Noelle Burton, Psy.D.

Relational perspectives on the nature of self and the unconscious have transformed how we can understand addictions and substance use problems. Addictions have received little attention in the contemporary literature and therapeutic approaches outside of psychoanalysis have been skeptical of psychoanalytic approaches. It is my contention that viewing substance use problems through the lens of a relational/multiple self-state model offers new clinical possibilities resulting in greater success in treating these patients. In this model, addictive behavior is seen as embedded in dissociated self-states. Therapy focuses on helping the patient to move from dissociation to a true multiplicity and a decreased dependence on substances.

“I WANT TO KILL MYSELF.” CAROL’S WORDS FELL FROM HER LIPS, TIRED and leaden, matching her face and the deadness in her eyes. This was our first meeting. In her mid-40s and married with two adolescent children, she worked full time as a successful corporate senior executive. Carol told me that her husband, already brain-injured subsequent to neurosurgery that had occurred ten years into their marriage, had been involved in a car accident about a month ago in which he sustained a head injury. He was much worse now, and nobody knew to what extent he would recover to his previous, already compromised, cognitive level. Since the accident,

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Carol had spiraled deeper into depression and hopelessness while trying to care for her children, administer to her husband's schedule of medical appointments and therapies, and maintain her high level of responsibility in her demanding position at work. Hers was a grim, gray picture of despair and unrelenting pressure. She was quite serious about ending it all.

Within the first three months of therapy, as we addressed her current situation of overwhelming stress, Carol and I became aware of her alcohol problem. She was drinking up to two bottles of wine nightly. I asked her more about her drinking, learned about the chronicity of her current level of use (she had been drinking heavily since adolescence), and expressed my concern about her likely dependence on alcohol. She agreed that it didn't seem healthy and said that she had begun to wonder if her love of fine wine in the evenings had gone too far. I broached the idea of finding support through AA. Shortly thereafter, she told me that she had stopped drinking and attended her first AA meeting. I was pleasantly surprised by her motivation and apparent readiness to stop. My previous experience in working with alcoholics had been quite different—I had grown accustomed to the inevitable time lag between my recognition of the alcoholism and the patient's. This was different. But I saw Carol as a mature and pragmatic can-do type of person, and so her approach to her alcohol dependence fit in with her style of solving problems.

I learned that she was the second of five children, raised in a small New England town. She told me that her younger sister had died of complications related to alcoholism and drug addiction. Carol's responses to questions about her family and growing up were vague, and she often reported that she simply couldn't remember much. She did say that she had had a normal childhood and seemed satisfied to leave it at that. I was intrigued by her impoverished memory of her past and her indifference to her memory difficulties.

Early on, Carol was flummoxed by the entire therapy process. She told me she didn't know what she felt or at least could not name it, didn't dream or daydream, and did not know what she should talk about. Carol did not reflect on her behavior, drinking or otherwise. It was apparent to me that Carol was unaware that she possessed an interior. In my office, Carol could not rely on the comfort of corporate structure and clear agendas to address her problems. The lack of engagement between Carol and me, and even between Carol and herself, created an arid climate that left me feeling uncomfortable.

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I remember how uncertain I felt about whether or not she would return the following week and how I would check with her about making an appointment at the end of sessions; this uncertainty and my own doubt as to whether I was helping her continued over the next five to six months. Sensing that she needed me to actively engage her, I asked many questions about her experiences both internal and external, hoping that she would continue and that her story would become clearer over time.

Despite Carol's initial effort to become sober, she frequently found herself slipping back into drinking. With my encouragement, she eventually entered an intensive outpatient rehabilitation program when she realized that she needed more structure to help her stop drinking, and we continued to meet for sessions during this time.

Carol had intentionally selected a sponsor who had a reputation for being “tough and structured,” and she told me how she needed someone who would monitor her closely. When we explored her fantasies about a
sponsor, Carol told me that it would be difficult for her to initiate contact with another and that was the reason why she wanted someone who would “stay on top of things.” She stated rather matter-of-factly that she didn't expect others to care or to be involved with her. “People say they care but they don't really mean it,” she said simply. Here, we can hear Carol's hopefulness and desire to be cared for alongside her hopelessness about that possibility.

Psychoanalytic treatment for alcoholism and other addictions has been controversial in the psychotherapy community. In the addictions field, psychoanalytic therapy for alcoholism has long been viewed as ineffective at best and enabling or destructive at worst. It seems there has been a disconnect between our conceptualizations of the addictions and the empirical literature on chemical dependence, which may be another reason underlying the skeptical attitude held by addictions researchers and clinicians toward psychoanalysis.

Although some psychoanalytic writers have addressed substance abuse and dependence specifically (e.g., Krystal and Raskin, 1970; McDougall, 1974; Wurmsen, 1974; Khantzian, 1978), psychoanalysis as a whole has tended to shy away from the conceptualization and treatment of addictions (with the exception of some very early writers such as Glover, 1932). Sabshin (1995) has commented on the frustration involved in treating addicts from a psychoanalytic perspective, noting the frequency of relapse and the continuation of drinking behavior despite interpretation of unconscious motivations. The dominance of the disease model of addiction among therapists, as well as in our culture at large, has further “depsychologized” addiction and alcoholism (Sabshin, 1995).

