamic side, he emphasized the narcissistic disturbance in alcoholism. Seeing the potential of AA for containing primitive aggression, he proposed an alliance between the self-help movement and analysis.

Thomas Szasz (1958) viewed addictions as counterphobic activities. The drinker drinks to confront and master intolerable fears of being addicted, absorbed by symbiotic merger, and annihilated by regressive fragmentation. Experientially, these fears are death. Thus, alcoholics self-inflict death to master fear of death. So seen, alcoholics are mythic heroes who descend to the underworld and emerge intact—at least, that is their hope. Defensive grandiosity is fed by participation in this unconscious drama.

Krystal and Raskin (1970) proposed a theory of affect regression in alcoholism in which discrimination is lost and the predominant affect becomes diffuse dysphoria, a murky muddle of anxiety and depression. This theory has important clinical implications, since the alcoholic patient does not know what he or she is feeling. Recognition of affect is at least partially learned. Affect labeling is a highly affective object-relational experience. If it was missed or has been lost by affect regression in the course of addiction, it becomes vital for the therapist to label affect for the patient.

Carl Jung had an important, albeit indirect, role in the founding of Alcoholics Anonymous. Jung had treated a patient known in the AA literature as Roland H. for his alcoholism. Having undergone a seemingly successful analysis, Roland left Zurich certain he had been cured. In a short time, he returned to Jung drunk and in despair. Jung told him that only a major personality reorganization driven by powerful emotion—in essence, a "conversion experience"—could save him. Jung's words touched something deep inside him, and he did what AA would later call "hitting bottom." In his despair, he did indeed have a conversion experience, joined the Oxford Movement, and became and remained sober. The Oxford Movement had a set of spiritual steps that became the basis of the 12 steps of AA. Roland's experience was communicated to Bill Wilson, the founder of AA, who was still drinking. He too had a "peak" experience and became sober. Many years later, Wilson wrote to Jung to tell him the story, and Jung (1961/1973) replied that Roland's "craving for alcohol was equivalent on a low level of the spiritual thirst . . . for wholeness, expressed in medieval language: the union with God. . . . You see, 'alcohol' in Latin is 'spiritus' and you use the same word for the highest religious experience as well as for the most depraving poison. The hopeful formulae, is *Spiritus contra spiritum"* (p. 623).

More recent psychoanalytic theorists, including Hartocollis (1968), Kohut (1977a), Wurmser (1978), and Levin (1987,1991,1994), emphasize impairments in ego functioning, lack of affect tolerance, and the use of

primitive defense mechanisms, including splitting, projection, and denial. These theorists stress the adaptive function of addiction. Kohut and the present author believe that alcoholism, on its psychological side, is a futile attempt to remediate deficits in the self. Alcohol is experienced as an all-powerful mother with whom the drinker merges in order to raise self-esteem, quell anxiety, feel soothed, feel cohesive and whole, feel full as opposed to empty, feel companioned as opposed to alone, and feel safe. Since alcohol cannot do any of these things for very long and in fact exacerbates the very deficits it is used to ameliorate, an addictive cycle is set up.

INCLUSION/EXCLUSION CRITERIA

Alcohol abuse is a behavioral disorder and is best diagnosed by behavioral criteria. If drinking is causing detriment in the drinker's physical health, emotional well-being, or social or economic functioning, it is abusive. Problem drinking is detrimental but may remit, allowing the problem drinker to return to non-injurious social drinking. Social drinking is not possible for alcoholics. The abstinent alcoholic who returns to drinking will re-experiencing the same or more severe symptoms.

The attempt to define alcoholism has a long and vexed history. The lack of agreement among authorities makes research studies incommensurate and hampers clinical work. The more severe the alcohol abuse, the easier it is to

see. It is the functional alcoholics who are underdiagnosed.

There are two clear behavioral definitions of alcoholism, that of the World Health Organization (WHO) and that of the American Psychiatric Association (APA). In the WHO definition (Keller, 1958), alcoholism is "a chronic behavioral disorder manifested by repeated drinking of alcoholic beverages in excess of the dietary and social uses of the community, and to the extent that it interferes with the drinker's health or his social or economic functioning" (p. 1).

The *DSM-III* and *DSM-III-R* have categories of "substance use disorders," which are classified according to severity as either substance abuse or substance dependence. Pathological use of alcohol is treated this way. "The essential feature of alcohol abuse is a pattern of pathological use of at least a month that causes impairment in social or occupational functioning [evidenced by]: a need for daily use of alcohol for adequate functioning; inability to cut down or stop drinking; repeated efforts to control or reduce excessive drinking by 'going on the wagon' . . .; binges; occasional consumption of a fifth of spirits; amnesiac periods for events occurring while intoxicated; continuation of drinking despite a serious physical disorder; drinking non-beverage alcohol" (*DSM-III*, p. 169) Alcohol dependence is diagnosed by the presence of withdrawal symptoms.

The *DSM-IV* continues to distinguish between abuse and dependence but is clearer on the seriousness of abuse, which is now defined as recurrent use in spite of adversive consequences of various kinds. The *DSM-IV* adds a useful category of alcohol-induced psychiatric disorders.

Many patients who are in fact alcohol abusers come for psychodynamic therapy without presenting excessive drinking as a problem. Most often the complaint is depression, anxiety, or martial conflict. In my experience, if patients feel safe enough, they will tell therapists their secrets. For the most part, patients diagnose themselves. However, denial leads to minimalization, and inquiries upon intake as to drinking behavior miss the problem. This is usually not conscious deception on the part of the patient. There are a number of self-evaluations for alcohol abuse that the therapist can administer to the patient. The two best are the MAST (Michigan Alcoholism Screening Test) (Selzer, 1971) and AA's 12 questions contained in the pamphlet *Is AA for You?* (A.A. World Services, 1974). The following are signs of alcoholism: the drinker does not remember what happened when he or she was drinking; radical personality change when drinking; Monday morning absences from work; fighting and abusive behavior while drinking; health problems related to drinking; depression that does not remit with appropriate treatment; defensiveness about drinking that sounds crazy because what the drinker maintains is so clearly contrary to fact; trouble on the job, especially otherwise unexplained faltering performance; otherwise unexplained

detriment in functioning in any important life sphere; passing out, usually rationalized as "relaxing after dinner"; violence when drinking; restlessness and agitation when alcohol is not available; morning drinking; the shakes and other symptoms of withdrawal; neglect of personal hygiene; daily drinking of more than socially accepted proportions; frequent drunkenness; otherwise unexplained moodiness and emotional withdrawal; increasing suspiciousness and exclusiveness; increasing self-centeredness in a person who was not previously self-centered.

DYNAMIC ISSUES: FIXATION/REGRESSION TO PATHOLOGICAL NARCISSISM AS THE PSYCHODYNAMIC CORRELATIVE OF ALCOHOL ABUSE

I do not wish to say that all alcoholics have narcissistic personality disorders as defined by the *DSM-III-R* and *DSM-IV,* an assertion that would be contrary to fact, or that all pathology is self-pathology, as the more radical self-psychologists maintain. But I do wish to say that alcohol abuse is one possible consequence of fixation to the stage of the archaic nuclear self (see below), and that alcohol abuse that does not flow from such fixation results in a regression to it. I cannot stress too much that a great deal of what we see in active alcoholism and alcohol abuse—depression, anxiety, rage, and self-centeredness—is caused by the drinking. To some extent, that is also true of pathological narcissism, albeit the pathological narcissism remits much more slowly than the depression and anxiety do when the patient ceases drinking.

In cases in which the pathological narcissism is antecedent and etiological, the drinking exacerbates it and makes its remediation impossible.

