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ADDICTION AS A FORM OF PERVERSION

Psychoanalytic treatment of addiction is often ineffectiue because therapists fail to recognize addiction as a discrete disorder. The author reviews psychoanalytic theories of addiction and presents an alternative concept comprising biological, behavioral, and psychological characteristics. She compares the structural similarities between addiction and perversion and describes the use of the addictive substance as a selfish object. Finally, she discusses the implications of psychoanalytically oriented treatment and advocates a multimodal treatment approach. (Bulletin of the Menninger Clinic, 56, 221-231)

Psychoanalytic treatment of addiction has not been effective because of the mistaken assumption that addiction is a symptom of underlying psychopathology. Psychoanalytic theorists have focused on trying to identify the underlying psychopathology and have failed to integrate the evidence that addiction constitutes a separate disorder that can occur across diagnostic categories (e.g., Brickman, 1988; Knight, 1938; Vaillant, 1981, 1983; Vetter, 1985). This failure has apparently resulted from confusion over primary and secondary psychopathology (Brickman, 1988). Certain character traits may predispose people to addictions. However, addictions can cause extensive secondary pathology (e.g., Vaillant, 1983; Vetter, 1985) and, at the start of treatment, it is not always possible to know which pathology is primary and which is secondary.

A great deal of psychoanalytic writing on alcoholism and addiction reports a generally poor outcome of treatment (e.g., Frosch, l 970; Savitt, 1963; Vetter,

1985). The common thread in psychoanalytic theories of addiction is the search for a common underlying psychopathology that predisposes people to addiction, and the debate has focused on attempts to identify that psychopathology. Freud (1950/l 966) stated that "masturbation is the ... 'primal addiction'" (p. 272) basic to all other addictions. Later psychoanalytic theorists identified oral characteristics (Fenichel, 1945), paranoid psychosis (Grover, l932), and passive dependency (Knight, 1937) as the underlying pathology. Borderline and narcissistic pathologies have also been implicated (Kernberg, 1975; Kohut, 1976/1978; Rado, 1928). More recently, self psychology has been used to explain addiction as a failure of self-regulation (Chelton & Bonney, 1987; Levin, 1987) or a failure of affect regulation (Khantzian, 1978).

All these theories ignore the accumulating evidence that addiction constitutes a separate disorder that can occur across diagnostic categories. For example, in a prospective study of 250 alcoholic individuals who had been followed in college prior to becoming alcoholic, Vaillant (1983) found that an unhappy childhood led to mental illness, lack of friends, and low self-esteem, but not to alcoholism. Alcoholism was found to be most highly correlated with ethnicity and with alcoholism in relatives. Vaillant also presented convincing evidence that alcoholism produces extensive secondary psychopathology. In a retrospective study of heroin addicts, Zinberg (1975) found that the subjects exhibited similar current psychopathology in spite of consistently different family dynamics and little evidence of psychopathology prior to the addiction. He concluded that the addiction to heroin, with all the consequent disruption of social and familial ties, may have produced the so-called junkie personality. Simmel (1948) wrote that "it must be determined whether the disintegration of the ego is the cause or the result of the alcoholic's chronic consumption of liquor" (p. 8).

Psychoanalytic theorists and clinicians have failed to take account of the evidence that addiction is a separate disorder; they have continued to assume that retrospective accounts based on memories and experiences of the active addict provide a sufficient basis for ideas about predisposing psychopathology. This assumption, however calls to mind the dilemma in psychoanalytic treatment that Schafer (1983), among others, has discussed--the idea that the patient composes a narrative that changes as the patient's understanding changes. Such a narrative by a patient--and certainly an addicted patient--cannot be relied on as literal fact.