Very recently, Director (2002) has introduced and argued persuasively for a relational psychoanalytic treatment for addictions. I agree with Director's assertion that the emphasis on working within enactments, as relational theorists advocate, is ideally suited to a population that is so action-oriented. It is my contention that the traditional substance abuse psychotherapy models, as well as the current dominant psychoanalytic therapies for addictions, may be missing something, especially with regard to the specific self-states, or self-other organizations, of the individual who engages in addictive behavior.

Some relational theorists assert that affect, behavior, language, memory, cognitive level, values, body experiences, gender, and even sexual object choice are embedded in particular self-organizations, especially in the context of trauma (Bromberg, 1991, 1993, 1994, 1995, 1996, 1998; Harris, 1991, 1996, 2000; Davies and Frawley, 1992, 1994; Pizer, 1992, 1998; Mitchell, 1993; Ogden, 1994; Aron, 1995; Benjamin, 1995; Davies, 1996a, b, 1997, 1998, 2001; Grand, 1997). How might this relational perspective impact how we look at addictions? Would it help us in understanding addictive behaviors to think of them as being embedded in particular self-states? Is the alcoholic or addict immersed in a significantly different self-state when relapsing as compared to the self-organization containing the motivation to remain sober? If these are significantly different self-states, what are the implications for treating addictions? Is it possible that pockets of experience may be missed in the treatment unless these self-states are contacted and worked with directly and engaged in a careful, detailed inquiry centered on the drinking and drug-taking behavior? Can therapeutic interventions that strive to contact these states directly, similar to those established in the trauma literature for dissociative identity disorder (e.g., Putnam, 1989) and in the relational literature as Davies (1998) has
advocated, improve the effectiveness of psychoanalysis as a treatment modality for addiction?

In this paper, I consider these questions in case material from an ongoing three-year treatment of an alcoholic woman. I describe the kind of initial therapeutic work that can be done to lay the groundwork for more direct work with specific self-states. In addition, this paper is written in response to Connors's (2001) observation that relational authors have seldom focused on the treatment of specific symptoms and disorders in their writings.

The following discussion is organized into four sections: (1) a summary of the major contemporary psychoanalytic perspectives on addiction; (2) a presentation of relevant research findings from the literature on childhood trauma, dissociation, and addiction; (3) a brief review of the relational literature on dissociation and self-organizations; and (4) clinical material illustrating the usefulness of a relational/self-state model in treating addictions.

Psychoanalysis and Addiction

A thorough history of the literature on psychoanalysis and addiction is beyond the scope of this paper, so the reader is referred to Yalisove (1992) and Sabshin (1995) for excellent reviews. Currently, the four dominant psychoanalytic views of alcoholism and addiction and their treatment include the work of Edward Khantzian, Henry Krystal, Joyce McDougall, and Leon Wurmser. Each theorist offers his or her own unique perspective on addictive processes, yet despite apparent theoretical differences between them, in some cases, these writers also overlap a great deal. Common to all of these models is the acceptance of the utility of Alcoholics Anonymous (AA) and groups like it (Yalisove, 1992). There seem to be several general areas of focus for these authors: affect disturbances; the somatization of affect and psychosomatic illness; problems with access to fantasy, play, and subsequent symbolization; and characteristics of the transference-countertransference field.

All four of these theorists have emphasized disturbances in affect as being central to understanding chemical dependence. In working with these patients, we cannot assume in asking the question, “What are you feeling?” that the person is going to be able to describe or label his or her emotions. Often there is (1) an inability to identify affects and differentiate between affective states (Krystal, 1962); (2) an inability to use affects as signals to one's self, coupled with a general lack of reflective awareness (Krystal, 1974; McDougall, 1985); and (3) a tendency to experience bodily sensations as opposed to feelings, that is, addicted individuals experience anxiety and depression as somatic states rather than psychological ones (Krystal and Raskin, 1970).
This observation of the somatization of affect in these patients (Wurmser, 1995) led McDougall (1974) to regard addictions as a manifestation of psychosomatic illness. In fact, she referred to addictions as “action disorders” (p. 449), in that emotional arousal is dispersed and evacuated through action rather than through feeling and talking. The clustering of these characteristic affective patterns, as just described, is referred to as alexithymia, a term coined by Sifneos (1967). Last, individuals with addictions are using substances to regulate (Khantzian, 1985), defend against (Wurmser, 1974), and contain (McDougall, 1985) overwhelming affect. This impairment in affect tolerance prompted Khantzian (1985) to introduce the “self-medication” hypothesis of addiction.

Krystal was so impressed with these various problems with affect that he recommended an initial phase of treatment that directly addresses and helps patients to improve their emotional functioning. He is in agreement with Sifneos (1973, 1975), who found that as long as these patients exhibited alexithymia, psychoanalytic therapy was quite limited in its usefulness.

Chemically dependent patients exhibit a striking absence of a fantasy life, especially in the capacity to utilize one's imagination in the service of self-soothing. To wander too far into the hypnotic world of one's fantasies is to risk an encounter with, as Krystal (1995) explains, “the split, idealized, but also vilified object. In analysis it is too dangerous to reopen the free fantasy life, for the analyst, like the primary object, may turn out to be the evil witch who delights in torture” (p. 94). It is the addicted person's failures in symbolic functioning (Wurmser, 1974; McDougall, 1985) that result in a lack of awareness and reflection, as well as an absence of dream and fantasy material. Addicted individuals are unable to self-soothe due to the lack of “an internal representation of the mother as a caretaking introject” (McDougall, 1989). McDougall (1984) also noted “a psychic gap between emotions and their mental representations (p. 388).” Here is her description of these patients:

They appeared pragmatic and factual, unimaginative and unemotional, in the face of important events, as well as in relationships with important people in their lives. As time went on, these analysands made me feel paralyzed in my analytical functioning. I could neither help them to become more alive nor lead them to leave analysis. Their affectless type of analytic discourse made me feel tired and bored, and their spectacular lack of analytic progress made me feel guilty [p. 388].