It is to Kohut's (1971,1977b) conceptualization of pathological narcissism that I appeal. Kohut defines the self as a unit cohesive in space and enduring in time that is a center of initiative, and a recipient of impressions. It can be regarded either as a mental structure superordinate to the agencies of the mind (id, ego, and superego) or as a content of those agencies. According to Kohut, the infant develops a primitive (fragmented) sense of self very early. Each body part, each sensation, each mental content is experienced as belonging to a self, to a me; however, there is no synthesis of these experiences. The infant experiences selves but no unitary self. Nor does the infant experience clear boundaries between self and world. Kohut designates this stage that of the *fragmented self;* it is the stage at which psychotic persons are fixated.

At the next stage of development, an *archaic nuclear self* arises from the infant's experience of being related to as a self rather than as a collection of parts and sensations. This self is cohesive and enduring but not securely established. It is prone to regressive fragmentation, nuclear in the sense of having a center, and archaic in the sense of being a primitive (i.e., grandiose and undifferentiated) precursor of the mature self. The archaic nuclear self is bipolar in that it comprises two structures: the grandiose self and the

idealized parental imago. In this stage, there is a differentiated self, experienced as omnipotent, but no truly differentiated objects.

The internalization of psychic structure (Kohut's term for the capacity to do things once done by parents and now a part of self) is co-determinous with the formation of the nuclear self. Failure to adequately internalize functions originally performed by self-objects results in deficits in the self. A *self-object* is both the internal representation of an object perceived as an extension of the self and a person so experienced. Addiction is a futile attempt to compensate for this failure in internalization. Of crucial importance in creating a securely cohesive self are the internalization of the capacities for tension regulation, self-soothing, self-esteem regulation, and the self-object's function as stimulus barrier.

Pathological narcissism is the regression/fixation to the stage of the archaic nuclear self. It is characterized by the presence of a cohesive but insecure self that is threatened by regressive fragmentation; grandiosity of less than psychotic proportions that manifests itself in the form of arrogance, isolation, and unrealistic goals; low affect tolerance; feelings of entitlement; the need for omnipotent control; poor differentiation of self and object; and deficits in the self-regulating capacities of ego (self). The narcissistically regressed inpidual is subject to massive anxiety stemming from fear of annihilation (i.e., fear of fragmentation of the self) and to "empty" depression,

reflecting the paucity of psychic structure and good internal objects. These manifestations of the archaic self may be either blatantly apparent or deeply repressed and/or denied, with a resulting facade of pseudoself-sufficiency.

The overtly grandiose self is the result of merger with a parent who used the child to gratify narcissistic needs. It is a "false self" (Winnicott, 1960/1965). Kohut (1971) envisions this false self as insulated from the modifying influence of a reality ego by a "vertical split." The reality ego is in turn impoverished by the repression of unfulfilled, archaic narcissistic needs by a "horizontal split" (repression barrier). The overt grandiosity of the alcohol abuser is a manifestation of a false self that is isolated, both affectively and cognitively, from the more mature reality ego, which is itself enfeebled by its inability to integrate the archaic grandiosity—hence the coexistence of haughty arrogance and near-zero self-esteem in alcoholics.

It is no accident that the phrase "His Majesty, the baby," which comes from Freud's 1914 essay *On Narcissism: An Introduction,* plays such a prominent role in the AA literature. AA sees pathological narcissism as the central problem in alcoholism and, in its didactic way, emphasizes the necessity to outgrow the need for omnipotent control. The narcissistic rage that follows the failure to exercise omnipotent control all too easily leads to "slips."

There is a body of empirical psychological findings on the clinical alcoholic personality (to be distinguished from a pre-alcoholic personality, if there is one), including elevated psychopathic deviancy (Pd) and depression (D) on the Minnesota Multiphasic Personality Inventory (MMPI), field dependence, ego weakness, and stimulus augmentation. The concept of regression/fixation to pathological narcissism makes sense of these empirical findings. Elevation in the Pd scale of the MMPI in both active and recovering alcoholics, probably the most consistent finding in the literature, can be understood as a manifestation of the grandiose self, with its arrogance, isolation, and lack of realistic goals. The elevation of the D scale on the MMPI reflects both the psychopharmacological consequences of active alcoholism and the impoverishment of the self, riddled with structural deficits and impaired in its capacity for self-esteem regulation. Developmentally, the depression reflects the disappointment that results from inadequate phase-appropriate mirroring of the child's grandiose self. Additionally, alcoholism gives the alcoholic much to be realistically depressed about. Empirical findings, using adjective checklists and self-reports, of impoverishment of the self can be understood in the same way. The structurally deficient self of pathological narcissism is experienced as empty depression and is reported as lack of interest in people, activities, and goals. Even the self is uninteresting to the self. The regression to pathological narcissism concomitant with the alcoholic process progressively strips the already enfeebled ego of its

investment in objects and activities, leaving an empty self, an empty world, and an empty bottle.

Another consistent finding in alcoholics is field dependence. Field-dependent persons rely more on environmental clues than on proprioceptive input in construing the environment (Witkin, Karp, & Goodenough, 1959). Field dependence entails a relative inability to utilize internal resources, as well as impairments in the differentiations of body image, of figure and ground, and of self and world. The field-dependent person experiences the environment as a self-*object*— which is precisely how the person fixated/regressed to pathological narcissism experiences the world.

Ego weakness is a construct that integrates several empirically confirmed characteristics of alcoholics: impulsivity, lack of frustration tolerance, lack of differentiation of the self-concept. In terms of pathological narcissism, ego weakness in the alcoholic is understood in terms of structural deficits in the self. Stimulus augmentation (Petrie, 1967/1978), the experiencing of stimuli as impinging, has been found to be characteristic of alcoholics and contributes to their ego weakness. Stimulus augmentation can be understood in terms of pathological narcissism as a failure to internalize the mother's function as an auxiliary to the innate stimulus barrier.

Major theories of the psychodynamics of alcoholism, including the

dependency-conflict theory (drinking is a covert way of meeting unacceptable dependency needs), the need-for-personal-power theory (men drink to feel powerful), and the epistemological error theory (alcoholics drink to remediate a pathological severance of subject and object), are also given coherence and made consistent by the concept of regression/fixation to pathological narcissism. Because they experience others as extensions of themselves, the pathologically narcissistic are, by definition, dependent on those others for their very existence as integral selves. They can be neither independent nor interdependent; there is no one apart from themselves with whom to be interdependent. This is the ultimate basis of alcoholic loneliness. Further, because the very existence of the self is dependent on the object (experienced as a self-object), this dependency is fraught with primitive, massive, panic-level anxiety—hence the need for omnipotent control of the object. Any failure of the self-object to meet the needs of the archaic self is experienced as an injury to the self, which is reacted to with "narcissistic rage."

Although this deep need for fusion may be repressed from consciousness or dealt with by reaction formation, the alcoholic unerringly finds the "perfect" self-object with which to fuse—alcohol. Dependence on people is denied, while the pathological use of alcohol leads to enslavement.

Alcohol readily performs the normal self-functions of affect regulation,

stimulus attenuation, and self-soothing by anesthetizing painful drives, emotions, and sensations. It also raises self-esteem, at least initially. Fusion with the idealized, omnipotent self-object characteristic of the stage of the archaic cohesive self is driven by a wish to participate in the self-object's greatness and *power.* Alcoholics idealize alcohol, to which they attribute omnipotent power. Thus, the need for power as proposed in one theory of the dynamics of alcoholism (McClelland, Davis, Kalin, & Wanner, 1972) is also accounted for by regression/fixation to pathological narcissism.

The epistemological error theory of the dynamics of alcoholism (Bateson, 1971) sees the driving force behind alcoholism as an impossible misperception of reality that sets the alcoholic in opposition to the world and allows no meaningful interaction with that world. Rather than experiencing reality as an infinite set of interrelationships, interactions, and feedback loops, the alcoholic experiences it as a reified subject, acting on a disjunctive world. Since this experience is incongruent with the nature of things, conflict must ensue. This is precisely the phenomenology of the experiential world of the pathologically narcissistic.

