# SOME TREATMENT IMPLICATIONS OF THE EGO AND SELF DISTURBANCES IN ALCOHOLISM

E. J. KHANTZIAN

*Dynamic Approaches to the Understanding and Treatment of Alcoholism*

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# About the Author

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# Some Treatment Implications of the Ego and Self Disturbances in Alcoholism

*E. J. Khantzian*

Effective treatment of alcoholism must address the core problems of the alcoholic, namely, the enormous difficulties that such people have had in controlling and regulating their behavior, feelings, and selfesteem. Although psychoanalysis is rarely the treatment of choice for alcoholics, it does offer a special understanding of many of the alcoholic's problems and a rationale for the treatment choices and decisions that must be made to help the alcoholic.

Although in its early application to alcoholism[1] psychoanalysis stressed the instinctual and regressive-pleasurable aspects of alcohol use (Freud, 1905; Abraham, 1908; Rado, 1933; Knight, 1937a; Simmel, 1948), many investigators also appreciated other contributing factors such as mood disturbance, particularly depression, diminished self-esteem, faulty ego ideal formation, and other forms of narcissistic disturbance. Blum (1966), Blum and Blum (1967), Rosenfeld (1965), and Yorke (1970) have published excellent reviews and critiques of these trends in the literature. In this chapter I shall elaborate on more

recent psychoanalytic explanations which have attempted to identify more precisely impairments and disturbances in the ego and self, especially involving problems in self-care, affect management, and self-other relationships and related problems in coping. I shall then review through case examples some important implications for treatment of these ego and self disturbances in alcoholics.

Some of the distinctions made in this presentation between "ego" and "self" are arbitrary and artificial. Although structure and function are stressed in relation to the ego, and subjective attitudes and states in relation to the self, clearly the ego has subjective elements associated with it, and the self has structural and functional aspects. The distinctions are made for heuristic purposes and to delineate more precisely the nature and qualities of the alcoholic's psychological disturbances.

## Ego Functions and the Alcoholic

As already indicated, early formulations of alcoholism were heavily influenced by an instinct psychology that stressed the oral dependency and fixation of the alcoholic. More recent attempts to

explain alcoholism from a psychoanalytic point of view have understandably focused on the ego to delineate better the nature of the structural impairments that cause alcohol to become such a compelling and devastating influence in an individual's life. The nature of the ego disturbances and impairments in the alcoholic are varied and manifold. I shall selectively focus on and explore some of those that seem to me most germane in understanding a person's problems with alcohol.

In the broadest terms, it seems to me that the alcoholic has been most vulnerable and impaired in two areas of ego functioning. One area involves functions of self-care; whether sober or drunk, the alcoholic demonstrates a repeated tendency to revert to or persist in drinking behavior despite all the apparent indications that such behavior is self-damaging and dangerous. The second area of obvious difficulty has been in the alcoholic's inability to regulate his/her feelings. When sober, he/she often denies or is unable to identify or verbalize feelings. At other times he/she experiences nameless fears and suffers with depression that might be vaguely perceived or experienced as overwhelming and unbearable, even leading to suicide.

## THE EGO AND SELF-CARE

The defense mechanism of denial is frequently invoked to explain why or how alcoholics persist in their self-defeating behavior. In such instances the presence of conscious and unconscious destructive impulses. intentions, and behavior is assumed; presumably there is awareness of real or potential danger, but the individual resorts to an active process or defense against such awareness. Although there is probably a reasonable basis for these assumptions, such explanations are excessively influenced by early instinct theory that stressed pleasure seeking and life-death instincts to the exclusion of other considerations. In contradistinction to such a formulation, I am of the opinion that the self-damaging aspects of alcoholism can be better accounted for by considering a deficiency or impairment in development of an ego function we have designated as "self-care."[2]

The self-destructiveness apparent in alcoholism is not willed or unconsciously motivated by suicidal wishes (i.e., the model of the nemoses) as often as it is the result of impairments and deficiencies in ego functions whereby an individual fails to be aware, cautious, worried, or frightened enough to avoid or desist in behavior that has

damaging consequences. This function originates in the early child-mother relationship when the caring and protective functions of the mother are gradually internalized so that the individual can eventually take care of and adequately protect himself/herself from harm and dangerous situations (Khantzian et al., 1974; Khantzian, 1978). Extremes of parental deprivation or indulgence may have devastating subsequent effects, and it is not surprising that both patterns are frequently identified in the background of alcoholics (Knight, 1937a; Simmel, 1948; Blum, 1966).

Self-care is a generic or global function and is related to ego functions such as signal anxiety, reality testing, judgment, and synthesis. When self-care is impaired, certain other ego mechanisms of defense are prominent or exaggerated. In fact I suspect such mechanisms might be related to and perhaps even secondary to impairments in self-care. That is, in working with individuals who have self care problems I have been impressed by how they are vaguely aware of their susceptibility to mishaps and danger and they sense in themselves the lack of a self-protective or self-caring ability and thus need and depend on others to protect them and to help in making judgments about dangerous situations. The ill-defined fears of

vulnerability and feelings of helplessness associated with such states compel those who are so affected to counteract these feelings and to externalize their problem by resorting to such mechanisms as justification, projection, and phobic and counterphobic avoidance. In the absence of self-care, such defenses are prominent in alcoholics.

I believe that self-care is deficient, impaired, or absent in many if not most alcoholics and that this accounts for much of the disastrous and destructive behavior in their lives, in addition to the malignant involvement with alcohol. In studying over fifty alcoholics, I have observed the problem of self-care in their histories of poor attendance to preventable medical and dental problems, patterns of delinquent, accidental, and violent behavior, and other forms of impulsivity that predate their alcoholism. It is most obvious in their apparent disregard for the consequences of drinking; there is little evidence of fear, anxiety, or realistic evaluation of the deterioration and danger when they revert to or persist in drinking. Although much of this is secondary to the regression and deterioration in judgment as a function of continued drinking, I have been impressed by the presence and persistence of these tendencies in such individuals both prior to their becoming alcoholic and subsequent to detoxification and

stabilization (Khantzian, 1978, 1979b).

## THE EGO AND REGULATION OF FEELINGS

Whereas self-care serves to warn and protect against external dangers and the consequences of careless behavior, the ego functions involved in regulation of feelings serve as signals and guides in managing and protecting against instability and chaos in our internal emotional life. Many of the same processes which establish self-care functions and originate from the nurturing and protective role of the mother in infancy are involved in the development of ego functions that serve to regulate feelings. It is not surprising, then, that alcoholics also suffer from a range of ego impairments that affect their capacity to regulate their feeling life. These impairments take such forms as an inability to identify and verbalize feelings, an incapacity to tolerate painful feelings such as anxiety and depression, an inability to modulate feelings, problems in activation and initiative, and a tendency to exhibit extreme manifestations of feelings including hypomania, phobic-anxious states, panic attacks, and labile emotional outbursts.