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This description by McDougall alerts us to the potential difficulties in the transference-countertransference field. These various affect disturbances and problems with symbolizing experience may result in pronounced impairment in the ability to free-associate, dream, and engage in fantasy and play, thus profoundly impacting the relationship. Here is Krystal's (1995) description of his experience of his patients:

On first impression, the patients strike observers as especially practical (they like to think of themselves as “action people”). In actuality, they have a “thing” orientation as opposed to a people (and self) orientation [p. 69].

In the adult alexithymic, one is often misled by the appearance of superb adjustment to reality…. The combination of impairment in the capacity for fantasy and abstract thinking and the lack of affective clues deprive the patient of the ability to empathize and to be emotionally involved with their significant objects.
This development results in a particularly “dead” and dull transference relationship as well.... The difficulty in engaging such individuals in psychotherapy has accounted for a major portion of the failures that have characterized psychoanalytic approaches to addiction [1982, pp. 610-611].

Krystal (1995) emphasized that signs of posttraumatic stress are routinely encountered in addicted individuals. In addition to alexithymia and affect intolerance, inhibitions in self-care (Khantzian, 1985; Krystal, 1995) and a pervasive distrust of people (Krystal, 1995) have been observed.

Intriguingly, Khantzian (1978) and Wurmser (1985, 1995) have written about the contradictory and alternating sides or attitudes of these patients. Khantzian (1978) has referenced Kernberg's (1975) writing on splitting and primitive dissociation evident in narcissistic disorders, in which apparently opposite and extreme attitudes may coexist in alternating patterns, as a way to explain why addicted individuals exhibit these ways of relating. In making reference to these patterns, Khantzian (1978) states, “These are not at all uncommon characteristics and modes of defense in narcotic addicts with whom I have worked; and I believe these characteristics account for so much of the unevenness in function, and unpredictability and contradiction in attitudes in such patients” (p. 196).

Wurmser (1985) has noted the presence of “split identities” in patients with addictions:

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It is striking how often we may observe as if another personality took over; many of our patients describe it that way too.... In those observable sequences the avowal of one part-identity necessarily means the denial (or disavowal) of the other—hence the tremendous importance of narrowing down or falsifying the perception by denial.... The duality of denial and countervailing fantasy has impressed me clinically less than duality of two alternate part identities—part personalities of great complexity and in sharp conflict with each other that use denial as their main weapon against the other [p. 91].

If we strip away the theoretical language from Khantzian's and Wurmser's clinical descriptions, we see phenomena that are remarkably consistent with observations of dissociative processes (Bromberg, 1998; Davies and Frawley, 1994). Wurmser describes how abruptly these patients can shift from one self-state to another—self-states that may completely contradict each other (Bromberg, 1993; Davies, 1996a). He states that these part identities are in conflict with each other but what if instead the individual is alternating between dissociated states that are more or less impermeable to each other (Bromberg, 1993; Davies, 1996b)? For the patient to experience and be able to reflect on his or her experience of conflict, he or she would need to have simultaneous access to more than one self-state, which would be a major therapeutic achievement and signal an increased fluidity between self-states (Bromberg, 1993). To illustrate further, listen to McDougall's (1989) observation of her patient Tim:

During a session in which Tim again complained of feeling lifeless and useless, I said that it must have been difficult for a little boy of seven suddenly to find himself the man of the household without any father to tell him how to be a man. To my surprise, and Tim's intense embarrassment, he burst into tears—his first tears, in many long years, so far as he could remember.... Several days later when I referred again to the little bereaved boy, Tim could scarcely remember that he had cried and had totally forgotten the content of the session! This was to become a repeated pattern, as though any thoughts capable of reactivating emotion had
to be swiftly evacuated from consciousness. Tim's unconscious psychic pattern of cutting any link to ideas charged with affect, whether pleasurable or painful, was the most striking feature of his mode of mental functioning.

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… Previous clinical experience had led me to the conclusion that these archaic forms of defense against mental pain, in which splitting and projection had to do duty for repression, were frequently connected with early psychic trauma. I had also discovered in my practice that this specific way of psychic functioning was often associated with addictive proclivities, as well as with severe psychosomatic manifestations [pp. 123-124, italics added].

If we were to view McDougall's example through the lens of Davies's (1996b, 1998) work on ‘therapeutic dissociation’, we would see Tim as having temporarily shifted into another self-organization and now able to access self-experience previously walled off by dissociation, including memory associated with affective, cognitive, behavioral, and relational components. I believe that what I am offering here is a logical extension and revision of these formulations by Khantzian, Krystal, McDougall, and Wurmser through the incorporation of the theoretical and clinical contributions of relational analysts. The relational perspective brings an explicit recognition of the role of dissociation in addictive behavior and substance abuse and the clinical implications of viewing addiction in this way, i.e., intervening in ways that directly address these disavowed, alternative selves. Now let us turn to the empirical literature in order to get a better sense of the links existing between addictions and trauma.