Although alcoholics in their pathological narcissism may have selves experienced as separate from the world (grandiose self), they do not have a world experienced as separate from them. The inflated ego has no world with which to establish interdependence. What is seen in structural terms as an

archaic self is seen by Bateson in cybernetic terms as an information system without feedback loops, as cognitive error.

Kohut (1971,1977b) speaks of self-object transferences in which the analysand experiences the analyst as an extension of self, as a self-object, in one of two ways: in the mirror transference, the analyst is an extension of the grandiose self, whose only function is to mirror and confirm the patient's grandiosity; in the idealizing transference, the situation is reversed and the analyst, experienced as omnipotent and perfect, is fused with so that the patient partakes of the analyst's perfection. This is exactly what alcohol abusers do with alcohol: They experience alcohol either as a mirror that confirms their grandiosity or as an all-powerful parent who will provide the goods. The essence of treatment is to transfer the alcohol abuser's need for a self-object relationship from a chemical, alcohol, to a relationship with the therapist, where it can be understood and worked through.

Alcoholics who have achieved sobriety often manifest obsessive-compulsive personality traits. The sober alcoholic's newfound compulsivity is a defense, a reaction formation, against underlying impulsivity. However, there is a more profound reason for this phenomenon: Both the impulsivity of active alcoholism and the compulsivity of arrested alcoholism are manifestations of the alcoholic's pathological narcissism. The bridge between them is the need for omnipotent control characteristic of the grandiose self. In

alcohol addiction, such power and control are sought in fusion with an omnipotent self-object, alcohol; in recovery, power and control are sought in ritual, rigidity, and other character defenses. AA rightly sees the modification, or treatment, of the underlying pathological narcissism as the key issue. Untreated, its outward manifestation quickly reverts from compulsivity to impulsivity, and the alcoholic is once again drinking.

The most important clinical implication of the dynamics of alcoholism is the light it casts on the newly sober alcoholic's needs for mirroring, idealized objects, and omnipotent control and disabilities in managing intense feelings, quieting anxiety, and maintaining self-esteem. This dynamic model understands anxiety in early sobriety as the panic-terror of regression to the stage of the fragmented self (psychic death) and understands depression in early sobriety as both an empty depression consequent upon failures of internalization and an angry depression consequent upon turning narcissistic rage against the self.

TREATMENT GOALS

The treatment goal with alcoholics and most alcohol abusers must be sobriety—sustained, total abstinence from alcohol. Some problem drinkers can return to normal social drinking when the psychological conflicts that drove their abusive drinking have been resolved; however, their initial goal

must still be abstinence. The more severe the alcohol abuse and the more symptomatic the drinker, the less the chance that social drinking is a feasible goal. It rarely is. Therefore, it becomes crucial that the alcohol be replaced with something that does the job better—relationship. Drinking is taking something from the outside in, in a futile attempt to provide what is missing inside. Therefore, the long-term goal must be the internalization of psychic structure, that is, acquiring the abilities to self-soothe, modulate and maintain a reasonably high level of self-esteem, tolerate affects, and feel securely cohesive, enduring, and capable of initiative.

The treatment of alcohol abuse takes place in three stages: diagnosis, confrontation, and education. Once the diagnosis has been made, the next step is confrontation. Since the patient rarely shares the therapist's goal of abstinence from alcohol, conflict is inevitable. Alcoholism counseling has been compared to taking a bone away from a hungry Doberman. This metaphor is not always appropriate: Some patients are extremely disturbed by their alcohol abuse, feel out of control, and are desperately begging for help in their effort to cease drinking. However, such patients are unusual. What we are more commonly confronted with are denial and rationalization. Hence, there is a real discrepancy in treatment goals between the therapist, who wishes the patient to stop drinking and work on psychological and emotional problems, and the patient, who wants to learn to drink without experiencing problems. The first goal must be the establishment of a working alliance,

always a difficult task with alcohol abusers. It is reached by empathic understanding of the drinker's dilemma: At some point he or she feels, consciously or unconsciously, that drinking is now impossible yet life is not possible without drinking. The therapist must always be on the side of reality and do everything possible not to be perceived as the withholding, punitive, introjected parents of the superego. Hence, matter-of-factness in the educative task is crucial. The degree to which the patient's distress is caused by drinking, even though the patient believes the opposite, must be communicated. In the confrontation—which is essentially a matter of saying, "You think you drink because you're crazy, but did it ever occur to you that you might be crazy [or "in pain," "depressed," "anxious," "despairing," "desperate"] because you drink?"—the patient's and the therapist's goals are made congruent.

With the goal of abstinence established, a treatment plan is put in place to bring it about. That treatment plan may include a period of detoxification and/or a period of inpatient treatment in an alcoholic rehabilitation center, but most frequently it is simply a planned progressive decrease to zero in the patient's drinking. Slips are to be expected and must be treated in a nonpunitive way. Slips can be analyzed, as can any other behavioral manifestation. Once sobriety is achieved, the next goal is building affect tolerance. Lack of affect tolerance will lead to relapse. This is the stage in which the therapist interprets what the patient is feeling, labels it, contains it,

and helps the patient process it. Helping the patient deal with anger is crucial. Most slips are infantile expressions of repressed rage. The long-term goal is to make the patient less narcissistically vulnerable so that he or she is not in an almost constant state of rage; however, this takes time, and in the beginning what is needed is to help the patient become conscious of and verbalize in treatment his or her rage so that it is not acted out. Additional goals in early sobriety are making the patient aware of the "places, people, and things" that act as triggers. Affect is an important trigger. After a period of six months to a year of sobriety, treatment goals change and become focused on the transmuting internalization of the therapist so that the therapist's functions as a self-object become part of the patient's resources. AA speaks of providing its members with "tools for living sober." AA's tools are Kohut's psychic structure. The long, slow process of internalizing the self-object functions performed by the therapist and working through disturbances in the therapeutic relationship is of the essence of treatment. No part of this process precludes the resolution of structural (id-ego-superego) conflicts. However, the initial focus is on self-esteem maintenance. In Kohut's terms, the goal is to move from the stage of the archaic nuclear self to the stage of the mature self.

THEORY OF CHANGE

Since alcohol abuse is a pharmacological as well as a psychodynamic disorder, the changes that come about in sobriety are multifaceted. The most

striking change is that which follows cessation of drinking. The neurochemical and neurophysiological effects of ethanol on the nervous system are profound. In effect, it induces a transient organic brain syndrome. On the cognitive side, that means that there are impairments in the ability to abstract, reason, and remember. The patient tends to be confused. On the affective side, the transient organic brain syndrome manifests itself as emotional liability. The patient is up, down, and sideways. This instability only adds to his or her confusion and disorientation. Recovery from the effects of alcohol abuse takes a long time. In working with the alcohol abuser, anywhere from three months to two years must elapse before full neurochemical recovery takes place. This means that in doing therapy with early sobriety patients, we are working with people who are not playing with a full deck. In terms of technique, interventions must be simple, clear, and redundant. They are not well processed, because of both neurochemical impairments in cognition and the dynamic effects of denial. What is needed to change all this is simply abstinence from alcohol. Essentially, we are buying time for nature to take its course.

Cessation of drinking has psychodynamic as well pharmacological consequences. Alcohol abusers, for all their bluster and denial, hate themselves because of their drinking. With the cessation of alcohol abuse, that self-hatred abates, although not quickly or all at once. One might think that since drinking serves a psychodynamic function, patients will do worse sober.