As has been suggested for other mental processes and functions, affects develop along certain lines and are subject to fixation, distortions, and regression. Krystal and Raskin (1970) have helpfully traced and formulated how the affects of anxiety and depression develop out of a common undifferentiated matrix. At the outset feelings are undifferentiated, somatized, and not verbalized. Normally, the tendency is for feelings to become differentiated, desomatized, and verbalized. If this process proceeds optimally, it contributes significantly to the development of an effective stimulus barrier. As used here, "stimulus barrier" refers to aspects of ego function that maintain minimal levels of unpleasant feelings through appropriate action and mechanisms of defense when they reach high or intolerable levels (Krystal & Raskin, 1970; Khantzian, 1978). In such instances, feelings act as a guide or signal to mobilize ego mechanisms of defense in response to internal emotions and external stimuli. Either as a result of developmental arrest or because of regression caused by traumatic events later in life, alcoholics fail to differentiate successfully, with the consequence that they are unable to use feelings as signals or guides because they are unable to identify affects or their feelings are unbearable or overwhelming. Because of defects in the

stimulus barrier, alcoholics use denial and/or the effects of alcohol to ward off overwhelming affects (e.g., undifferentiated anxiety-depression). That is, in lieu of an affective stimulus barrier "drugs or alcohol are used to avoid impending psychic trauma in circumstances which would not be potentially traumatic to other people" (Krystal & Raskin, 1970, p. 31).

Borderline and narcissistic pathology has been implicated in alcoholism (Kernberg. 1975. p. 117; Kohut, 1971. p. 46; Klein, 1975), but there has been little systematic attempt to understand the relationship between the structural impairments of such pathology and alcoholism. Kernberg has emphasized ego weakness in borderline conditions and has singled out lack of anxiety tolerance and impulse control, primitive defensive operations including rigid walling off of good and bad introjects. and splitting and denial in the service of preventing anxiety related to aggression (pp. 25-45). Kernberg fails to make it clear whether he believes that such borderline symptomatology is at the root of alcohol problems or that borderline conditions and alcoholism have similar processes operating that affect both conditions. Presumably, the borderline processes delineated by Kernberg are consistent with those identified by Krystal and Raskin,

who have detailed more precisely how such problems in coping with feelings affect alcoholics.

Taking a somewhat more descriptive approach, Klein has similarly focused on unpleasant dysphoric affect states associated with borderline conditions and alcoholism. He discounts the role of “ego defects” in borderline conditions and instead emphasizes the importance of a descriptive approach for purposes of diagnosis and classification. Klein stresses the ubiquity of labile, anxious, and depressive states associated with so-called borderline pathology. He believes the “border” in such conditions is more with affective disorders than with neurosis, character pathology, or schizophrenia, and that it is on such a basis that certain individuals welcome the effects of alcohol. He has singled out several syndromes which alcohol and antianxiety agents are sought for relief, namely hysteroid (“rejection sensitive”) dysphoria, chronic anxiety- tension states, and phobic neurosis with panic attacks. Despite his disclaimer about ego defects in such conditions, I believe his own description of these problems as an “affective or activation disorder, or a stereotyped affective overresponse” (Klein, 1975, p. 369) speaks for an impairment in the ego's capacity to regulate feelings in such individuals. This is

further supported by his observation that psychoactive drugs are effective with such patients because "they modify states of dysregulation of affect and activation." Along these lines, Quitkin et al. (1972) have impressively demonstrated that a small but significant proportion of alcoholics suffer from a phobic-anxious syndrome and respond to imipramine with marked symptomatic improvement and elimination of their dependence on alcohol.

In brief, then, I believe there is convincing evidence from several convergent lines of inquiry to support the point of view that significant impairments in ego structure predispose to alcoholism. Impairments in self-care leave individuals ill equipped to properly weigh, anticipate, and assess the consequences of risky and self-damaging behavior, but particularly in relation to the consequences of their alcohol involvement. The other area of ego impairment in alcoholics involves problems in recognizing, regulating, and harnessing feeling states to the point that conditions of immobilization or being overwhelmed with affects result, and alcohol is sought to overcome or relieve such dilemmas.

## The Self and the Alcoholic

Alcoholics suffer not only because of impairments in their ego. They also suffer because of impairments and injury in their sense of self. As in ego disturbances, developmental problems loom large in the self disturbances of alcoholics. Both the development of the ego and the sense of self are results of internalization processes. Optimally, the developing child acquires qualities and functions from the caring parents such that the individual can eventually take care of himself. When successful, the process of internalization establishes within the person a coherent sense of the self, an appreciation of the separate existence of others, and adequate ego functions that serve purposes of defense and adaptation (Khantzian, 1978).

In the previous sections we focused on how alcohol problems were related to impairments in ego function which resulted in a deficiency and/or inability to appreciate consequences of dangerous behavior and to regulate emotion. In this section I will emphasize and explore how alcohol problems are also the result of impairments in the sense of self whereby the individual is unable or ill equipped to value, comfort, soothe, care for, and express himself/herself. Although I have designated the impairments around self-care and affect regulation as ego disturbances, such problems are not entirely distinguishable from

self disturbances. As indicated at the outset of this chapter, some of these distinctions are arbitrary. It is likely that the nature of the self disturbances I will delineate in this section significantly impact upon and interact with ego disturbances involving self-care and (affect) regulation.

## DEPENDENCY AND THE SELF

Alcoholics are desperately dependent people. Formulations about the nature of this dependency have, however, been overly simplistic and reductionistic, placing undue emphasis on the symbolic, oral, regressive aspects of the alcoholic's dependency on the substance itself. Similarly, the personal relationships of the alcoholic are characterized as infantile and clinging (Khantzian, 1979b). The dependency of alcoholics is not primarily the result of oral fixations and oral cravings. The dependency has more to do with deficits and defects in psychological structure and sense of self whereby the alcoholic depends on the effects of alcohol and attaches himself to others to compensate for deficiencies in self-care, affect regulation, self-esteem, and subjective sense of well-being.

Balint (1968) has characterized the alcoholic's dependency as a "basic fault." He emphasizes that it does not have the form of an instinct or of conflict, but is "something wrong in the mind, a kind of deficiency which must be put right." According to Balint, the alcoholic seeks the effects of alcohol to establish a feeling of "harmony—a feeling that everything is now well between them and their environment—and ... the yearning for this feeling of harmony is the most important cause of alcoholism or, for that matter, any form of addiction" (p. 56). Along these same lines, Kohut (1971) has observed that dependency of such people on substances (Kohut does not distinguish between alcohol and other substances) says less about the person's attachment to substances and/or people as loved or loving objects than about the search for "a replacement for a defect in psychological structure" (p. 46).

