A view of chronic drug use that draws on central assumptions in relational theory is proposed. Namely, chronic substance use is seen as being driven by conflicting and unresolved relational dynamics that derive from the early organizing relationships in a person's life. In the case of the substance user, the terms of this conflict find concrete expression in characteristic acts of drug use that serve to perpetuate it through the combined effects of reinforcement and disguise. The goal of treatment is for patient and therapist to find the components of the relational bind that are embedded in the drug use, to reformulate these forces in symbolic terms, and to revisit them in the dynamics of the transference, alongside opportunities for new exchange. Seen this way, the treatment needs of substance users can best be met by a relational model of psychoanalysis, augmented by other approaches needed to address addiction. In particular, the relational emphasis on the role of enactment as a vehicle for the expression of unsymbolized experience, and therefore the source of the phenomena to be analyzed and understood, makes this model especially well suited to substance-using people.

A Handsome young man Searches for the Right Words to describe the way he feels at the outset of his drinking binges. “Sometimes,” he says, “when I'm just about to drink, I feel as if I could swallow the world.”

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This statement captures the larger-than-life appetite that this man allowed himself in fantasy alone. A trained artist, he could almost never do the artwork he said he longed to do. In fact, he had entered therapy for the purpose of understanding the debilitating fatigue that seemed to overtake him whenever he set out for his studio. In therapy, he came to recognize the powerful forces that served as injunctions against his realizing his own wishes in his life. He was the child of a prosperous man and an insecure woman who seemed to have relinquished her own potential to be with her husband. It was no surprise that the patient viewed “living” as a series of calculated sacrifices, made to achieve marital or material ends.

His “self” was not extinguished, though, so much as it was in hiding, as was evident in his dreams, where he often assumed superhuman powers. Dreams seemed to afford him a paradoxical freedom—he came to life whenever he went to sleep—contingent on the premise that they were never going to be. How perfectly, then, did drinking, too, offer him an outlet for conditional aliveness. In his binges, as in his dreams, he could be tireless and powerful, outdoing others in his stamina; seductive and purposeful, zeroing in on a partner and capturing his goal. He could act without pause, without any awareness of the constraints and concessions that real life or relationships imposed. But the patient was drawn to drunkenness both for its empowering and time-limited effects. He could do or be whatever he wanted—he could take in the world—in drink or dream alone.

What drives most people's chronic drug use? As with this man, underlying most compulsive use, and its obvious chemical components, is a relational impasse that finds concrete expression in the act of drug use, that, in turn, sustains it. More than any other symptom, drug use lends itself to an infinite array of possible relational meanings. But, in brief, what are some of the relational appeals that people express in their drug use? In their choice of drugs, specific methods of using, states of intoxication and aftereffects, people enact—among countless other scenarios—demands for power, desires for surrender, pleas for caretaking, requests for sexual license, and longings to be left alone in perfect solitude. The point is that unresolved standoffs between such forces as dependency and defiance, domination and submission, sacrifice and greed (as in the case I've described) drive chronic drug use. These standoffs appear in patients' relationships to their drugs and attain further elaboration through the rituals of their use.

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That is why many substance users continue to use their drugs long after they are able to get pleasurable effects from them: these users are bound to the relational agendas reproduced in their drug use as nowhere else in their lives. This is not to deny the role of pharmacology in addiction, or the potent chemical effects of the drugs that people seek out. The deeper any involvement with drug use gets, the more it is driven by physiological mechanisms, until, in the case of frank addiction, use of the drug becomes a physiological absolute. But the physical forces that propel drug use, and ultimately threaten to overtake it, attain additional value to drug users for their preemptive effects: they keep them, and other people in their lives, from recognizing and resolving their deeper conflicts. That is, the drug, and the act of drug use around it, is a decoy for a matching and equally repetitive bind that the person faces in his life: between opposing sets of needs that are often bound by rigid rules governing expressions of self and conditions for engagement in the drug user's world.

How does the drug often serve as such a decoy? To take an obvious example, all addiction revolves around the experience of “wanting”: wanting to get high, stoned, drunk, wasted. In a sense, addiction can be seen as
a dynamic of “wanting” that has gone haywire. But how are we to understand the relentless “wanting” that seems to drive the user? Is he at the mercy of his drug's effects, as he himself so often believes; or is he susceptible to drug use precisely because (among other reasons) he is beset by another set of wants, inaccessible but even more proscribed, that are rendered so faithfully in the act of drug use, with the added benefit of delivering a punishment at the end? We have long recognized the role of neurochemistry in shaping addiction; it is time to grant the underlying forces of relationship their essential place.

That is why a relational model of psychoanalytically based treatment holds value for chronic drug and alcohol users. This statement may seem surprising on two accounts: psychoanalysis has often been considered useless for active substance users, and substance users have often been judged unsuitable for psychoanalysis. Both assumptions are false, though accepted as truths in the mental health and chemical-dependency treatment worlds. Recent changes that have taken place in the understanding of the psychoanalytic process make relationally informed psychoanalysis an ideal therapeutic venue for drug users. These shifts in psychoanalysis have reversed its previous lack of fit for substance users.