Vaillant (1983) found that the narrative of drunken or recently sober patients is likely to include a bleak picture of their parents that may bear little resemblance to their descriptions before becoming alcoholic or after a long period of abstinence. Vaillant attributed this negative picture to rationalization and the need to identify retrospective reasons for becoming alcoholic. One supervisor told about two sons of an alcoholic father, one who became a teetotaler and the other an alcoholic. Both asked rhetorically, "With a father like mine, what else could I be?"

Components of addiction

Addiction has three components: biochemical/genetic, behavioral, and psychological. Numerous studies have provided extensive evidence for the genetic transmission of a vulnerability to alcoholism (e.g., Conroy, 1988; Goodwin, Schulsinger, Hermansen, Guze, & Winokur, 1973; Schuckit, Goodwin,

& Winokur, 1972). The addicted person is vulnerable not only to genetic influence, but also to many substances of abuse that cause biochemical changes resulting in habituation and physiological dependence, changes that are more or less powerful depending on the substance. For example, the results of smoking crack--a powerful form of cocaine--illustrate an extreme of the physiological changes that occur with addiction. Crack cocaine stimulates the release of dopamine, which produces an intense high. But the cocaine also interferes with the replenishment of the dopamine, producing a low that stimulates a strong craving for more cocaine. A therapist who interprets this craving as a psychological phenomenon makes a grave error. One psychoanalyst (Fine, 1972) reported a case of addiction to morphine and gave a detailed psychological interpretation of the patient's repeated relapse at exactly 3 days of abstinence. The author did not report considering that the time period coincided with a crucial, physiologically determined peak of withdrawal symptoms. Even apparently pure behavioral disturbances, such as compulsive shopping or gambling or exercise, seem to produce a high that functions in much the same way as a drug-induced high, that is, as a powerful reinforcer for the behavior. Bejerot (1980) theorized that addiction represents a newly acquired drive state arising from exposure to chemical substances that affect brain chemistry. The new drive state can overpower natural drive states such as hunger and sex.

Addiction also has a powerful behavioral component resulting from both positive and negative reinforcement of the addictive behavior. The cues for substance abuse spread rapidly, and they are tenacious and difficult to extinguish. The person begins to use drugs for a variety of reasons (e.g., stress, anxiety, or depression), any of which can be associated with different underlying psychopathology. The user then feels better, which reinforces the behavior and makes repetition more likely. Addiction results when the drug becomes an exclusive method for dealing with needs. The negative consequences of the addiction include feelings of guilt, loss of self-esteem, and loss of a sense of identity, all of which can result in the repetitive use of the substance to avoid these painful affective states. The drug may be taken to achieve pleasure at first, but subsequently it is taken to ward off pain.

The third aspect of addiction is psychological. Although the psychology of addiction is complicated and multifactorial, a common and primary characteristic of the psychological functioning of addicted individuals is the use of the substance as a fetish object (e.g., Glover, 1928/1984; McDougall, 1985). This perversion or degradation of the common, normal use of transitional objects and phenomena (Winnicott, 1953/ 1975) is a substitution by the addicted person of concrete actions for symbolic activity or play, resulting in a collapse of potential space.

To clarify my meaning, I will briefly define the concepts of perversion, fetish objects, transitional objects, and potential space. A perversion occurs as a solution to the blocking of sexual pleasure or adequacy by castration anxiety (Fenichel, 1945). The use of a fetish object is one way to bypass that block by bringing an "anxiety-provoking situation under the illusory control of the individual" (Greenacre, l969, p. l50). The fetish object serves as proof of a female or maternal phallus, thus soothing castration anxiety sufficiently to ensure sexual performance (Bak, 1974; Greenacre, l969; Winnicott, 1953/1975). The infant's

use of transitional objects, according to Winnicott (1953/1975), is a necessary aid to psychological development: "In relation to the transitional object the infant passes from (magical) omnipotent control to control by manipulation (involving muscle erotism and coordination pleasure)" (p. 236). The infant uses transitional objects to ease the strain of preserving a boundary between inside and outside, fantasy and reality. Because the task of reality acceptance and differentiation of reality from fantasy is never complete, no one is entirely free from the strain. Intermediate areas of experience that are not challenged, such as art or religion (Winnicott, 1953/1975), provide relief from this strain. Therapy might also be added to this list.