The "fault" or "defect" that alcoholics experience in their psychological-self structure is the result of developmental failures in ego ideal formation. The developing child and adolescent insufficiently experience admired and admiring feelings in response to parents and other adult figures. Because of this deficiency in the relationship with parents and others, such individuals fail to internalize and identify

with the encouraging, valued, and idealized qualities of important adults.

Although alcoholics indeed suffer as a result of conscience or superego and seek to drown their guilt and self-condemnation in alcohol, I am impressed that they suffer more from the lack of an adequate ego ideal that would otherwise help them to evaluate themselves as worthwhile and good enough in a whole range of human involvements and activities. Because of faulty ego ideal formation, self-esteem suffers and there is an inability or failure to judge one's relationships, work, or play as sufficient or satisfactory. As a result, individuals so afflicted constantly seek external sources of reassurance, recognition, solace, and approval. Such individuals feel especially wanting from within for an approved self by an approving ego ideal, and it is in this respect that they are so desperately dependent. They seek out alcohol, people, and activities not primarily for gratification of oral, infantile drives and wishes, but more in an attempt to feel better or good about themselves, as they are almost totally unable to achieve this feeling for themselves from within.

Corollary to the disturbance in ego ideal formation are

disturbances related to the capacity to comfort, soothe, and care for oneself. Alcoholics seem to adopt modes of polar extremes with regard to such needs and functions. Alcoholics' search for "external supplies," their dependency on alcohol and leaning on others, are the result of a failure to internalize adequately and to develop capacities for nurturance within the self, which causes them to turn primarily outside themselves for comfort, soothing and caring, or defensively to deny such needs or wants.

## PATHOLOGICAL SELF-FORMATIONS

One of the main consequences of the ego and self disturbances in alcoholics is that such individuals have developed and display troublesome and self-defeating compensatory defenses and pathological selfstructures in response to underlying conflicts around need satisfaction and dependency. In some instances the defenses that are employed serve to compensate for and counteract the sense of incompleteness such people feel as a result of deficits in affect defense and self-esteem. In other instances the more rigid and primitive defenses that are employed seem to be the result of pathological internalizations, identifications, and self-structures. The alcoholic

seeks the releasing effect of alcohol to overcome rigid and overdrawn defenses and to facilitate and regulate the experiencing and expression of affectionate or aggressive feelings in the absence of ego and self structure that helps to modulate such affects and drives (Khantzian, 1979a).

Some of the recent elaborations on self-pathology are probably pertinent with regard to the facilitating and regulating influences of alcohol and help to explain why alcoholics need to depend on such effects. Kernberg (1975) has emphasized the importance of pathological self structures in borderline conditions and has also implicated them in alcoholism. He believes that rigid and primitive defenses of splitting, denial, and projection serve to cause the repression, splitting off, and dissociation of parts of the self, and that the effect of alcohol acts to "refuel" the grandiose self and to activate the "all good" self and object images and to deny the "all bad" internalized objects (p. 222). Despite the emphasis on a deficit psychology, Kohut places equal if not greater emphasis on compensatory and defensive reactions such as massive repression, self-disavowal, and denial of needs. According to Kohut, substance users resort to the effects of substances to lift these defenses in order

to feel the soothing and resurgence of self-esteem they are otherwise unable to experience (Kohut 1977a). Although Kohut does not specify any particular drugs or substance, in my experience it is precisely this effect that the alcoholic seeks to achieve with the use of alcohol.

On a similar basis, Krystal and Raskin (1970) and Krystal (1977) stress the special and exaggerated defenses of denial and splitting that are adopted by individuals dependent on alcohol. These defenses serve to "wall off" and suppress aggressive and loving feelings in relation to the self and others. Krystal emphasizes the great difficulty alcoholics have with ambivalence, and how they prefer to use the short-acting effect of alcohol to experience and give vent to such feelings briefly, and therefore "safely. "

Finally, on a somewhat different basis, Silber (1970, 1974) has focused on the developmental impairments of alcoholics that have been the result of pathological and destructive identifications with psychotic and/or very disturbed parents. The self-damaging and destructive aspects of alcohol involvement parallel and represent identifications with self- neglecting, self-destructive aspects of the parents.

## Treatment Implications

As I have indicated, alcoholics suffer tremendously in their attempts to regulate their behavior, feelings, and relationships with other people. Effective treatment of these problems must be based on a more precise identification of the disturbances in the ego and self structures of alcoholics, and our psychotherapeutic and psychopharmacological interventions should be based on such an appreciation. In this final section, using case material, I will explore some treatment implications of the alcoholic's ego and self disturbances.

### IMPLICATIONS FOR INITIAL CARE

At the outset, the most urgent and often life-threatening aspect of alcoholism must be faced, namely, the impulsive unbridled use of alcohol. Alcoholics Anonymous has been most effective in helping alcoholics gain control over their drinking; "They have become experts in sobriety" (Mack—personal communication). It is little wonder that A. A.'s success rests upon an emphasis on abstinence as the single most important goal to be achieved by the alcoholic. A. A. has often worked because it skillfully manages and compensates for the impairments in

self-care. A. A. also works because it contains and partly satisfies some of the other determinants of alcoholism, namely, problems in regulating emotions and maintaining self-esteem and related dependency problems.

Unfortunately, A.A. is unacceptable for many if not a majority of alcoholics. For many alcoholics, psychiatric and psychological approaches become a logical if not necessary alternative. If such becomes the case, it remains critical that the clinician appreciate, as much as A.A. has, the urgency and dangers of the uncontrolled drinking, as the equally important determinants and causes of the alcoholism are explored and understood. Clearly, until control over the drinking is established, exploration of predisposing causes is of little value.

I have evolved an approach that has proved to be surprisingly useful and effective in dealing with uncontrolled drinking when contact is first made with the alcoholic. As indicated, it is in regard to the uncontrolled drinking that impairments in self-care are most alarmingly and dangerously apparent, and this must become the first focus of any treatment intervention. Rather than stress abstinence or

sobriety, I immediately attempt to ascertain the amount and pattern of drinking and ask the patient respectfully and empathically to share with me his/her own reasons for drinking, especially what the drinking does for him/her. I also ask patients as tactfully as I can to reflect on how much danger and harm they have caused themselves as a result of their drinking. Such an approach helps a patient to ease into a treatment relationship where his or her enormous shame about and desperate dependence on alcohol are not immediately challenged or threatened, but which at the same time begins to focus early on some of the important determinants of the uncontrolled drinking.