This is never the case. Whatever psychodynamic issues the patient may have are always exacerbated by the alcohol abuse, so that even if they are not ameliorated by sobriety alone, a change in the patient's state of being comes about that makes treatment possible. Since the patient has lost a script, a lifestyle, a way of structuring time, a defense, and an anesthetic, it is vital that all these be replaced by a relationship with a therapist, and preferably a relationship with a self-help group as well. The regressive pull of addiction is overwhelmingly powerful, and forces of equal or greater weight pulling in the opposite direction toward differentiation and integration must be put in place. That is why I believe that the best chance for recovery occurs when the patient is simultaneously in professional treatment and a member of a self-help group. Things can be accomplished in therapy that cannot be accomplished in a self-help group, and no therapist can provide the kind of safety net and support system that AA offers. (There are patients who find AA and its ideology unacceptable. Some do fine without it, others are best referred to other support systems such as an early recovery therapy group or a Rational Recovery [RR] meeting.)

Many patients are in a state of euphoria, which AA refers to as a "pink cloud," in early sobriety. This is a response to escape from a life-threatening, progressive disability. There is certainly denial in the pink cloud, denial of the devastation that alcohol abuse has visited on the patient. However, that denial is adaptive, and although it is wise for the therapist to alert the patient to its

temporary status and to be alert for signs of an impending crash, the patient should basically be allowed to enjoy it. Usually three or four months into sobriety reality penetrates in ways that are often very difficult for the recovering person to cope with.

There are other reasons the patient usually feels better in sobriety. Not only is self-hatred radically reduced, but the environment becomes less retaliatory and punitive. People are no longer scornful of and angry at the alcohol abuser. Now playing with a fuller deck, with augmented resources, the recovering alcoholic is in a much better position to cope with the tasks of life, internal and external. His or her existential position has been radically altered for the better. It is also true that a need for self-punishment or for provoking the environment to inflict that punishment may still be very much in place. Therefore, the therapist must interpret, and if possible anticipate, acts of self-destruction and the motivations for them.

Once the patient settles down, the most powerful vehicle for change is the transference. Alcohol abusers usually form self-object (narcissistic) transferences. It is rare that the patient forms only a mirror or only an idealizing transference. Rather, there is usually alternation between the two. Patients with such fragile self-esteem and such tenuous self-cohesion as those in the early stages of recovery are desperately in need of the affirmation of the mirroring transference. Additionally, their boundaries are none too firm,

and they easily enter into mergers. Inevitably, the therapist fails to be a perfect self-object and a disruption of the relationship takes place. In working through and mending such breaches of the self-object transference, a process Kohut (1971) calls "transmuting internalization," the functions of the therapist as provider of self-object functions are internalized a little bit at a time. If the therapist always perfectly performed these functions, the patient would have no reason to acquire these skills, capacities, and structure for him- or herself, and if the needs are not met or are met too unreliably, then there is no opportunity for internalization. This notion is very similar to the traditional psychoanalytic notion of optimal frustration.

The patient is also desperately in need of an object to idealize. Alcohol had been the ideal object. Now it is gone and must be replaced. Generally, that replacement takes place through idealization of a therapist, an AA sponsor, an AA group, the AA program, or AA's "higher power." Kohut maintains (1977b) that the needs for mirroring and idealization, the needs of the narcissistic segment of the personality, are just as immemorial as the need for instinctual gratification. If they are not met in healthy ways, they will inevitably be met in unhealthy ones. The formation of a self-object transference provides the patient with the stability and security out of which growth from the stage of the archaic nuclear self into the stage of the mature self can take place.

In the latter stages of recovery, psychodynamic therapy tends to move

toward a more traditional psychoanalytic set of tasks. The patient increasingly relates to the therapist as an object rather than as a self-object, and reenactments of early object relations in the transference provide an opportunity for understanding and working through Oedipal conflicts.

Change is thus brought about by a combination of educational (cognitive behavioral) interventions and the acquisition of psychic structure through transmuting internalization. In many ways, such therapy constitutes a corrective emotional experience. The patient has either not had phase-appropriate, growth-promoting self-object relationships or has suffered massive regression, so that psychic structure was lost—so to speak washed out. He or she now has an opportunity to learn (or to relearn) how to manage feelings and conflicts without anesthetizing them.

Another way change takes place is through the labeling and verbalization of affect. Affect tolerance is built through practice in the same way one builds a muscle, by exercising it. Each time the patient is able to express a feeling in the transference and that feeling is accepted by the therapist, the capacity for affect tolerance is increased. Narcissistic rage that was previously either acted out or turned against the self, perhaps simultaneously by drinking, is now verbalized and in the course of time plays a less significant role as increased ego strength and self-cohesion reduce vulnerability. The patient is less easily hurt, therefore less enraged. Anxiety

that had been experienced as panic-dread of dissolution of the self and anesthetized is now tolerated. The therapist has faith that the patient will not disintegrate, and through identification, the patient's terror diminishes. Panic-terror becomes signal anxiety, and the patient learns that he or she can take action to deal with the danger. Self-cohesion is increased with sobriety and treatment, so there is less reason to fear regressive fragmentation.

Winnicott points out that "the capacity to be alone" (1958/1965) is a paradox. It is acquired through the experience of being alone with another person who is not impinging but allows us to be. If we are so fortunate as to have enough such experiences, the non-impinging other becomes internalized and we can be comfortably alone without the physical presence of another—because we are not really alone, there is someone within us. Winnicott's "capacity to be alone" is the diametric opposite of defensive isolation: The first is a sine qua non of all creativity, while the second is driven by fear and terror. Alcohol abuse is often the consequence of the failure to acquire the capacity to be alone. Once again, something outside is being put inside because something inside is missing. People drink to be companioned. In the dyadic relationship of therapy, the conditions necessary to acquire the capacity to be alone are present. The patient "plays" in the presence of an attentive yet non-impinging other, and in the course of time that attentive and non-impinging other becomes a part of self and the patient can be comfortably alone without turning to alcohol for companionship.

Alcohol abusers are often themselves children of alcohol abusers. When that is the case, it is inevitable that traumatic failure to meet narcissistic needs is part of their childhood history. The damage may be far more than that of omission; it often includes that of commission, including physical and sexual abuse. Although not all alcohol abusers were abused children, many were. Very often, the abuse is denied or repressed. The therapeutic task is de-repression, and the key factor in de-repression is providing a safe enough environment in which it can happen. I do not believe that a transferential reenactment of childhood horrors is curative. What is needed is a sufficient feeling of safety so that the patient can remember and feel and eventually work through childhood trauma.

The disease concept of alcoholism, if the patient comes to believe in it, is also an agent of change and should be taught. "You're not a bad person trying to be good; you're a sick person trying to be well." Alcoholism was viewed as a disease as early as the American Revolution by Surgeon General Benjamin Rush. In the 19th century, Thomas Trotter, an English naval physician, proposed that alcoholism is a disease caused by premature weaning and heredity, not a bad intuitive guess. More recently, the disease concept of alcoholism has been promoted by AA and given scientific support by Jellinek (1960). All of our official bodies, the AMA, both the APAs, and the courts, now regard alcoholism as an illness. It is a notion with extraordinary healing power. The disease concept reduces guilt (and what alcohol abusers do with

guilt is drink). One might think that teaching that alcoholism is a disease would lessen the chances of recovery by providing a rationalization for drinking. Although this is true of some patients, they are unusual. What happens for most alcohol abusers is that the disease concept reduces anxiety by providing a way of understanding what has been a hellish experience. Cognitive structure reduces anxiety, and patients come to believe that they are responsible for their recovery but need not feel guilty about being alcoholic. Alcohol abusers, contrary to the stereotype, often have severe superegos. What appears to be sociopathic behavior flows from the desperation of the need to attain supplies to maintain the addiction. The exception is a type of severe early-onset alcoholism called "male-limited alcoholism," which Cloninger (1983) believes to be biologically mediated. For the vast majority of alcohol abusers, however, the disease concept is mutative and enables a sustained recovery.