### Trauma, Dissociation, and Addiction

The relationship between trauma, particularly childhood sexual or physical abuse, and dissociation is well established. Pathological dissociation is best predicted by the early onset of severe, chronic, and multiple experiences of trauma (Nijenhuis, et al., 1998).

The relationship between childhood abuse and substance abuse/dependence is increasingly being recognized, by both researchers and clinicians, as pivotal in many chemically dependent patients. Young (1995) stated, “One of the greatest unacknowledged contributors to recidivism in alcoholism and other addictions may be the failure to identify and treat underlying childhood sexual abuse issues” (p. 451). In a large-scale review of studies correlating childhood sexual and

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physical abuse with substance use problems, Simpson and Miller (2002) found that among individuals in treatment for substance abuse, 44.5% (versus 27% in the general population) of women reported histories of childhood sexual abuse and 38.7% (versus 21% in the general population) reported histories of childhood physical abuse. In addition, women with histories of childhood sexual abuse who were seeking psychotherapy were almost three times more likely to report substance problems than were compared with those in the general population.1

The strength of these findings suggests that childhood abuse may be a significant etiological factor in the development of addictions in women. In addition, alcoholism and severe childhood sexual abuse were included among factors most associated with dissociation among a group of psychosomatic patients (Engel, Walker, and Katon, 1996), lending support to McDougall's and Krystal's formulations about the interrelatedness of somatic phenomena, addiction, dissociation, and trauma. Given the high correlation between childhood trauma and dissociation, it can be suggested that a significant number of alcoholic and/or addicted women are dissociative and, in some cases, do not remember their abuse histories.

Some have suggested (in support of Khantzian's hypothesis) that alcohol and drugs may be used by survivors of childhood abuse to self-medicate symptoms such as anxiety and depression (Roesler and Dafler, 1993). Also relevant is the high co-occurrence of posttraumatic stress disorder with substance use disorders in women (Najavits, Weiss, and Shaw, 1997), which is related to their higher incidence of childhood trauma. Women substance abusers with histories of childhood sexual abuse who exhibited PTSD symptoms were more likely to drop out of substance abuse treatment than those without PTSD symptoms. In summarizing the research on the relationship between childhood abuse, drug and alcohol problems, and PTSD, Simpson and Miller (2002) speculate that drugs and alcohol are used to cope with the overwhelming arousal symptoms associated with PTSD.

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1 Interestingly, among men in substance abuse treatment, the rate for sexual and physical abuse were the same as that found in the general population: 16% and 31%, respectively. However, men with histories of childhood sexual abuse seeking psychotherapy, like women, were almost three times as likely to have drug or alcohol problems. In attempting to explain this data, the authors hypothesized that men with substance abuse problems may be less likely to disclose childhood abuse due to fears of homosexual stigmatization (Simpson and Miller, 2002).

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Others have framed the abuse of substances as an attempt at “chemical dissociation” (Briere and Runtz, 1987; Roesler and Dafler, 1993) where adolescents and adults have adopted the use of substances as a method of avoiding traumatic memories and affects. In addition to being used to block out the knowledge of abuse, drug and alcohol use are also believed to suppress dissociative symptoms (Ross et al., 1992). And so the fog of intoxication rolls in, blurring and muting the sharp features of intense affective/somatic states and providing plausible cover for gaps in time, knowledge, and memory resulting...
from dissociation. It is reassuring to chalk it all up to a blackout or general fuzziness resulting from a hangover, rather than being left to question one's sanity.

Relational Psychoanalysis, Dissociation, and Multiplicity

There has been a growing consensus among some relational theorists that the mind is comprised of organizing patterns of experience, multiple self-states, and various complementarities of self-in-relation-to-other organizations, through which individuals filter, organize, and live their experience. Philip Bromberg (1991, 1993, 1994, 1995, 1996, 1998) and Jody Davies (Davies and Frawley, 1992, 1994; Davies, 1996a, b, 1998, 1999) have been advancing models of clinical intervention that view the mind as a complex system of discontinuous and shifting states of consciousness, held together by an individual's unique balance between the centrifugal forces of association and the centripetal forces of dissociation (Davies, 1996b). These dynamically interacting multiple self-states are likely organized and layered developmentally and are more or less permeable and accessible to each other. This emerging model in relational psychoanalysis views multiplicity as a continuum, with traumatic dissociation being on the extreme end, the most severe case being multiple personality/dissociative identity disorder. From this perspective, we are all multiple selves, with the particular self-other organization that we find ourselves in determining who we are at any given moment (I am including both the interpersonal context and the internalized object relationship here). This self-other context is itself in flux, possibly shifting from moment to moment and also holding in more stable patterns over time. These shifts can be dramatic or subtle, both in the individual and interpersonally, changing the overall intrapsychic and interpersonal picture, as in Davies's (Davies, 1996b) apt metaphor of the kaleidoscope. The complexity introduced into the treatment process by these shifting states of consciousness in the patient and therapist has been written about elsewhere (e.g., Mitchell, 1993; Davies and Frawley, 1994; Bromberg, 1998; Davies, 1999; Harris and Gold, 2001).

Another paper could be written, perhaps needs to be written, to further delineate what is meant by dissociation. If we are using the term more broadly to think about how the mind is structured as opposed to more narrowly, referring to a specific type of defense or as a response to such traumas as sexual or physical abuse, perhaps we need a different word to emphasize this distinction (Davies, 2003, personal communication). Although I am using dissociation to refer to both throughout this paper, it is the structuring of the mind through associational-dissociational processes and the clinical implications of this psychic structure in which I am most interested.