Once satisfied that the drinking is out of control, I emphatically point this out with undisguised concern and stress that it is the single most immediate problem to be faced. Unrecognized impairments and evident rationalizations are identified as well as the unacknowledged physical and behavioral consequences of the drinking. I openly discuss how difficult it will be to stop drinking, but share with the patient my conviction about the urgency for control and an intention to keep this the main focus for both of us until it is achieved. Keeping the focus on control allows a strategy to develop that avoids premature insistence on permanent abstinence, or an equally untenable permissive

acceptance of uncontrolled drinking. Alternative models and methods of control are described explicitly, such as gradual curtailment or abrupt cessation with short-term drug substitution if physiological dependence is evident. If the latter is the case, or if deterioration is evident and/or there is need for external support and control, hospitalization is recommended. In some cases I insist upon it if it seems necessary. Surprisingly, this is rarely the case, and often there is a margin and opportunity in such an approach for the therapist to share with the patient information, experiences, and knowledge about how others have gained control over their drinking. In most instances then, the emphasis in this approach is on establishing control and giving the patient a chance to make a choice.

In one case the discovery that a choice about one's drinking can be made in collaboration with the therapist evolved over several months.

**CASE I**

This patient was a fifty-one-year-old tradesman who had worked successfully at his job and consumed large amounts of distilled alcohol daily dating back to his late teenage years. He was considered a leader among his

peers and until four years prior to seeking treatment had functioned effectively as the elected shop steward for his union. His drinking usually began at mid-day, and he continued drinking from the end of the workday at 4:00 p.m. until supper. He drank with his co-workers in a local pub which was also a gathering place for people of his own nationality. He insisted and his wife confirmed that he never was drunk or reacted adversely to alcohol until four years before, when his shoe shop went out of business and he was unable to find employment because most of the other shoe shops in the area were also going out of business.

At the time of evaluation he indicated that over the past year and a half his drinking had been totally out of control, stating, “I wouldn't dare count how much I was drinking a day this past year or so—all I know is I needed it to start the day and finish the day.” He stated that during this period he was experiencing “shakes” every morning. I immediately shared with him my sense that his drinking was out of control and agreed with him that it probably dated back to the loss of his job. I indicated that it would be extremely important to gain control, but I avoided explaining then what this would entail. During the initial sessions he alternated between being garrulous, expansive, and bantering and being irritable and defensive, especially about his drinking. According to the patient.— again confirmed by his wife, who was reliable—he made significant but only moderately successful efforts to curtail his drinking over the first two months of weekly

contacts with me. After his ninth session I felt he was more at ease with me as he was sharing both pleasant and troubling reminiscences from his childhood years, as well as his challenges and experiences as a union steward. In this context of a more relaxed treatment relationship with me I expressed my concern that he was not sufficiently controlling his drinking. I told him that I was not sure he could take one or two drinks and then leave it alone. I told him that curtailment could be one form of control but I suspected it was not working for him. I shared with him my own discovery that I could not control my use of cigarettes and that smoking one cigarette inevitably led to my resuming smoking a pack a day and how after much experimentation I had learned that abstinence from cigarettes (and the occasional substitution of a cigar) worked best for me. I reviewed with him my knowledge of A. A. and my experience with other patients for whom abstinence from alcohol seemed to work best as a form of control, but I said it remained to be seen what would work for him.

In an interview one month later he reported being discouraged in his efforts to modify his drinking and appeared dejected and depressed. In this context I told him that he seemed to be least able to control his drinking when he felt "lousy. " Shortly after this session he stopped drinking. In an interview another month later in which he was evidently feeling much better, he indicated he was not craving alcohol at all. After a thoughtful review on his part of how he planned to approach finding a new job, I puzzled out loud with

him how he had managed to gain control over his drinking. He told me that he had thought about my comment two months previously about whether he could have one or two drinks and then stop. He said he decided to try it out and he discovered he couldn't. Again he stressed that once he had stopped drinking, he didn't crave alcohol at all. Reflecting out loud, he reminded me again how much alcohol he needed to get a "little high," an amount that would make others "go staggering." Not without significance and characteristic of this man. he made a playful reference to my example of substituting cigars for cigarettes and revealed some successful substitutions of his own—he said he was "drinking lots of Moxie [a bittersweet, pungent carbonated beverage] and milk." He also added that he was eating well. Over two years of follow-up this man has remained totally sober and abstinent, and he has resumed working in a supervisory capacity. He has also considerably improved his relationship with his wife.

Taking an approach such as the one I have presented here, I have now had the experience of seeing several patients significantly modify and ultimately gain control over their drinking behavior. However, in the majority of the cases I have treated, the patients have chosen abstinence as the most reliable means of control. For some, this occurs at the outset; for others, after some tentative experimentation and

attempts at continued drinking, such as those I described in Case 1. What has been most impressive has been the salutary discovery by the patient and myself that some choice can be exercised in achieving the goal of control over drinking behavior. In taking such an approach, struggles tend to be avoided, the patient feels a gradual sense of mastery over his/her own problems, and the joint effort to solve a problem fosters a healthy alliance rather than an adversary role between patient and therapist (Khantzian, 1980).

As the urgency and danger of the destructive drinking behavior recede and the patient begins to develop an alliance with the therapist, examination and treatment of the predisposing disturbances can and should be considered. Although psychotherapeutic and psychopharmacological treatment of alcoholics has often been dismissed as ineffective and possibly even dangerous, I believe growing clinical understanding and experience with alcoholics suggest that alcoholics are eminently suitable for such treatment. In the preliminary phases of treatment it is most important that decisions about treatment alternatives (psychotherapy and/or drug therapy) be based on identifying more precisely the particular qualities and extent of the ego and self disturbances and other target symptoms that are

ascertained. Although I have stressed certain ego and self disturbances in this chapter, it should be apparent that a whole range of psychiatric problems may contribute to or be a part of an alcohol problem, and specific treatment modalities should be tailored to the particular psychopathology or symptoms that may be identified. Of course allowances should also be made in the early phases of treatment, especially with psychotherapy, for cognitive impairments due to toxic aftereffects of prolonged drinking (usually reversible) that make integration of information and interpretations more difficult for the patient (Krystal, 1962; Moore. 1962; Rosett, unpublished).

## IMPLICATIONS FOR PSYCHOTHERAPY

Critics of psychotherapy for alcoholism have focused on the impulsive, dependent, demanding characteristics and lack of introspection of alcoholics which make them ill suited for therapy, and others have stressed the destructive and unworkable regressive transferences that develop in psychotherapeutic relationships with alcoholics (Hill & Blane, 1967; Canter, 1969; Pattison, 1972). These accounts give an unnecessarily pessimistic view of the alcoholic and do not consider how such reactions surface as a result of passivity on

the part of the therapist and an outmoded model of therapy that emphasizes uncovering techniques alone. These approaches reflect once again the influences of an early instinct psychology that is based on the assumption that recovery and cure take place by making the unconscious conscious, reconstructing the past, and uncovering feelings. More recent approaches have better taken into account the alcoholic's impairments and disturbances in identifying and tolerating painful feelings, and have a clearer appreciation of the nature of alcoholics' dependency needs and major problems around self-esteem. In contrast to early psychotherapeutic models, more recent approaches have appreciated the importance of structure, continuity, activity, and empathy in engaging and retaining alcoholics in treatment (Chafetz et al., 1962; Silber, 1970, 1974; Krystal & Raskin, 1970; Khantzian, 1980).