AA speaks of the necessity for surrender, or what Tiebout (1957) called "ego deflation." What both terms refer to is the relinquishing of reactive grandiosity. Alcoholic grandiosity, which Kohut (1977a, 1977b) would understand as unintegrated archaic grandiosity separated from the reality ego by the vertical split, serves no purpose but to keep the patient drinking. The patient holds onto the notion that he has power over alcohol, when in fact alcohol has power over him. Recognizing this reality and relinquishing the myth of omnipotent power is extraordinarily liberating. What had been

anticipated as a dreadful, even life-threatening deprivation is now experienced as freedom. The AA literature has many accounts of such ego deflations. I too believe that a radical reorganization of psychic forces, which takes place if the proper environment is provided and information is conveyed in a way that the patient can hear it, is curative. The notion of surrender sounds as if it would be narcissistically injurious to those who are already narcissistically injured. This is simply not the case. The experience, although defended against with the energy of desperation, is in fact narcissistically sustaining because what is given up is pure illusion. The patient who has had the surrender experience no longer needs to fight an impossible battle and can use his or her energy in the service of growth and integration.

To sum up, change takes place through the cessation of drinking, with its neurochemical, psychic, and interpersonal consequences; through didactic intervention, which reduces anxiety by providing cognitive structure for chaotic experience; through providing tools for living, the psychic structure needed to deal with feelings and conflicts; through the reversal of affect regression; through internalization, transmuting and otherwise; through de-repression; and through the breakdown of defensive isolation through integration into a community of recovering persons.

TECHNIQUES

The therapist's first task with the alcohol abuser is *building a relationship.* Because treatment will end unless the therapist succeeds in establishing a meaningful relationship with the alcoholic, the building and preserving of bonds takes precedence in the therapeutic interaction. Bonds are built by empathic listening, supplemented by the clearing of resistances. Confrontation of addiction is an empathic response. We tend to think of confrontation as unempathic, but that is not the case.

It is the *attitude* of the therapist that is crucial. What is required is active listening, the projection of interest and concern, and nonjudgmental positive regard. However, the situation with the active or newly sober alcoholic requires modifications of Freud's (1913/1958) excellent advice on beginning the treatment. Freud advised the analyst to remain silent so that the transference could develop until resistance manifested itself and then to interpret the resistance. That procedure will not work with alcohol abusers. The required modification consists of greater overt activity on the part of the therapist. Although empathic listening and the clearing of resistances remain paramount, the therapist must also serve as an expert on the disease of alcoholism; he or she has an educative function to perform.

The therapist is dealing with an impulse disorder that may be acted out at any time, ending treatment. Insofar as possible, this acting out must be anticipated and circumvented. Intolerable affects result in drinking.

Unconscious, disavowed affects are particularly dangerous, but any intense feelings, "positive" or "negative," conscious or unconscious, that remain unverbalized are a threat to sobriety. The therapist must actively encourage the expression of feelings and must appropriately interpret some of the emotional discomfort in early recovery as a symptom of that recovery. The therapist tells the patient, "When you are feeling upset, we'll try and understand it together, in terms of what's going on in your life or your relationships with people, or things that have happened to you in your past, including your childhood, but we're going to find that very often, when you're feeling badly, we will not be able to find any reason for it. The reason that is so is that your discomfort will be a symptom of the healing of your nervous system after the assault that alcohol has made on it. If you don't drink, the discomfort will disappear." The foregoing is an example of an educative intervention, albeit one with dynamic import.

The acting out of resistance by drinking must be anticipated and dealt with before it occurs. Of course, this is not always possible; it is a goal, not a demand on the therapist. Therapy in early recovery is difficult because the therapist has little time in which to deal with the patient's conflicts, since those conflicts may be acted out through drinking. We do not have the luxury of waiting the patient out. What is required is a bob and weave on the part of the therapist. Empathic listening, imparting of information, and the elicitation of feelings must be integrated into a coherent style. It requires a great deal of

"therapeutic tact" for the therapist to sense when to do what in order to maintain the relationship. However, the growing attachment of the patient to the therapist provides the cement that holds both the patient and the therapeutic relationship together. Some form of self-object transference is being elicited, be that a mirror transference, an idealizing transference, or an oscillation between the two.

Virtually no chronic alcohol abuser wants to get sober. The fear and pain are too great. The regressive pull is too great. That is why external events—such as loss of a job or loss of a mate—are so often the precipitant of an emotional crisis that results in sobriety. These external events furnish the apparent motive for sobriety. At this point, the alcoholic is "doing it for them." Such motivation is often not sufficient, and external controls such as those provided by hospitalization may be necessary to achieve sobriety of any duration.

Whether or not the patient has had some sort of inpatient experience, it is my belief that referral to Alcoholics Anonymous is a crucial part of the therapeutic process. (As noted previously, there are patients for whom AA is the wrong treatment. These include severe borderlines and schizoids as well as those who find AA's approach repugnant.) Patients often have a great fear of A A and many misunderstandings of it. Therefore, the therapist needs to be thoroughly familiar with and comfortable with 12-step programs. Many

therapists are uncomfortable with the language of the 12-step movement and with its spirituality. So are many patients. It is important that the therapist be able to present the program in a way that will be palatable to the particular patient. AA's "higher power" can be interpreted as the group, and such AA slogans as "Let go and let God" can be interpreted as "Get out of your own way." They are essentially injunctions to relinquish omnipotent control. The therapist needs to work through his or her own power and control issues in order to be comfortable with the AA approach to recovery. This does not entail ideological commitment to the beliefs of AA; the therapist needs to be objective. Not all of the patient's complaints about AA are resistances or symptoms of denial, and it is important to understand that. I tell patients that AA is a support network that will enable them to remain sober and to share their experience and deliquesce their guilt. I also tell them that they need not believe everything they hear there, and that they can regard it is a smorgasbord from which they should take what they can use most profitably.

In one way or another, omnipotent control as expressed in the belief, "I can drink as much as I want without it damaging me or controlling me," must be relinquished. The paradox of recovery is that the patient must relinquish control in order to gain control. Alcohol abusers, at the end of their drinking, have tenuous control of their sobriety at best. That is why some form of external control is often needed, whether that control is coming from the AA group, from the therapist, from a hospital, or from Anabuse, a drug that does

not permit you to drink. Eventually, such controls become internalized. It is not known exactly how this happens. Identification helps; in fact, it may be the key. This is one reason AA is so effective in establishing stable sobriety. AA provides the alcoholic with figures with whom to identify. They too are alcoholic, but they no longer drink; they are recovering. It is not with Bob or Jane or John or Sally that the alcoholic must identify, but with their sobriety. The alcoholic may also identify with his or her nonalcoholic therapist's sobriety, although here the identification is less direct.

With time, sobriety becomes more rewarding. The pain of early sobriety recedes, the residual pain is endurable, and the alcoholic wants to remain sober. Sobriety becomes part of the recovering alcohol abuser's ego-ideal. Living up to one's ego-ideal increases self-esteem, and that feels good; hence, it becomes a behavior the patient tries to maintain. Remaining sober is then no longer a struggle; it is an increasingly comfortable decision.

Self-psychology, as I have modified it for the treatment of alcohol abusers, suggests a number of powerful interventions for use in working with those abusers. Each addresses what theory understands as narcissistic deficit and narcissistic injury and their attempted self-cure through alcohol abuse; the attempt to fill inner emptiness due to failures in transmuting internalization by drinking; the acting out of narcissistic rage and turning it against the self; idealizing and mirror transferences to alcohol; attempts at

omnipotent control through alcohol abuse; attempts to boost abysmally low self-esteem through abuse of alcohol; and shame experiences, both antecedent to and consequent upon alcohol abuse. The following ways to translate theory into concrete interventions need to be modified so a particular patient can hear them.