When I first became aware of Carol's alcoholism, I did not know how prevalent childhood sexual abuse, as well as physical abuse, were in the histories of alcoholics. Discovering the strength of this correlation in the
empirical literature only reinforced my suspicion that the person who shows up to therapy sessions (and perhaps rehabilitation programs and AA meetings as well) is not necessarily the person who drinks. To borrow from Grotstein (1979), we need to find out who is the drinker who drinks the drink. Donnel Stern (1997) captures this sensibility when he asks the question, “What if action and effort are required, not to keep experience out of consciousness, but to bring it in?” (p. 85). The relational literature on the treatment of trauma survivors informs us that we must reach these disavowed, dissociated selves and carry out the work of affective integration and subsequent symbolization, all in a relational context that offers new possibilities. It is this relational context that facilitates the patient's simultaneous recognition and awareness of the multiple representations of self and other through which all of his or her experience is organized (Davies and Frawley, 1994).

Many chemically dependent and dissociative patients have enormous difficulty reflecting on their experiences and themselves, or, as Bromberg (1998) has said, there is “thought without a thinker” (p. 200). Moving from a dissociative structure where there is little or no capacity to reflect on one's self to the experience of internal conflict

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where one may become aware of a multitude of various or contradictory attitudes is a major developmental achievement (Bromberg, 1995).

Fantasies, dreams, free associations, playing, and reverie states (all signaling access to one's unconscious) may be conspicuously absent in the session work with these patients. Stern's (1997) observation that “the opposite of dissociation is the particular kind of vivid and feeling-saturated thinking and talking that we call imagination” (p. 94) is relevant here; hence, the oft-noted deadness encountered in the therapeutic atmosphere with chemically dependent patients. Just as these individuals are closed off to their own unconscious, they are also embalmed in a reassuringly rigid adultness. The opening up and creation of possibilities for varieties of self-experience through regression (that is, a process that reaches previously disavowed and dissociated selves) is a vital necessity for these individuals, and yet to approach the experience of surrender (Ghent, 1990) is to risk the terrifying experience of entering into a masochistic submission to the other.

With regard to technique, relational authors have discussed several ways in which to engage dissociated aspects of the patient. I will discuss these in the body of clinical material in the following section.

**Continuation of Clinical Material**

A little over a year into treatment, Carol was much less depressed and attending AA with regularity, but she continued to have frequent relapses and I felt she needed a more intensive treatment. Much of the initial therapeutic work helped her to link bodily sensations to specific emotional states, and now she could talk about what exactly she was feeling; she was no longer alexithymic. I told Carol my concerns about her continued drinking and asked if she'd be interested in coming twice a week. She said that she'd been thinking about it herself but that she was afraid I would want her to see someone else because of her continued
relapses. I felt surprised by her fantasy but then remembered my earlier sense of uncertainty about whether or not she would be returning each week and her own stated expectation that others wouldn't care. I became aware of my assumption at the time that she was not attached to me and could easily leave me at any moment. This change in session frequency, coupled with our

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exploration of her expectations of my wanting to refer her, ushered in a much richer, more intimate atmosphere between us. Carol began bringing in dreams, took more initiative in the sessions, and became significantly more reflective with her fantasies, impulses, and behavior. This was also the beginning of her longest period of sobriety up to that point.

One day Carol told me about her very old house and how she and one of her children wondered together about the possibility of ghosts residing there. She then associated to times as a child and adolescent when she had “premonition dreams,” dreams of things that later came true. I was struck by the inconsistency of this side of her with her very pragmatic, no-nonsense self I'd come to know. I felt drawn in, more interested in her, yet I couldn't imagine Carol entertaining seriously this kind of phenomena. I pointed out this intriguing contradiction to her. She readily agreed and talked about what she labeled as her “intuitive” side and how she had left this aspect of her behind, in the past. She said that as she progressed in her recovery, this intuitive side of her was becoming more prominent. When I inquired more about this aspect of her and why it had been left behind, she initially replied that it wasn't a very realistic or practical way to view life and that she thought some of the ideas she had while in her intuitive mode were silly and fanciful. Invoking Davies's (1998) use of therapeutic dissociation, I told Carol that I was very curious and interested in this intuitive version of her and hoped we could both get to know “her” much better. At that point Carol responded, “I don't know why, but it feels like there's a lot of intensity that comes with that side. I don't understand it. It's like if I get into that part of me for too long or look too closely, it will be too much.”

In this period of our work, Carol remembered some experiences from adolescence that she hadn't thought about since they happened. She told me, “I remembered that, as a preteen, I liked the show Marcus Welby, M.D., and I remember sitting there once watching the show and thinking, ‘I need to find Marcus Welby.’; I have no idea why I remembered this or why I would have that thought. The other thing I remembered is that I became suicidal as a teenager. I was about 12 or 13. I can't remember why now but I do remember I went to the minister who was part of the church youth group I was involved in. I told him how I felt but he really didn't seem to take me seriously.” “What happened?” I asked. “I don't remember much,” she replied, “but I did try again. I remember I was getting a ride home from the other minister.

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We were in the car together and I was more direct this time about telling him how bad I felt, that I wanted to kill myself. I don't remember him really reacting. I guess it just didn't go anywhere. Now that I think about it, that was around that time I told you about, when I started hanging out with this bad crowd and doing a lot of
drinking and taking drugs.”