For some, the initial work of therapy becomes that of gradually discovering and identifying states of anxiety and/or depression that have been relieved by drinking. For others, a gradual identification of the forms their dependency has taken, such as a denial of their needs or counterdependent attitudes, becomes important. In early phases of treatment there is a need for the therapist to be active, and to share

openly his understanding of the alcoholic's problems, particularly how his use of alcohol has interacted with the particular ego and self disturbances that have been identified.

Some of the alcoholic's disturbances in identifying and experiencing his feelings and rigidly defending against affects have particular psychotherapeutic implications. Krystal has suggested that a "pretherapy" phase of psychotherapy (personal communication) may be necessary with such patients to teach them about their feelings by helping them to identify and label them, particularly feelings of anxiety, fear, and depression. Krystal (1977) has also focused on alcoholics' use of splitting and other rigid defenses to wall off their ambivalent feelings. He has emphasized that effective therapy with such individuals hinges on helping them to master their fear of closeness with the therapist (related to reactivated childhood longings and feelings of aggression), to learn to grieve effectively, to take responsibility for their destructive feelings, and, perhaps most important, to overcome the barriers (i.e., rigid defenses) that prevent effective comforting of themselves. In my own work with alcoholics I have been impressed with how the affect disturbances significantly contribute to the self-care impairments of alcoholics and how

necessary and useful it is to help such patients realize how feelings can be used as a guide for one's behavior and actions.

## CASE 2

Psychotherapeutic interaction with a fifty-one-year-old man who had a combined alcohol-drug problem nicely demonstrated elements of such affect disturbance, and how such disturbances may be psychotherapeutically managed and brought into the patient's awareness. This patient also gave dramatic evidence of impairments in self-care and some of the more extreme and primitive defenses that are adopted in the absence of self-care, namely denial, counterphobia, and massive repression.

This man had achieved a significant amount of success in his life and his work despite an early childhood in which he suffered much traumatic neglect as a result of his mother's alcoholism and father's chronic depression and absorption with his wife's alcoholism.

Subsequent to the patient's eleven-year-old son's contracting a severe illness, the patient had recently become more withdrawn, depending increasingly on alcohol and drugs himself, and he had been mandated for treatment as a result of indiscriminate behavior at work as a result of his drug-alcohol use. The two most outstanding features of this man. not unrelated to each other, were (a) the direction his interests took starting in

early adolescence, and (b) his almost total inability to talk about his feelings. Starting at around age ten he precociously and actively became sexually involved with the opposite sex. Early in his teenage years he turned to and became involved with hobbies that he has continued up until the present which have definite danger and/or violence associated with them. Except for his quick wit (sometimes biting) he displays very little emotion, usually appearing indifferent or apathetic in his facial expressions. Attempts to elicit or draw out feelings are met with either frank denial or. at best, tentative acknowledgment that he might be feeling something.

During one group therapy session the patient reviewed some of his recent indiscretions in his work situation that resulted in possibly jeopardizing his job. He went into great detail about the events, which could have resulted in harm to himself and others. He appeared to be strikingly devoid of feelings as he elaborated on his behavior. A group member immediately exclaimed, “Didn't you realize how vulnerable you were leaving yourself?” The patient insisted that he never gave the situation a thought and denied being fearful about dangerous consequences for himself or others. Other members of the group persisted in inferring an unconscious self-destructive motive. I chose to comment on the patient’s insistence that he had neither thought about the danger nor experienced any fear in relation to his behavior. I shared with him and the group my sense of his reluctance and inability to “fuss” over himself or to admit to any worry or fear. I suggested

that this difficulty was perhaps a reflection of insufficient “fussing” over him earlier in his life when his parents were too tied up with themselves and their own problems.

As the group meeting continued, a curious and revealing exchange developed between myself and the patient in which he gave further evidence of his deficiencies in signal affects (i.e., feelings in the service of mobilizing mechanisms of defense and/or restraint over impulses). This exchange also demonstrated the necessity for the therapist to be ready to use his/her own feelings and reactions with such patients as an object lesson in helping them to use feelings to better serve and care for themselves. The patient commented on and inquired about my seemingly gruff response in a recent individual psychotherapy hour when he had corrected me on some technicality. I hesitantly acknowledged that he might have been correct in his impression, and I indicated that I knew this was a trait of mine when I am worried and I believed it reflected my worrying about his problem. I subsequently offered that I was worrying for him when he was not sufficiently worrying about himself. He next disclosed to the group and myself how at times in our individual sessions he often deliberately “eyeballed” me and stared me down and that he was surprised that I repeatedly looked away, and again he asked why I reacted in that way. I was surprised again and somewhat caught off guard (perhaps I should not have been) that a man who was so unaware of his own reactions could be so fined tuned to my reactions.

Pausing for a moment to get over my surprise, I answered him by acknowledging once again that he was most likely correct in his observation and that my reaction was probably a function of some self-consciousness as a result of his staring at me. I told him that I thought his puzzlement and surprise were some indication that he was unable to admit to any such part of himself, but that if he could continue to watch for other people's self-consciousness, especially in group therapy, he might better develop this in himself to his own benefit. I emphasized how my self-consciousness and others' can actually act as a guide and that being insufficiently self-conscious caused him to get into trouble. Toward the end of the group meeting he began mildly to taunt one of the patients on the number of cups of coffee he drank during the group meeting. Piecing this together with his uncharacteristic confrontations about my behavior, I interpreted his provocativeness to be a function of having overexposed himself and his behavioral difficulties early in the meeting. I pointed out that it was to his credit that he was courageous enough to share his problems with the group, but that I was also equally concerned that he might have overexposed himself; I told him that someone else might not have been as open and as explicit, leading to so much exposure, but that in his case he was not sufficiently self- conscious to protect himself from overexposure.

## DURATION AND GOALS OF PSYCHOTHERAPY

Decisions about the duration and goals of psychotherapy with alcoholics should remain flexible and should be based on a consideration of the patient's wishes and a judgment by the therapist, weighing the indications and necessity for continued treatment against the hazards and risks. Many patients feel great relief and appreciation when they are able to control their drinking and know that someone who understands and accepts their problems is available. Such patients often decide for themselves that this is enough of a goal. If the patient is out of immediate danger, I often agree to stop, albeit my decision at times might be based as much on my clinical judgments about the patient as simply on what the patient wants to do, or even based more on my judgment. The following case illustrates how clinical judgments to stop treatment and what the patient wants are not mutually exclusive.