1. *Not being able to drink "like other people" inflicts a narcissistic wound.* The admission that one is powerless over alcohol is extremely painful. It is experienced as a defect in the self, which is intolerable for those who are as perfectionistic as most alcohol abusers. The self must not be so damaged. Additionally, to be able to "drink like a man" or "drink like a lady" may be a central component of the alcoholic's self-image, of his or her identity. This self-image is particularly compelling for "macho" men but is by no means restricted to them. The therapist must recognize and articulate the conflict between the patient's wish to stop drinking and the patient's feeling that to do so entails admitting that he or she is flawed in a fundamental way. The therapist does this by saying, "You don't so much want to drink, as not want not to be able to drink." This makes the patient conscious of the conflict in an empathic way, allows him or her to struggle with the issue, and often opens the way for the patient to achieve stable sobriety.

2. *Alcoholism is one long experience of narcissistic injury.* Failure stalks the alcoholic like a shadow. As one of my patients put it, "When I drink, everything turns to shit." Career setbacks, job losses, rejection by loved ones, humiliations of various sorts,

ill health, economic decline, accidental injury, and enduring "bad luck" are all too frequent concomitants of alcoholism. Each is a narcissistic insult. Cumulatively, they constitute a massive narcissistic wound. Even if outward blows have not yet come, the inner blows—self-hatred and low self-regard—are always there. The alcoholic has all too often heard, "It's all your fault," in one guise or another. The therapist must empathize with the alcoholic's suffering. "Your disease has cost you so much," "You have lost so much," and, "Your self-respect is gone," are some ways the therapist can make contact with the alcohol abuser's pain and facilitate his or her ability to experience this pain instead of denying, acting out, and/or anesthetizing it.

3. *Alcoholics feel empty.* Either they have never had much good stuff inside or they have long since flushed it out with alcohol. "You drink so much because you feel empty" not only makes the connection but brings into awareness the horrible experience of an inner void. After sobriety has been achieved, the genetic determinants of the paucity of psychic structure experienced as emptiness can also be interpreted.

4. *Alcoholics frequently lack a firm sense of identity.* How can you know who you are if your experience of self is tenuous and its inner representation lacks cohesion? The therapist can comment on this and point out that being an alcoholic is at least something definite—an identity of sorts. When an AA member says, "My name is ____, and I am an alcoholic," he or she is affirming that he or she exists and has at least one attribute. With sobriety, many more attributes will accrue—

the self will enrich and cohere. One way of conveying this prospect to the patient is by saying, "You are confused and not quite sure who you are. That is partly because of your drinking. Acknowledging your alcoholism will lessen your confusion as to who you are and give you a base on which to build a firm and positive identity."

5. *Many people drink because they cannot stand to be alone.* This should be interpreted: "You drink so much because you can't bear to be alone, and alcohol gives you the illusion of having company, of being with a friend. After you stop drinking, it will be important for us to discover why it is so painful for you to be alone."

6. *Alcoholics form self-object (idealizing and mirror) transferences to alcohol.* The imago of the archaic, idealized parent is projected onto alcohol, which is experienced as an all-powerful, all-good object with which the drinker merges in order to participate in its omnipotence. "Alcohol will deliver the goods and give me love, power, and whatever else I desire" is the drinker's unconscious fantasy. The therapist should interpret this: "Alcohol protected you and made you feel wonderful, and that is why you have loved it so much. Now drinking isn't working for you anymore, and you are disillusioned and afraid."

7. *One reason alcoholics are devoted to the consumption of alcohol is that it confirms their grandiosity.* In other words, alcoholics form a mirror transference to alcohol. I once had an alcoholic patient who told me that he felt thrilled when he read that a

sixth Nobel prize was to be added to the original five. His not-so-unconscious fantasy was winning all six.

The therapist should make the mirror transference to alcohol conscious by interpreting it: "When you drink, you feel that you can do anything, be anything, achieve anything, and that feels wonderful. No wonder you don't want to give it up."

8. *Alcoholics, without exception, have abysmally low self-esteem.* Self-psychology understands this as an impoverishment of the reality ego consequent upon failure to integrate archaic grandiosity. The therapist needs to say, "You feel like shit, and that you are shit, and all your claims to greatness are ways of avoiding knowing that you feel that way. You don't know it, but way down somewhere inside, you feel genuinely special. We need to put you in touch with the real stuff so you don't need alcohol to help you believe that the phony stuff is real." The particular reasons, antecedent to and consequent upon the alcohol abuse, that the patient values him- or herself so little need to be elucidated and worked through.

9. *Sometimes the patient's crazy grandiosity is simultaneously a defense against and an acting out of the narcissistic cathexis of the patient by a parent.* That is, the patient is attempting to fulfill the parent's dreams in fantasy while making sure not to fulfill them in reality. This is especially likely to be the case with ACOAs (adult children of alcoholics). Heavy drinking makes such a defense/acting-out easy. If the alcoholic patient's grandiosity seems to be a response to being treated

as an extension of themselves by either parent, the therapist can say, "One reason you feel so rotten about yourself is that you're always doing it for Mom or Dad, and not for yourself. You resent this and spite them by undermining yourself by drinking."

10. *Alcoholics have a pathological need for omnipotent control.* Alcohol is simultaneously experienced as an object they can totally control and coerce into doing their will and an object that gives them total control of their subjective states. Alcoholics frequently treat people, including the therapist, as extensions of themselves. The AA slogans "Get out of the driver's seat" and "Let go and let God" are cognitive behavioral ways of loosening the need to control. Therapists should interpret the need to control in the patient's relationship with alcohol, other people, and the therapist. For example: "You think that when you drink you can feel any way you wish," "You go into a rage and drink whenever your wife doesn't do as you wish," or, "You thought of drinking because you were upset with me when I didn't respond as you thought I would."

11. *Alcoholics and their children suffer greatly from shame experiences.* Alcoholic patients are ashamed of having been ashamed and often drink to alleviate feelings of shame. Therapists need to help alcoholic patients experience rather than anesthetize their feelings of shame. One way to do this is to identify feelings of shame that are not recognized as such. For example: "You felt so much shame when you realized that you were alcoholic that you kept on drinking so you

wouldn't feel your shame."

12. *Alcoholics who achieve sobriety need to mourn their lost "friend."* Therapists should encourage them to speak about the loss of script, companion, soother, and lifestyle.

All of the above interventions and techniques are specific to active alcoholism and early recovery. Once stable sobriety is achieved, the attenuated withdrawal syndrome over, the pink cloud lived through, and the patient stably sober, therapeutic work continues in pretty much the same way as in any psychodynamic psychotherapy. What remains particular in the treatment of the alcohol abuser is the therapist's awareness of the ongoing danger of regression and return to active alcohol abuse. The focus on narcissistic injury as opposed to a focus on structural conflict also continues, but the balance shifts so that the therapeutic work encompasses both.

CASE EXAMPLE

Kirk, a tall, articulate man in his mid-twenties, entered psychotherapy because he was chronically depressed. Although a careful history was taken, nothing indicative of an alcohol problem was uncovered. Kirk was the third son of a prominent lawyer with whom he had an intense and stormy relationship. He told the therapist that his father, who loomed large in his mind, had 500 suits. Kirk said little about his mother, except that she fought frequently and violently with his father. His brothers, emotionally troubled

and unhappy inpiduals, were seven and twelve years older than he.