About a month later, Carol mentioned that for the past two months she'd become aware of a fantasy of “wanting to be taken care of.” She said she associated this fantasy with “a younger me.” “It's a sad, heavy side of me and it seems to come over me and disappear again,” she told me. Around this time, she also became aware of another version of herself. Carol described this side of her as completely hopeless. When immersed in this self-state, she would find herself consumed with wishes to die and struggling with impulses to drive her car over an embankment.

We can hear the emergence of Carol's different self-organizations in these memories and experiences. On one hand, there is the hopeful Carol who longs to be dependent on a good, helpful, more powerful other symbolized by Marcus Welby, and on the other, the self who is unseen in her despair and given up on the hope of finding an understanding other. To view Carol as shifting between these very different and dissociated self-states provides an explanation for Carol's inability to have consistent access to hope and to the self-organization motivated toward recovery. In fact, she experiences states of extreme hopelessness and despair and, while in these states, she becomes convinced that this is all she has ever felt and will ever feel—which may be completely true in the experience of these particular self-organizations.

Listening for these inconsistencies in Carol and noting the contrasts between these different sides of her became a focus of our work together. The more closely we listened and observed these paradoxes in her, the more we were able to flesh out these various self-organizations. We became aware of how contradictory they could be, how radically different she could feel and behave. The Carol I saw in the sessions was, for the most part, serious and motivated to remain sober. Carol would come into a session after having relapsed and be quite puzzled or foggy as to why she drank. To discuss relapse prevention with this self would be like preaching to the choir. The self-states that experience the urges to drink needed to be fully engaged in the treatment. Contained in these self-organizations were the

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feelings, thoughts, fantasies, memories, somatic states, and behavior that are intimately bound up with drinking. Gaining access to these selves is a major task in the therapeutic work. As I struggled to understand the emotional context of Carol's relapses and close calls, she became aware of shifts in her self-state during these times. A detailed inquiry (Sullivan, 1954) of these occasions revealed yet another self-organization. Carol told me that she would not only find herself unconcerned about her sobriety and her AA program, but also that her overriding feeling could be summarized as “Fuck it!” I encouraged her to tell me more about this very different attitude.

Carol: “You know, I was thinking about this side of me that is the addict and I thought to myself, even if I had the chance to remove that side of me from myself—I realized I wouldn't do it. I realized that I like the addict side.”

NB: “What do you like about that side of you?”

Carol: “I like the euphoria too much. Not just the euphoria that comes from drinking, that's not what I mean. It's the euphoria that comes from craving, from living on the edge.”
Carol: “I remember this time when I was traveling for business. I was running late to catch my plane and I was driving to the airport. I was speeding. There was this semi in front of me and I could see up ahead that the lanes were narrowing to one. I wanted to pass the semi—I told myself I had to pass it because I would miss my plane if I didn't.” She laughed. “It sounded logical at the time. Anyway, I slammed on the gas, as far as the pedal would go. I pushed the car to its limit. I remember being parallel with the semi, racing it, and then I abruptly swerved ahead of it at the last minute when the highway narrowed. And there would have been no place to go. There was this embankment just beyond where the lane ended. I'd say there was a 50/50 chance of making it. And the crazy thing about all this is that I loved it! I was laughing in the car after the whole thing happened. There was a rationale for my behaving this way so I didn't question it. But now I reflect on it and I think, what the hell was I doing? The rationale doesn't hold up, and yet it seems to at the time.”

NB: “It's almost like there's a deception going on. You hear the rationale and you don't have to question yourself any further.”

Carol: “Yeah, that's true. It is a deception and I just don't see it at the time. And then these experiences just become part of the past.”

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Here, we can observe Carol's experience of seamlessness between dramatically different organizations of self and her growing awareness of the dissociative processes operating in her mind.

In a later session, she told me about a relapse experience. She found herself laughing in the car on the way to the liquor store. I asked about the laughter and she said, “When I think about it now, it seems so strange, because I'd characterize the laughter as evil. Like this part of me was free to do whatever she wants.” I replied, “I don't know if she's evil, but she certainly likes to live life on the edge.” Carol came to realize that this was one of the states connected with her drinking. We learned that this side of her was rebellious and cynical and sought excitement. This was a version of her that would spontaneously call up men with whom she'd had brief affairs, throughout her marriage, and schedule a weekend “road trip” visit consisting of drinking and sex. I have to say that, at this point in my relationship with her, I was stunned to find out about the affairs and the incident with the semi truck. This behavior and even her language (e.g., referring to road trips) didn't fit with this very responsible, conscientious, and businesslike person I met with each week.

In further exploring this side of her, Carol told me that this part of her didn't care about anything or anyone. I asked why this was the case and Carol responded that she didn't know. I then asked her, “Perhaps this other version of you could tell us more. I want to ask her, what do you have against hope?” Carol reacted with a startled look and responded, “It's stupid! I just heard this very clear thought go through my head, more of a voice, after you asked that question, and that was the thought I just had.” “I want to hear more,” I encouraged her, but she said, “It's disappeared. Whatever was there is gone. It's like someone tapping you on the shoulder in a crowd and you turn around and they're gone.” Here is a clear example of Carol's inability to simultaneously hold both self-organizations in mind. The dissociated, alternative self who had the thought, “It's stupid!” is not available for her to reflect on as another part of herself but rather has broken into her
consciousness abruptly and intrusively, an alien invader who comes and goes as she pleases. It was becoming more apparent that Carol was severely dissociative.