**CASE 3**

This patient, a forty-two-year-old, very intense and conscientious man, gave me good reasons pragmatically and clinically to take him seriously when he proposed that it was best to settle for the initial gains we had made and to discontinue his individual psychotherapy with me after a brief intervention

that lasted about three months.

His initial meeting with me was prompted by a crisis that had been precipitated in his second marriage as a result of continued, recurrent alcoholic binges. He had recently remarried, entered into a new small business venture and relocated on the East Coast—all in an attempt to build a new life. He was originally from an extremely wealthy Midwestern family. After attending an exclusive college and doing a tour of duty as a jet pilot in the military, he joined his family's large corporate business. From his late college years and through the military he was a heavy social drinker. Upon joining the family business and over the subsequent ten years, his drinking became increasingly heavy, which ultimately led to a decline and deterioration in his social standing, his marriage, and his job.

By the time he came for his first interview he had rejoined Alcoholics Anonymous (he belonged once before) and was having some success in abstaining from alcohol. In the first visit with me he reviewed how success, ambition, and achievement had always been tremendously important. He went back and forth from examining my professional certificates on the wall to discussing his father's great business success (despite being an extremely heavy drinker himself) to his own lack of achievement and his alcoholic decline. He then went on to express in a most poignant way how there had been a lifelong strained relationship of aloofness and distance between his father and himself and how he had always longed for a better relationship. In

this and subsequent interviews it was quickly evident that his longings for a closer relationship with his father coexisted with feelings of just as much bitterness and hatred. Strikingly and in contrast, during the same initial interview he reviewed with me some of his work in Alcoholics Anonymous and how it was helping him. He said the people there were “real—and seeking alternatives to destructiveness.” He stressed how they were able to get into the issues of alcohol, and that the feelings of “warmness, camaraderie, and family” were very important to him. At the end of the first hour we agreed that there was a “cauldron of issues bubbling inside” with which he struggled, but that for a while we would focus on his marital problems and he would continue to work on his sobriety through Alcoholics Anonymous. He agreed to join a couples group in which a common denominator was that the life of one of the spouses in each couple had been affected by drug or alcohol dependence. He also agreed to see me for individual psychotherapy.

Over the next several months his ambivalence toward me became evident. On the one hand he admired my achievements and how I seemed to be able to understand him. However, he also regularly made it clear that psychiatrists understood little about alcoholism or alcoholics. In his first interview with me he said, “My [previous] psychiatrist never even asked about the alcohol—he gave me medicine saying it might help to deal with some of the underlying feelings so that I wouldn't have to use alcohol—and that when we got to the root of the problem, then maybe I wouldn’t need to

drink. I liked him, but I don't think he understood anything about alcohol." In subsequent visits he either would totally accept my clarifications and interpretations or just as arbitrarily would argue a point based on "strict principles" and a conviction that A.A. could serve him better, adding, furthermore, that it didn't cost anything.

After two months of individual and couples group meetings he became more clear and explicit about the reasons for his reluctance to continue in individual and ultimately group psychotherapy. He worried that his dependency on me and my ideas might be too consuming emotionally and financially (despite relatively unlimited financial backing from his family). References to competitive situations and stories where someone or an animal was killed or hurt only thinly masked concerns about his relationship with me. In one group meeting someone asked him about his tendency to avoid people with whom he identified. He responded that he tended to become anxious and then resort to "impulsive and compulsive behavior." About six weeks into the treatment (in association with a drinking setback) he sent a letter to me stating he would not see me anymore, indicating he did "not want to go back into the 'cauldron of issues' anymore." With one phone call from me he agreed to return, but he persisted in his ambivalence about continuing in individual psychotherapy. I told him I respected his wishes, and we met a

few more times. In one of his final regularly scheduled meetings he once again spoke with concern about his tendency to adopt and depend upon others wholesale but said that he wanted and intended to continue group because he could “sample” other people’s ideas and thoughts with “a little more protection. ” In this hour he made a reference to “symbiotic relationships” and commented on some stories about the Pharaoh and the “tooth scraper” and a crocodile who had a bird picking his teeth.

Considering that his drinking was under control, that he had by then joined several A. A. groups in which he felt comfortable, and the help obtained from the couples group, I decided that he had gained enough personal support and control over his drinking to stop his individual meetings. He also asked if he might periodically see me if he felt the need (which he has since done). I felt that the limited goals and involvement of obtaining support, clarification, and sobriety for this man were sufficient and outweighed the risks that were possible, given the intensity of his ambivalence toward me.

As the above case demonstrates, the risks of ongoing psychotherapy with certain alcoholics outweight the advantages that might be achieved, and limited goals of clarification and support are preferable. However, in many other cases disabilities and problems surface for which psychoanalytic psychotherapy should be considered, and in fact might be the treatment of choice. Many patients continue to

evidence considerable impairment and vulnerability, and the constant threat of reversion to alcohol and other forms of impulsivity remains apparent. In still other instances, despite considerable stability and improvement the patient and the therapist begin to sense and identify the persistence of subtle indications that things are not right: dissatisfactions in relationships or feelings of loneliness, isolation, and unhappiness emerge; or vague feelings of tension, anxiety, and depression continue; or self-defeating personality characteristics continue to plague a person, and related complaints and conflicts previously masked by the alcohol and associated acting out become more apparent. Qualities and characteristics often emerge in the treatment relationship that are symptomatic of ego and self impairments and become the basis for judgments about continued, long-term treatment.

In some cases more definitive long-term analysis-treatment of the determinants of the ego and self disturbances is not only possible but indicated. In my experience there is no basis to conclude categorically that a person with an alcohol problem lacks the requisite ego strength and capacity for an alliance to do such psychotherapeutic work. In such cases it is important for the therapist to combine

elements of empathy and ego analysis to help patients gain an understanding of their dilemmas, as the following case illustrates.

**CASE 4**

Taking such an approach with a twenty-nine-year-old resident internist was particularly useful. Worried that he might be prone to alcoholism, he described a drinking pattern that involved regular, daily consumption of moderate to heavy amounts of beer interspersed with periodic episodes of extremely heavy drinking at various social get-togethers in which he might become amnesic for part of or all the episode.