Kirk remembered himself as a lonely, self-conscious, overweight, socially awkward child. He had felt alienated and isolated. As he put it, "The cliques were already formed when I got to kindergarten." Feelings of estrangement, uniqueness, and alienation are well-nigh universally reported by alcoholics. Kirk felt the sense of being different with exquisite intensity. He seemed to have experienced little support from his self-involved and volatile parents. He remembered that he and his brothers would cry out, "Battle stations!" when their father returned home from work. When his oldest brother left for prep school, Kirk felt bereaved and abandoned. When the middle brother left, his fear turned to terror as he became the sole witness to his parents' erotic, violent quarrels. The one bright light during Kirk's childhood was his relationship with Maggie, the family's black housekeeper. An island of sanity in an ocean of irrationality, she gave him the feeling that he was important to somebody. At age eight, Kirk was sent to sleepaway camp, and when he returned, Maggie was gone. Not long after Maggie's disappearance, Kirk's parents transferred him out of his public school, where he felt somewhat comfortable, into a high-pressure private day school to which he never adjusted.

After the middle brother's departure, Kirk's parents increasingly involved him in their sexualized fighting. He was forced to play voyeur to

their exhibitionism. He learned to be a spectator rather than a participant in life, although he was not always a spectator: He once tried to stab his father. Although this kind of craziness is not uncommon in alcoholic households, nothing in Kirk's story suggested parental alcoholism. Given the histrionic quality of his home life, it was not surprising that Kirk developed an intense interest in movies.

Kirk had a miserable time during his preteen years. He became fat and remained obese into early adulthood. His compulsive overeating was his first addiction. Kirk went through high school in a fog. He mentioned smoking pot as if his use were nothing more than typical teenage exploration. Unlike his brothers, he did not attend an Ivy League college, making his father furious. Instead, he studied film. In the years since graduation, he had worked in menial jobs. Kirk's love life was restricted to anonymous, impersonal sex. He had few friends, although he was prone to engage in rescue operations of troubled people. He was particularly involved with an elderly couple who went from crisis to crisis; Kirk took them to psychiatric emergency rooms. His rescue efforts provided him with pseudo-intimacy and were unconscious reenactments of his attempts to rescue his mother from his father.

Kirk was a believer in God. When his mother, socially active in a wealthy Jewish congregation, told him she did not believe in God, Kirk was shattered, as he was when she said she was going to buy her infant granddaughter a

diaphragm. Both comments were in character yet deeply hurt Kirk. His disillusionment was a reflection of his intense need for an object worthy of idealization.

Kirk's history and current functioning were indicative of serious psychopathology. His object relations were impoverished, his vocational function marginal, and he was deeply depressed. He frequently thought of suicide. It was not without significance that Kirk's one enduring social activity was attendance at meetings of the family burial society.

Kirk's initial diagnosis was dysthymic disorder. Only later did his correct primary diagnosis, alcoholism, become apparent. He also suffered from a personality disorder that had both schizoid and narcissistic aspects.

During early sessions, Kirk was consumed with his feelings toward his powerful and difficult father. He made little mention of his mother. Ultimately, her alcoholism and Valium addiction became clear. Denial of other peoples' alcoholism is as common as denial of one's own. Kirk got some relief from pouring out his feelings and developed a strong and trusting bond with the therapist, but his depression did not improve. Kirk entered treatment starved for meaningful human contact. He had never had anyone *really* listen to him or treat him as an "end in himself." His current human relationships could hardly have been more empty, yet he yearned for intimacy as much as he

feared it. His hunger for relationship grew stronger than his fear. For all of his disappointments in people, he still wanted to be listened to, to be heard, to be responded to in a non-manipulative manner, and he was willing to take a risk to get that. Kirk desperately needed not to be impinged upon, to be left alone in the presence of an empathic other, to be understood rather than acted upon. Winnicott (1952/1958) has written about the deleterious effects of impingement; Kohut also stresses the dangers to normal development of unempathic overstimulation. Therefore, I was relatively "inactive." Kirk responded by developing an idealizing transference.

Denial is never complete. Alcoholics know at some level that they are destroying themselves. Fear prevents this knowledge from becoming fully conscious. On a conscious level, alcoholic denial manifests in dissimulation and evasiveness; on the preconscious level, in self-deception; on the dynamic unconscious level, in panic-terror of return of the repressed, which would confront the alcoholic with the necessity of giving up that which he believes he cannot live without. Kirk was in denial on all these levels. His denial encompassed not only his own alcoholism but also his mother's. He had started drinking in high school. By his senior year, he was getting high every day. His preference for alcohol was an identification with his mother. Kirk's drinking accelerated during college. By the time he had been out of college six months, he was getting drunk every night. He began to experience blackouts, was increasingly ill in the mornings, and suffered more and more from guilt,

remorse, self-reproach, and depression. However, Kirk did not allow himself to see the connection between his drinking and his increasing misery. The defense of isolation of thought and affect supported his denial. His conscious belief was that alcohol was a harmless pleasure. His nightly escapades were "fun." Thus, Kirk was being honest when he told me drinking was not a problem.

When he entered therapy, his denial was total. Treatment changed this. As he increasingly trusted, admired, and even loved his therapist, he became less guarded. He thus became aware of much that he had not previously known, and even the conscious became more emotionally real. Dialogue vivifies. Although I offered few interpretations, I did ask questions, seeking more specificity and detail. I was now eliciting far more spontaneous responses, and it became increasingly clear that Kirk drank a great deal. The more Kirk disclosed about his life, the more alcoholism became a probable diagnosis. Paradoxically, it was Kirk's denial that allowed him to provide the information I needed to diagnose his alcoholism. The same facts that spelled alcohol abuse to me spelled recreational drinking to him. Kirk's denial also protected him from facing his mother's alcoholism. Retrospective idealization of parents is common. Kirk's idealization of me gave him an alternative idealized object and enabled him to risk losing his mother as an ideal object. This loosened his whole defensive structure.

Alcohol served him as a source of omnipotent power; it too was an ideal object. His relationship with me gave Kirk the freedom to risk losing his most important love object, alcohol. Having replaced his relationship with alcohol before he actually had to relinquish it, he became willing to risk this loss—relationship and rum before relationship instead of rum. Kirk told me that he was alcoholic before he was able to tell himself. Such classic tipoffs as Monday morning absences from work, puffy face, and blackouts convinced me that Kirk was an alcohol abuser. He did not come in and report that he had had a blackout; rather, he would hesitatingly report incidents such as waking up in bed with someone he did not recognize. He also began talking about his mother's frequent drunkenness and dependence on tranquilizers. It was as if he had always known this without knowing it. By now it was apparent that Kirk's alcoholism was progressing and a danger to him. When he reported finding himself suddenly awakening in a subway train in a dangerous neighborhood at three in the morning, with no inkling of how he had got there, the diagnosis was no longer in doubt. The therapeutic relationship was solid, and I decided to make my move.

I told Kirk that he had had an alcoholic blackout and that blackouts are dangerous. I told him a lot about alcoholism. Confrontation overlapped education. Ignorance is the handmaiden of denial. Rational explanation does not replace the work of overcoming emotionally powerful resistance, but it does facilitate it. I confronted Kirk with a detailed account of his alcoholic

symptoms. I told him that he had a serious drinking problem and that his depression was incurable until he stopped drinking. Kirk did not respond. Consciously, he was still in denial; however, his unconscious responded with a dream. Early in treatment, he had reported the following dream: "I was walking along the street. A violent wind began to blow. I felt I would be swept away. Just as I was about to lose my footing and fly off, I reached out in desperation and barely managed to grab hold of a nearby fence. The wind started to blow me away and I was swept off my feet, my body flying upward. I held on by my fingertips as my body was about to be tom loose and carried away. I awoke sweating and trembling."

This dream has many meanings, but I understood it as a visual representation of Kirk's existential position—barely holding on by his fingertips as the winds of psychosis threatened to sweep him away. His hold on reality was tenuous, and his links with the earth could snap at any time. Kirk's basic conflict was between his unconscious wish to fly away, to get and remain "high," and his wish to remain on earth, to stay sane, to not get "high."