Drawing from the work of trauma theorists Braun (1984) and Kluft (1982), I used a modified form of what they refer to as “talking through,” that is, speaking more directly to a particular dissociated self-state. I said the following to Carol: “I want to say something now

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to that part of you who says she doesn't care about anything. I think you do want to talk to someone, maybe even to me, but no one's ever listened before, so why should you get your hopes up now? Well, I want to hear from you because I don't think anyone should be alone with the kinds of dark feelings you've had. I'm here when you're ready.” Carol looked up at me with surprise. “It's weird; I have this feeling of sadness—it just came over me. It doesn't feel like my sadness though. It feels connected to what you just said but I'm not sure why,” she described. In this way, I began to build a foundation for relating to this specific dissociated self-organization of Carol's.

Perhaps for some, if not all, addicted individuals, drinking and drug use are state dependent; that is, a self-state or self-states have coalesced around drinking and using behavior. It would make sense that some alcoholics would be more pervasively dissociative than others, depending on their histories of trauma. In the case of very dissociative alcoholics, the organizations of self involved in drinking may be quite cut off from other self-states. It became increasingly clear that Carol's urges to drink were state dependent and that aspects of her that were committed to sobriety could move in and out of awareness. Carol was dissociative to the point that she could not hold her desire for recovery and her urges to drink in the same consciousness. These contradictory desires were contained in two very different and discrete self organizations. Carol related the following experience.

"I was in an AA meeting the other night. I had gone with a friend, and unfortunately it was a smoking meeting. It was pretty smoky in there, which I didn't like. My eyes were starting to bother me, so I closed them and just started wishing I wasn't there. Then there was this jolt. I opened my eyes, looked around and thought, 'What the hell am I doing here? I don't want to be here. I don't want to be around these people.' And for the life of me I couldn't remember or identify with any reason as to why I'd ever want to be in an AA meeting. I just wanted to leave right then.”

A large part of the work early on with Carol was helping her to become aware of and tolerate a disavowed, very needy and dependent younger self. Whenever this self would begin to become more conscious, Carol would initially experience puzzlement, because she did not identify with the dependent feelings. She told me, “I know there is a sadness and some dependent feelings in me, but I don't feel personally connected to them. It's like some part of me really misses

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you, but it's not me. I just start to feel really agitated and edgy.” Carol's confusion over these dependent feelings would then give way to an impulse to leave her situation—whether she was at work, home, an AA meeting, or whatever—and drive directly to the nearest liquor store. These impulses were embedded in a self quite different from the dependent self. Carol told me it was the more impulsive, “I don't care about anything” self-state. This part of her was utterly unconcerned with consequences, other persons' needs, or her own safety. This side of Carol liked drinking and had no desire for sobriety.

Clearly these were the times that were most dangerous for Carol. We needed to make room for other perspectives to be represented simultaneously so that Carol could at least have an internal argument over the impulse to drink. Although Carol has few childhood memories, another goal of treatment is to begin to link these different self-states to the historical/relational contexts where these selves were created. Over time, the analyst wants to help the patient to link these contradictory selves to irreconcilable identifications and counter-identifications.

It is important to help the patient view relapse and struggles with sobriety as opportunities to begin to experience ambivalence. Bromberg (1995) has described the inability of dissociative patients to experience internal conflict. The patient either experiences one side of the conflict or the other, and when caught up in one side of the struggle, he or she is not aware that another side even exists. After a relapse, the patient shifts to the other side and often has the sense of returning to square one—that all that was gained is now lost—a kind of black-and-white thinking that actually helps to maintain dissociation. Ultimately, we want to help the patient to achieve simultaneous awareness of the side of her that is committed to recovery and the side that wants to drink.

One late afternoon I got a call from Carol. She was sitting at her desk at work. “I'm paralyzed,” she said, a quiet fear enveloping her words as she spoke. “Tell me what's going on,” I asked. “Well,” she chuckled, shifting now, sounding somewhat more relaxed, “what I've been able to make out so far is that one part of me really wants to go drink, real bad. And usually when I feel that, I just go. But this time there's this younger feeling here too—it's a sadness, and it feels like that side of me doesn't want to drink. And I just feel displaced. God,

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I have the worst headache right now. In fact, the more I talk about this stuff with you, the worse it gets. Anyway, I feel like there's World War III going on inside me. The worst part is that I feel like I can't function. I'm just sitting here, unable to work. I'm really paralyzed. I wish it would stop. I called you because I was thinking about drinking just to quiet all this noise in my head.”

The ability to achieve simultaneous awareness depends on several factors: an increased capacity for affect tolerance, symbolic functioning, and reflective awareness, the ability to perceive one's self as shifting into different psychological states as opposed to purely somatic ones, and a capacity to use the therapist as someone who can help to recognize, regulate, empathize, and understand all of one's various self organizations. Having lived for so long cocooned in the insulating layers of dissociation and inebriation, Carol was unprepared to regulate her affective states. One aspect of her, a younger, dependent self was drawn to others and desired the closeness that would help her to contain her intense
feelings. Other self-organizations are not expecting, or necessarily desiring, emotional intimacy. The self-states that avoid intimacy use alcohol to preserve a state of interpersonal isolation. Perhaps these selves are motivated to drown out voices of dependency and hope for connection. The patient may experience the emerging conflicts between self-states as unbearably painful and may want to drink to suppress the conflicts and tranquilize intense emotions. Pizer (1998) contends that addictions are examples of the nonnegotiable because they are essentially nonrelational, serving the purpose of insulating patients from meaningful, affective contact with themselves and others. To quote Pizer, “These persons rapidly deploy ‘action’ defenses to dispel affect upon arrival. They empty themselves of feeling (I assume, through dissociation) and maintain action techniques (the addictions, compulsions, perversions, externalizations) to mask their inner void and hold at bay near-psychotic anxieties” (p. 116).