The developments over the course of a particular treatment hour demonstrated how empathy with the patient's embarrassment and shame over his need to be appreciated, reassured, and understood led to a better elucidation and understanding of certain ego traits (cynicism and suspiciousness) and the uneven and self-defeating ways in which he satisfied his dependency including his use of alcohol. At the beginning of the hour he mentioned that he had to present a problem case to a senior attending physician at grand rounds. With a certain degree of detachment he observed that it would be interesting to see what the attending physician had to say on the case. He quickly became aware of and commented on his own “cynicism” and then conceded that the attending physician might also feel under

pressure to do a good job. He wondered out loud some more as to the meaning of his cynicism. He speculated that it had to do with feeling "on the outside" and trying to get "in" himself. In an aside he complained of feeling "hung over" from the previous evening, when he had drunk a considerable amount of beer. He then joked about a new symptom of bruxism and lightly reviewed in the same vein how he frequently washed his hands, drank a lot. and "twiddled" his fingers. At this point I observed that he began to be self-conscious and wonder about his own cynicism and then to make light of his symptoms at the point where he indicated his more sympathetic appreciation that both the attending physician and myself might feel pressure to do a good job. He quickly agreed and volunteered that he was quick to disbelieve the intentions of people. He gave the example of people in medicine professing a motive of wanting to help when he suspected the motive of wanting money and prestige. He went on to say that he became defensive when a consultant such as the attending physician "delivers on what I implicitly ask for—or want." He also indicated he felt the same with me when I delivered on what he wanted. Among the forms his "defensiveness" might take he listed cynicism, humor, and a "carping anger." He reflected that he might be self-defeating, for example with the attending physician at grand rounds, and he might become obsequious, and he then questioned whether there might be a parallel pattern with me. I gently confirmed that such alternating patterns

had occurred with me.

After a slight pause he began quietly to review how he thought a lot went into his reactions. He said, “Part of me wants to make repair of the things that are bad; part of me wants to exaggerate and make too much or the most of things. Somewhere in here there is a part of me that emerges that I don't know very well—it reminds me of how I recently told you I didn’t know what my father thought of me. I still wonder how people see me.”

He then began to address himself more directly to me. “Although you don’t see me in action, I think you know me pretty well and have a pretty fair idea of how I interact with people. But I don’t know how you see me—so I wonder what I am.” His mood shifted abruptly and with a hint of embarrassment and some more evident impatience with himself he protested, “This is getting too complicated for this hour of the morning.” I told him that I thought he was talking about something important but that he became uncomfortable when he approached a part of himself that he wanted me to know and understand better; he had become embarrassed as he did so, as was evident when he tried to dismiss his thoughts by commenting on the hour of the morning. He then associated to wanting to have children but returned to his embarrassment reaction and the wishes behind such reactions that I had been “able to pick up.” He said, “You will think, how self-centered of me.” I responded that he not only was embarrassed, but even

more, he was ashamed of his wishes towards me. I suggested that he was experiencing in a small way with me the ways he got stuck in his life with his defensiveness, wherein he went from one extreme or the other, so that he couldn't allow himself anything he wanted or indulged himself too much. He quickly interjected that drinking was his main "self-indulgence" and then chastised himself, saying twice, "God, I wish I didn't drink! " He promptly qualified this, reassuring me and himself he had been doing better. He then just as promptly castigated himself for reassuring himself. I ended the hour by pointing out that he berated and put himself down for reassuring himself. I said that reassuring himself was important and that if he could not allow that kind of indulgence for himself it was understandable how he could continue to resort to more extreme, self-defeating indulgences.

This case demonstrates how certain patients adopt exaggerated postures of indifference and self-sufficiency to defend against their dependent longings and needs. Empathically focusing on the patient's discomfort, shame, and embarrassment reactions allowed the therapist to analyze with the patient how he repeatedly and characteristically denied and avoided his wish for recognition and approbation. Taking such an approach also makes extreme and alternating patterns of self-indulgence and denial more understandable, and thus more controllable—patterns that are

otherwise driven, repetitious, and self-defeating. Such reactions suggest the operation of narcissistic resistances analogous to neurotic transference resistances, and represent opportunities for the patient and therapist to understand together, in the treatment relationship, the nature and origins of core conflicts around need satisfaction and dependency problems.

Many of the defenses and reactive patterns of alcoholics, including those of the patient just reviewed, resemble aspects and features of borderline and narcissistic conditions described by Kohut and Kernberg. Although they differ in their theoretical understanding and clinical application of these problems, they have both implicated such processes in drug-alcohol problems, and certain of their observations and approaches to such patients seem worth considering. In my opinion it is not clear whether borderline and narcissistic conditions share in common with alcoholics processes that are similar though not necessarily the same, or whether borderline and narcissistic pathology is at the root of alcoholism. However, the more recent emphasis on treatment of the deficits and pathology in ego and self structures is a promising and hopeful development for alcoholism treatment. I also believe we are still in a discovery phase of

understanding narcissistic pathology in general, and how such pathology and its treatment applies in cases of alcoholism.

## IMPLICATIONS FOR PSYCHOPHARMACOLOGICAL TREATMENT

The use of psychotropic drugs has a legitimate place among the treatment alternatives for alcohol problems and alcoholism. However, the literature on the efficacy of psychotropic agents in the treatment of alcoholism is for the most part confusing and discouraging. Part of the problem in drawing conclusions from these reports is that few if any of the studies are comparable. First, standard criteria for diagnosis of the alcoholism or the presumed underlying condition which is being treated are lacking. Another problem is related to the fact that depending on the study, different facets of the problem are studied to judge the usefulness of various psychopharmacological agents. In some reports relief of target symptoms such as sleeplessness, anorexia, and anergia is studied, in others whether abstinence is achieved, and in others overall improvement of depression. Reviews by Mottin (1973), Viamontes (1972), and Greenblatt and Shader (1973) are generally pessimistic about all classes of psychopharmacological agents in the treatment of alcoholism. Mottin

is most negative with regard to drug therapy. Viamontes's review reveals that the majority of uncontrolled clinical trials using antidepressants, phenothiazines, and benzodiazepines are effective in the treatment of alcoholism. Mottin, Viamontes, and Greenblatt and Shader uniformly emphasize the methodological problems of clinical trials with these drugs and cite the lack of double-blind controlled studies that might better establish the efficacy of these drugs.

Notwithstanding these methodological inconsistencies and shortcomings, a number of carefully controlled and executed studies over the past decade have proved to be promising and hopeful with regard to the use of drug therapy in alcoholism. Bliding (1973) demonstrated the benzodiazepine oxazepam to be more effective than chlorprothixene or placebo in the treatment of chronic alcoholism. Kissin and Gross (1968) showed chlordiazepoxide combined with imipramine to be effective in controlling drinking behavior and furthering overall improvement. In studies by Butterworth (1971) and Overall et al. (1973), the use of tricyclic antidepressants and to a lesser extent phenothiazines has proved effective in relieving symptoms of underlying depression (also anxiety in the Overall et al. study). In another important study conducted by Quitkin et al. (1972) target

symptoms of phobia and anxiety in a subsegment of alcoholics were dramatically relieved by imipramine with significant improvement of drinking behavior. More recently, reports by Wren et al. (1974), Kline et al. (1974), and Merry et al. (1976) suggest that lithium is effective in cases of alcoholism associated with depression.