Potential space is the intermediate area of experiencing that lies between fantasy end reality (Ogden, 1986; Winnicott, 1971). It is within potential space that the infant creates and uses the transitional object without being disturbed by the question of whether it is real. According to Ogden (1986), "That space between symbol and symbolized, mediated by an interpreting self ... is the space in which we are alive as human beings, as opposed to being simply reflexively reactive beings. This is Winnicott's potential space" (p. 213). Psychotherapy makes use of the human ability to create potential space in the therapeutic relationship so that meanings and symbols can be played with in a way that makes growth and development possible. This is analytic space (Ogden, 1986).

In addiction, all the person's energy, including sexual energy, becomes bound up by the relationship to the addictive substance until the person is no longer living in an object-related world. The function of transitional objects appears to be degraded into fetishism, resulting in a collapse of the ability tO symbolize. The substance is used to achieve an omnipotent sense of illusory self-reliance and to deny realistic human dependency. This process is similar to the degrading of the transitional use of medication into the addictive or fetishistic use described by Hausner (1985-1986). The addicted person uses the substance to manage and magically control multiple forms of anxiety and affect related to both interpersonal and intrapsychic situations, while the fetishist uses a fetish object to relieve momentary castration anxiety so that sexual performance can occur. Just as the development of a fetish or other perversion results in a block to full, free, relational sexuality, the fetishistic use of an addictive substance results in a defensive process made concrete and tangible in a way that precludes the further development of object relations or erodes levels of object relations already achieved.

Winnicott (1971) stated, "There is a direct development from transitional phenomena to playing, and from playing to shared playing, and from this to cultural experiences" (p. 51). The addicted patient's reliance on concretizing magical solutions to real problems through the abuse of substances precludes the opening of potential space in therapy and thus prevents the use of therapy to aid progressive development. When the object is used in a transitional way, "This interplay enhances reality testing, helps define body boundaries, furthers differentiation of self and object representations, and builds a sense of self via increased internalization and assimilation" (Grolnick, 1985-1986, p. 404). In contrast, the addicted patient uses the substance as a fetish object, resulting in disturbance of reality testing via splitting and denial, inhibition of play, regressive psychopathology or exacerbation of preexisting psychopathology, and increasing

damage to the integrity of the self as well as to relationships with other people. Continuing addiction of a patient in psychotherapy makes change impossible because the patient maintains his or her primary relationship or emotional investment in the addictive object (Conroy, 1988), and thus can never, within the therapy, open up the potential space that is necessary for therapeutic "playing."

The child's use of potential space as a forward-moving vehicle for mastery of anxiety as well as creativity is somewhat analogous to the patient's use of analytic space as an arena in which to begin living instead of stagnating. This possibility is abrogated by addiction. Addiction, or use of a substance as a fetish object, is limited to magical control, with a consequent failure to progress to action in reality. In other words, the addicted person attempts to solve problems or control anxiety through illusory means and is therefore doomed to repeat the action endlessly because use of the addictive substance has no effect in reality on the problem the individual is trying to solve. The process of becoming addicted seems to be an increasing reliance on the substance for magical solutions, to the exclusion of progressive development and mastery of conflicts.

A patient facing the real problems of loneliness and job dissatisfaction shops compulsively and reports that when she gives her creditcard and her purchase is approved, she "knows" that she is rich, powerful, and has many friends, in spite of her parallel and concurrent "knowing" that she is very lonely and has little money. The patient accepts the shopping as equivalent to actually involving herself with others and seeking improvement in her employment.