Relapses may also be viewed as valuable points of entry into the worlds of the selves that drink. Some of the reason these self-states turned to drinking in the first place was their sense that others were not interested in their problems; or if they were interested, that interest didn't last. The identities of these selves may be built around manic

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2 Some have associated headaches with conflicts between alter-personalities in the dissociative identity disorder literature (Solomon and Solomon, 1982; Coons, 1984).

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or action-oriented attitudes such as “I don't need anyone” or “I don't care about anything, including what happens to me.” With Carol, this particular self-organization experiences herself as unseen and neglected and is historically tied to an other who was unavailable and uninolved. The patient will inevitably enact this self-other organization. Gabbard (1992) and Davies and Frawley (1994) have noted that this particular transference-countertransference pairing is one of the first to emerge in work with dissociative patients and must be at least partially worked through in order to access other critical transference-countertransference experiences.

Perhaps my first glimpse of this self-other organization appeared when I suggested the increased frequency of sessions to Carol, and she was instead expecting that I would abandon her. It is likely that others in the patient's life, possibly including sponsors and AA members, may not have any interest in learning about or connecting with the self-states involved in addictive behaviors, thereby helping to maintain the dissociation of these selves. As therapists, it is our ability to fluidly move back and forth between our own self-states, with respect to the patient's, that deepens and furthers the facilitation of the experience of interiority (Slochower, 1999) and the transition from dissociation/enactment to conflict/self-reflective awareness (Bromberg, 1993). Our interest, desire to engage, and nonjudgmental attitude toward the selves that relapse, and our curiosity about why those selves like to drink, will facilitate transitional experiencing, association and linking, and the development of internal conflict in the patient. Davies (1998) refers to this analytic attitude toward the multiple self-states of the patient as a redefinition of analytic neutrality.
However, our interest and desire to connect with patients will cause major disruptions for them because we will inspire hope in some parts of them. Bromberg (1995) observed, “Hope compromises the vigilance a patient relies on to maintain control over the dissociative system,” and van der Kolk (1987) has even referred to traumatized patients as suffering from “disorders of hope” (p. 9). Hope is a dangerous experience because the patient has learned that it is only a matter of time until the other will disappoint him or her, through either abandonment or abuse. Hope threatens to set up the patient for traumatic levels of disappointment that would threaten to overwhelm him or her. In addition, to hope for connection without trauma is to be unrealistic and “stupid,” as one of Carol's self-states put it.

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The continued focus on these different interior states and their impact on her relationships helped Carol to become aware that she had an interior world and that she could embody very different and sometimes contradictory versions of herself. She was then able to maintain a cumulative and sequential memory of her experiences during the week—a foreign experience for Carol, who was accustomed to living only in the present. Now that she had a past that she could think about, she developed a capacity for reflective awareness. This capacity allowed her to experience conflict for the first time, which in turn opened up a space between her impulses and her actions. Gaining this space between her impulses and her actions helped significantly in her struggle to remain sober. “I'm not used to being torn in different directions,” Carol told me, somewhat vexed. “In some ways, I preferred my unconflicted state. Conflicts give me headaches!” In addition, our continued focus on Carol's multiple self-states facilitated the emergence of increasingly disturbing childhood memories, sometimes initially arising indirectly through her dreams and then directly through the appearance of dissociated self-states who remembered and described, abreactively, actual traumatic events.

Conclusion

Although there are many more aspects of treating addictions from this multiple self-state perspective that could be written about, including working in enactments as Director (2002) has, I have limited myself to a few objectives here. In summary, some chemically dependent patients—especially those who are more dissociative—engage in addictive behaviors in specific self-states. These states may be more or less disconnected from states containing the motivation for sobriety and the desire for relatedness with others. This state of affairs raises implications for treatment, including the use of therapeutic dissociation to more directly address those selves that engage in drinking and using. Relapses may be viewed as an opportunity for the patient to explore/facilitate experiences of internal conflict and also may serve as points of entry to dissociated self-states. In this way, we can access crucial self-organizations involved in addictive behaviors and ultimately provide the patient with a relationship.

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that can contain, link together, and integrate all of the various multiple selves.

Recently, Carol told me that she'd befriended a teenager she'd met in AA. “I approached her because you don't often see younger people come to meetings and when they do, they usually don't come back,” Carol explained. She went on, “I was talking to this girl and she was telling me how much she wanted to stop and how motivated she was feeling. But then she said, ‘The problem is that I don't always feel this way. Sometimes I just say, ‘Fuck it!’” Carol looked up at me and smiled and continued, “I told her, ‘I know.’ And at that moment I felt like there was one angry teenager reaching out to another, only at that moment, the teenagers weren't so angry—it actually felt hopeful.”

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file:///Users/manhattaninstitute2/Desktop/Developmental%20theory%20and%20Dissociation%20in%20the%20Treatment%20of%20Addictions.htm


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