What is to be made of these often confusing and contradictory findings? What should guide the practitioner in the decision to treat or not treat the alcoholic with these pharmacological agents? Do the findings of a dynamic approach that identifies structural impairments have any relevance to a descriptive approach that suggests such individuals might have pharmacologically treatable problems? Most if not all of the drug studies with alcoholics have been based on descriptive approaches in which target symptoms and psychopathology are identified. Nevertheless, I believe there is a basis for speculation that such target symptoms and psychopathology are the result of failures and deficits in ego and self structures, particularly those involving regulation of affects. I expect that these drugs work with alcoholics because they serve, support, and augment otherwise impaired ego capacities and disturbances in self-regulation.

The findings of descriptive psychiatry complement an approach aimed at identifying the ego and self disturbances in alcoholics. This is particularly so given recent trends in both descriptive psychiatry and psychoanalysis to state more explicitly the criteria for diagnosis and identify more precisely the nature of the psychopathology.[3] Such approaches are consistently demonstrating the ubiquity of depression, phobia, anxiety, and panic states in association with alcoholism (Weisman & Meyers, 1980; Weisman et al.; Winokur et al., 1970; Behar & Winokur, 1979; Klein, 1975; Quitkin et al., 1972). There is evidence that these conditions are as treatable in alcoholics as they are in other patients and that they are contributory to the alcoholism (Behar & Winokur, 1979; Klein, 1975; Quitkin et al., 1972). Although the incidence of depression in alcoholism has ranged from 3 to 98 percent in different studies, the application of precise diagnostic criteria for depression and phobic anxious states has produced more uniform results when attempts have been made more recently to identify these conditions in alcoholics (Weisman et al., 1980; Keeler et al., 1979). Moreover, when considered from a point of view taken by Klein (1975), where a more generic view of affective disturbance is considered symptoms of dysphoria, anergia, anxiety, and depression

become interacting, overlapping, and on a continuum and seem more to be evidence of the "dysregulation of affects" and "disorders of activation" to which Klein refers.

In the first part of this chapter I explored how self-care disturbances and disturbances in affect regulation predisposed individuals to alcoholism. I speculated that in the absence of adequate self-care functions, the individuals' vague sense of vulnerability might contribute to phobias in alcoholics. I also suggested that because of developmental failures alcoholics either overregulated or underregulated their affects and depended on the effects of alcohol to release or submerge their "good and bad" feelings. In my estimation, many of the symptomatic features of alcoholics, including, for example, anxiety, depression, dysphoria, and sleeplessness, are indicators and the result of more fundamental and serious disturbances in the ego and self structures that are responsible for affect regulation and the achievement of subjective states of well-being, including the maintenance of self-esteem. These disturbances seriously incapacitate the alcoholic and are not easily or readily influenced by psychotherapeutic interventions alone, especially early in treatment. It is exactly in this respect that many alcoholics need assistance with the

intolerable and overwhelming feeling states with which they suffer and why psychopharmacological agents might be considered useful if not necessary.

The common and prevalent distrust of alcoholics' suitability for drug therapy is unwarranted, in my opinion. Much of the controversy over drug use in alcoholism stems from a misunderstanding of the alcoholic's dependency problems. When considering psychopharmacological treatment of the alcoholic, it is understandable that we remain apprehensive about the ''regressive-oral" needs and inclinations of the alcoholic. However, when we consider the structural impairments with which alcoholics suffer, the use of psychoactive drugs becomes a logical alternative that should be seriously considered. In my own experience, using predominantly tricyclic antidepressants and/or benzodiazepines (particularly oxazepam), I have very rarely had patients abuse or misuse these drugs. On the other hand, I have seen several alcoholic patients in consultation who had overused prescribed benzodiazepines, and it has been my clinical impression that this was more likely to occur when they were prescribed in lieu of a treatment relationship that considered and tried to understand all aspects of the physiological and

psychological disturbances associated with alcohol problems.

For some the duration of need for these psychopharmacologic agents is short, and for others the need continues for longer periods. For many others there is no need for medication at all. The timing, duration, and choice of these agents should be based on clinical observations and judgments about each patient as he or she gains or attempts to gain control over drinking. I believe the cases requiring no medication or only short-term use of medication are those in which the disturbances are less severe and/or the regression is more readily reversible. The more usual case in my experience involves situations where as control is gained over the drinking, depressive anxious syndromes, including phobias, surface, which are evident and are most often quite disabling. For some, the severity of these symptoms seems to be secondary and related to regressive states associated with protracted drinking, but the symptoms nevertheless respond to antidepressants and/or benzodiazepines. In my experience the decision as to which of the two drugs to use or whether to combine them should be based on clinical judgment as to the predominant symptomatology. Perhaps Klein has properly elaborated on what one rationale might be for using these drugs in combination, namely that

the phobic and panic states often involved with alcohol problems respond to imipramine, but the anticipatory anxiety associated with the phobic states is unresponsive to this drug. The anticipatory anxiety does, however, respond to antianxiety drugs, and therefore these drugs might be indicated in alcohol problems associated with phobic states. In many instances the disturbances I have outlined are severe, ubiquitous, and persistent. The buffering, supporting action of these drugs in helping to manage affects is needed, and the need for a longer and more indefinite period of drug therapy is indicated. In those instances where the patient was slow to abstain or curtail his/her drinking, where all other efforts on the part of myself, A.A., the family, and others had failed, and where continued drinking threatened to be disastrous, I deliberately chose to initiate the use of antianxiety agents or antidepressants to help contain and cope with painful affects of anxiety and/or depression. This is admittedly risky, and I have in such cases involved family members for supervision and dispensed only small amounts of the medication. Fortunately these instances are rare.

In summary, I would suggest that it is often the combination of psychotherapeutic and psychopharmacologic interventions, especially early in treatment, that is critical in helping alcoholics overcome their

dependence on alcohol and assisting them with their enormous problems with self-care and affect regulation. In some instances the psychopharmacologic intervention may be time-limited and an adjunct to psychotherapy and other approaches, but in other instances it may be a definitive treatment for identified target symptoms and psychopathology.

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## Notes

[1] For the purposes of this presentation, "alcoholism" refers to a frequency and amount of alcohol consumption sufficient to result in significant physical-psychological, social, legal, or employment difficulties for the individual.

[2] I am indebted to Dr. John E. Mack for the germinal idea of self-care as an ego function. We are currently collaborating on a project to further explore and understand self-care functions.

[3] Editor's Note. *Archives of General Psychiatry*, 1979. 76, 3.