Just as the sexual perversion of fetishism provides only temporary relief from and no mastery of castration anxiety, so can addiction be described as "a magical solution to life ... which acts to alleviate tension in the face of a problem, but does nothing to alleviate the problem" (Peele, 198Z2 p.125). I would add that addictive behavior not only fails to address the original problem, but also creates a whole new set of problems with psychological, interpersonal, and social ramifications.

Interference with psychoanalytic treatment

Four characteristics of addictive disorders interfere with successful use of psychoanalytic psychotherapy: denial, secrecy, conditioned responses, and the use of the substance as a fetish object.

Denial is ubiquitous in patients with addictive disorders. Most such patients seek treatment not for the addiction, but for secondary anxiety, depression, or interpersonal difficulties. Both consciously and unconsciously, these patients deny the substance abuse and its damaging consequences. For example, obese patients may have a quasidelusional image of themselves. One patient, weighing about 320 pounds, reported a fear of becoming too thin after losing 20 pounds. Similarly, an alcoholic individual, with alcohol on his or her breath, may deny drinking. It would be a mistake, though, to consider these behaviors as evidence of antisocial characteristics. Patients with severe addictive disorders exhibit dissociative defenses that underlie denial. These patients, like those with perversions, both "know" and simultaneously "do not know" that they are addicted. The therapist is equally subject to denial of substance abuse problems. Therapist denial may be a residual effect of viewing addiction as a moral failure and addicted patients as unsavory characters. Therapists may even view

addiction as impossible to treat and avoid a sense of hopelessness by denying the addiction.

Secrecy and conscious dishonesty in the service of protecting the relationship with the addictive substance are also common. T. Cermak (personal communication, May 13, 1987), who specializes in the treatment of adult children of alcoholics, reported that about 25 % of the people who come to him for help are abusing drugs or alcohol but do not report it on intake.

The powerful conditioned responses that characterize addiction also interfere with successful psychoanalytic psychotherapy. These responses can precipitate relapse in the absence of psychological factors, and can interfere with the patient's ability to make use of insight and conflict resolution to effect change.

Finally, the use of the substance as a fetish object (as previously described) impedes psychoanalytic psychotherapy. The patient achieves an omnipotent and illusory sense of self-reliance based on the "illusory control" established by the use of inanimate substances that substitute for realistic human dependency. This illusion precludes the development of a working alliance because the patient makes a primary emotional investment in the relationship to the substance. The emotional interplay between patient and therapist (which is necessary for the creation of analytic space) cannot take place. Whether the patient comes to the therapy already secretly addicted or develops an addiction during the course of the therapy, once the addiction is in place, the space within which change can occur is constricted by the patient's emotional investment in the closed relationship with the substance.

The major risk of psychoanalytic psychotherapy with addicted patients is the danger that a transference-oriented psychotherapy will stagnate. The psychoanalytic psychotherapist bases treatment on the assumption that a therapeutic relationship allows for the replay and working through of conflicts and developmental deficits. Loewald (1960) defined the psychoanalytic process as "the significant interactions between patient and analyst which ultimately lead to structural changes in the patient's personality" (p. 16). Because addictions have been considered symptoms of underlying psychopathology, psychoanalytic therapists have assumed that an addiction can be influenced through interpretation (Brickman, 1988). Indeed, patients with hidden addiction frequently experience some relief--including a reduction in the frequency of abuse--on beginning treatment. This initial improvement encourages the psychoanalytic psychotherapist's belief (and the patient's hope) that the addiction will subside as the treatment progresses. The therapist who relies on transference interpretation as a major tool will interpret relapse as a transference phenomenon, just as the wife of the alcoholic individual interprets relapse as directed at her. The treatment will thus grind to a halt and founder on the mutual denial of patient and therapist. Brickman (1988) reviewed the cases he had handled over 20 years and found that 65 % of his treatment failures involved substance abuse.