Kirk came to the session following my confrontation looking less distressed. He said, "I had a dream in which I was walking with my mother. We were going across town. A bus came along. We ran for it, but the door closed. I realized that we had a chance to catch the bus at the next corner. I thought, if we don't make the bus, we will never get there. I told Mother to

run and started running myself. I put on a burst of speed, running flat-out, and reached the bus just as the doors were closing, throwing myself aboard. The doors closed; we pulled away. I looked around and saw Mother on the street; she had missed the bus. I left her behind."

This was a dream about separation-inpiduation, about finally escaping his mother, her alcoholism, pill addiction, and masochism. Kirk was leaving his mother behind in two senses—as a real and troubled person in his daily life, and as a part of his mental world, an internal object, a pathological introject. Kirk, his sense of self none too firm and his boundaries none too clear, had taken a big step toward disidentification with his mother and her alcoholism. No emotional battle is won once and for all. Naturally, Kirk's unhealthy identification with his mother was not dissolved instantly and permanently, but a Rubicon had been crossed.

I elicited Kirk's associations and reflected the accompanying affects. I was struck by the contrast between Kirk's loss of contact with the ground in the first dream and his landing on his feet on the bus in the second dream. Every dream reported in treatment is also a transference dream; it was not without significance that the bus Kirk boarded was going toward my office. Kirk's dream was "about" leaving his mother for his therapist, leaving alcoholic drinking for sobriety. Although neither Kirk nor I knew it then, Kirk had taken his last drink. He has now been sober for over 10 years.

Kirk's education about the effects of alcoholic drinking on body, mind, and spirit continued and was to do so for a long time. Therapists must tell patients about alcoholism in such a way that they can hear it. Since there is resistance, information must be presented simply, clearly, and repeatedly. Education about their disease provides alcoholics with a cognitive structure that reduces anxiety, lessens guilt, and makes sense of their experiences.

Kirk proved to be a quick learner. He had already learned enough to bring about the psychic reorganization that resulted in his dream, and he learned a good deal more in subsequent months. My next educational step was to tell Kirk about AA. Shortly thereafter, he arrived at a session looking sheepish. He said, "I went to my parents' Passover Seder . It was horrible. Everyone except my father was drunk. I had decided not to drink because of what you said about blackouts. I realized that I hadn't seen my family when I was sober for a long time. My oldest brother drank glass after glass of wine, became louder and louder, and made less and less sense. His girlfriend couldn't even stand up. My middle brother wasn't much better, and he kept saying vile things about my parents. My mother got to the point where she was slurring her words. Then she started to bait my father. He cursed her, and they got into a shoving match. He was about to hit her, until I said, 'Daddy, stop it.' It was awful, awful. It was my childhood all over again. I thought, 'Next year, in Bellevue,' and I walked out. [The Seder ends with the line, 'Next year, in Jerusalem.']

"I realized that my whole family was alcoholic. I didn't much care about any of them except Mother. It really hurts to think of her as a drunk. She didn't give me all that I wanted, but she loved me in her way. I started to cry. Suddenly I thought, 'My therapist is right—I am an alcoholic too.' Funny, but that didn't hurt in the same way as thinking about my mother being alcoholic. In fact, it was sort of a relief. I cried some more, deep sobs this time.

"I don't know where I got the idea, but I decided to go to an AA meeting. Maybe the idea had been in the back of my mind for a while. It was wonderful. I cried all the way through. I felt at home. I felt safe. Sometime in the course of the meeting, I thought, 'A Seder is supposed to be about every man's journey from slavery to freedom. My family's Seder sure wasn't that, but this meeting is about *my* journey from slavery to freedom.' I didn't want to live the way I had been living; I didn't want to drink anymore. As they say in AA, I had hit bottom. I walked out exhausted, a little empty, but feeling clean. I don't think I'm going to drink again, but I'm scared. I don't know how to live without alcohol."

Kirk started to cry. The massive emotional reorganization that he underwent between his blackout on the subway train and his experience at his parents' Seder is characteristic of many recoveries from alcoholism. Powerful emotion is a necessary, if not always sufficient, condition of recovery.

The intensity of Kirk's experience had convinced him that drinking meant death and enabled him, at a deep unconscious level, to choose life rather than death. The slow work of securing the insight and emotional realignment he had gained in his moments of illumination now began. It would take many years of therapy and many hundreds of AA meetings to secure and build on Kirk's realization that he was an alcoholic. It was most certainly not to be a story of linear progression; quite the contrary, it was to be two steps forward and one step back, but Kirk never again experienced suicidal depression, nor was he ever tormented by a desire to drink. The curative factors in Kirk's recovery were the development of an idealizing transference, confrontation, education, and interpretation of his internal world and its externalization in his drinking.

TRAINING

Training and experience as a dynamic psychotherapist is easily built on to develop the skills to treat alcohol abuse dynamically. Therapists with such a background need to expand their knowledge base to include a working knowledge of the theories of Kohut and Winnicott and their clinical application. However, the most important knowledge acquisition required is knowledge of alcoholism. The therapist working with this population must have a thorough acquaintance with the somatic, cognitive, emotional, intrapsychic and interpersonal effects of alcohol abuse. Additionally, the

therapist needs to be comfortable with and thoroughly acquainted with 12-step programs. The easiest way to acquire this knowledge is to read AA literature and attend AA "open" meetings. Once this knowledge base is acquired, the therapist needs experience working with alcohol abusers. Given the prevalence of the problem, this experience is not difficult to acquire. Clinical experience with alcohol abusers should be under the supervision of a clinician thoroughly experienced in its treatment. With the acquisition of the above knowledge base and a modicum of supervised experience, dynamic therapists work well with this population.

I think the key skill is the proper dosing of activity and inactivity. This skill is acquired only through experience. Some alcohol abusers require activity and confrontation on the part of the therapist early in treatment, while others need to be left alone so that transference can unfold and bonding occur. Again, the supervision of an experienced alcohol abuse therapist is the easiest way to learn how to dose interventions.

EMPIRICAL EVIDENCE FOR THE APPROACH

Although I have no rigorous outcome data for this approach to the treatment of alcohol abuse, I do have informal outcome data. Over the past 10 years, I have treated over 100 alcohol abusers. Many have come and gone. Those who are pressed into treatment by spouses are particularly prone to

leave before much has occurred. I would say about one-third of my alcoholic caseload never settled down and were in therapy only briefly. Of the remaining two-thirds, the overwhelming majority became and remained sober. Although slips occurred, approximately 80% of the two-thirds who remained in treatment became sober in the first year of therapy. Their slips were mostly in the first two years. Almost all of these patients remained in treatment for extended periods of time. To the best of my knowledge, they did not drink. The outlook, particularly with the change in social attitudes toward drinking and sobriety, is quite good in alcohol abuse. However, the sample I am reporting on consists of middle- and upper-middle-class functional alcoholics who for the most part voluntarily sought treatment, albeit often not treatment for excessive drinking. This is an atypical group of alcohol abusers. Their ego strength and relative socioeconomic stability gave them clear advantages over the alcoholic population in general.

Although radical improvement in the quality of life is the rule following adjustment to abstinence, grave emotional problems often, though by no means always, remain. The chances of resolving these problems are pretty much the same as for non-alcoholics with similar psychodynamic difficulties. However, alcoholics have both an advantage and a disadvantage. The disadvantage lies in the damage they have done to themselves and in the energy they must devote to preventing relapse. Their vulnerability to acting out to avoid conflict is also a liability in recovery. However, there are also

advantages in being a recovering alcohol abuser struggling with other emotional difficulties, usually around narcissistic injury and deficit. The advantage is the gain in self-esteem that comes from overcoming an addiction, as well as the support system and socialization into looking within rather than projecting and externalizing that comes from participation in AA and its affiliates.

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