Addictions interfere with treatment in a very specific way. The use of the substance as a fetish object prevents the emotional involvement of the patient in the therapy. For example, one patient, who revealed that she had been smoking marijuana before coming to sessions, described her careful empirical research to

discover the dosage that would create an optimal distance between us so that she could be with me and vet not with me in a way that froze the developing therapeutic relationship. "The addict ... always argues that he fights off loneliness with the drug, but he never realizes that he sometimes takes it to defeat the other's presence and company" (Etchegoyen, Lopez, & Rabih, 1987, p. 51). The patient maintains a primary emotional involvement with the substance and thus defeats the therapy and the therapist's presence. Therapists who believe that psychotherapy alone is sufficient will be differentially reinforced by the addicted patient's periods of abstinence and may develop magical beliefs in their own ability to prevent relapse or to cure such patients of their addiction (Vaillant, 1981).

The assumption that psychotherapy alone is sufficient has seldom been questioned. Not enough heed has been paid to Freud's (1920/1955) caution:

So long as we trace the development from its final outcome backwards, the chain of events appears continuous, and we feel we have gained an insight which is completely satisfactory or even exhaustive. But if we proceed the reverse way, if we start from the premises inferred from the analysis and try to follow these up to the final result, then we no longer get the impression of an inevitable sequence of events. (p. 167)

Implications for treatment

When making diagnostic formulations, clinicians must consider the possibility that evident psychopathology may be secondary to addiction, the stage of the addiction, and the patient's degree of emotional involvement in the addictive substance. For example, cocaine has a kindling effect on anxiety and panic attacks, and persons addicted to cocaine may be misdiagnosed with anxiety disorders. Abuse of cocaine and methamphetamine can produce states that mimic schizophrenia. Alcohol abuse can cause depressive disorders. In addition, the deleterious effects of the addiction can result in erosion of reality testing and in regression to primitive forms of defense. The therapist who is not knowledgeable about addiction may misdiagnose the patient because of the assumption that the presenting psychopathology is representative of the patient's preaddicted personality. Although tentative diagnostic conclusions are useful in developing a treatment plan, a firm diagnosis is impossible prior to a period of abstinence, the length of which will vary according to the substance being abused.

Psychoanalytic psychotherapy can be uniquely useful in treating addiction because of its efficacy in treating the defenses of splitting and depersonalization that characterize addiction. The psychoanalytic psychotherapist can help addicted individuals reengage in a fully human world as they extricate themselves from their attachment to the addictive object. Transference-oriented psychotherapy is an ideal approach to the problems that these patients face in attempting to reconnect with other people. However, it is rare that psychotherapy alone will produce a positive outcome. Adjunctive treatment for the addiction increases the likelihood that these patients will be able to make use of the therapy. The use of adjunctive treatment (e.g., 12-step programs modeled on Alcoholics Anonymous) and education about addiction can help patients achieve abstinence (Conroy, 1988; Dodes, 1988; Rosen, 1981). These groups provide

patients with interim support, group identification to combat their isolation, and the chance to make reparation, alleviate guilt feelings, and increase self-esteem through helping others.

The therapist must attend to the profound danger of an omnipotent countertransference. If the therapist comes to believe in his or her ability to take the place of the addictive object, the therapeutic relationship will stagnate. No responsible therapist would attempt to treat asthma or hypertension with psychotherapy alone. But through a failure to recognize that addiction is an overdetermined, separate disorder that can occur either in conjunction with other disorders or alone, many psychoanalytic therapists do attempt to address the addiction without collateral treatment.

Patients have many reasons for not using 12-step programs. I believe it is most useful to deal with those reasons through the familiar techniques of resistance analysis. However, a specific focus on the reluctance to accept realistic human dependency in place of the false self-reliance that patients achieve through substance abuse is crucial for the development of a working alliance. The therapist must confront the patient's fear of, and unwillingness to reenter, the world of human dependency and leave the magical, omnipotent world where the fetish object (addictive substance) aids in the creation of an illusion of self-reliance and magical solutions to life.

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