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Any therapist who has spent time working with substance users has heard, first-hand, accounts of the disrepute of psychoanalysis from the standpoint of addicted patients. The traditional analytic stance that emphasized observation smacked of passivity to substance users, and the priority given to etiology over symptoms often left patients' drinking and drug use unattended to. But contemporary psychoanalysis has shifted its style of investigation; as Mitchell (1997) stated, it has moved away from reliance on interpretation and insight as the primary tools for achieving therapeutic change. Rather, psychoanalysis today places emphasis on an analyst's ability to enter into a patient's dynamics, mobilized in transference-countertransference form; together with the patient to arrive at an understanding of these experiences; and, in the process, to find new forms of relating for the patient to trust, in the place of old, constraining patterns (Levenson, 1972; Bollas, 1987; Mitchell, 1988, 1997; Davies and Frawley, 1994; Bromberg, 1998; Hoffman, 1998). In short, today's psychoanalyst is every bit an engaged participant.

How does this development serve the substance-using patient? The substance user tends to be a do-er and acter, and, on technical grounds alone, needs an active approach to feel meaningfully engaged, even adequately “gripped” by the therapeutic process. But, on another level, it is precisely the substance user's recourse to action to express conflicting relational needs that is the target of treatment.

Reliance on action is a cornerstone of the drug user's characterologic makeup (Wurmser, 1977, 1978). It is typically this reliance that has earned him disfavor with psychoanalysts, whose work depends so on reflection and delay. Action serves many purposes for the substance user, but it is usually its defensive function that has been highlighted by theorists. In this view, as articulated by Wurmser, action gives the drug user a powerful alternative to, or, more accurately, means of flight from, painful affects and inadequate tools of symbolic expression. Drug users are notable for limitations in their symbolic functioning: Wurmser termed their difficulties “hyposymbolization,” describing deficits that range from a specific inability to recognize and label feelings to a more sweeping failure to engage in fantasy or exploration of their inner lives at all. In such a view, again elaborated by Wurmser, action serves as a special form of externalization, offering the person its magical, problem-solving properties and the appearance of narcissistic control.
But if, instead of emphasizing its defensive role, we view action as the vehicle substance users have for communicating un symbolized experience, then it is to their actions we must look for the initial outlines of their conflicts. Drug use is then far from unwelcome in undertaking analytic treatment of a substance user. It is the signature act of such a patient and, as such, contains the components of his unconscious and as yet un symbolized life; it is the starting point of treatment. The intended course of that treatment would then be for analyst and patient to begin to uncover the relational deadlock embedded in the drug use. Their aim is to discover that deadlock anew in the dynamics of the transference, often at first still involving instances of drug use, and eventually to locate it within the organizing relationships of the patient's early life, ultimately replayed and addressed free of reference to drugs, within the experience of the treatment relationship. In other words, the aim of therapeutic action would be to track, and deconstruct, the symptom from its extrapsychic form, concretized in drug use, 1 to its intrapsychic life in the patient's object relations (Boesky, 1982).

It is here that the needs of the substance user and the current state of psychoanalytic practice converge. Enactments, whereby patients draw their analysts into jointly realizing fantasied aspects of their object relations, play a recognized role in analytic practice today. Though theorists of various schools differ in their understanding of enactments, view of the analyst's role, and sense of their therapeutic value, there is general agreement in the field that enactments are inevitable manifestations of transference-countertransference forces at work in the analytic process (Ellman and Moskowitz, 1998). In relational theory, in particular, enactments are regarded not only as unavoidable, but also as the central medium of the work. They are the means through which patient and analyst are afforded the opportunity to revive old relational patterns jointly, as well as to reopen them to observation, understanding, and possibilities for change within the analytic relationship (Mitchell, 1988, 1997; Davies and Frawley, 1994; Bromberg, 1998; Hoffman, 1998; Black, accepted).

By placing enactment at the heart of analytic work, relational practitioners have opened the door of psychoanalysis to substance-using patients. This is so for several reasons: first, enactments provide substance users with a mode of communication tailormade to their needs to actualize, rather than reflect on, inner experience (Boesky, 1982). More important, enactments are a conduit for experience whose transitional properties uniquely serve the substance user—offering not

1 Concretization in drug use has been identified by Wurmser (1978, p. 147), who places it within his larger discussion of externalization.

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only a bridge between the patient's symptomatic behavior outside the consulting room to his conduct within
the treatment, but also, more generally, a bridge between action and meaning, drug and object, act of drug use and underlying relational needs. In theory and approach, then, the relational model provides the basis for the desired course of treatment for substance users that I have outlined.

To be sure, no treatment of substance users could be effective by attending to the relational underpinnings of drug use alone. Chronic drug use is a dangerous and potentially life-threatening problem; however derived, it nonetheless is sustained by the powerful pharmacological effects of drugs and the operation of the laws of conditioning on people's behavior. Any therapist working with substance users must have a working knowledge of a range of ancillary treatment modalities commonly needed during the course of their treatment. Such approaches include use of cognitive-behavioral interventions, referrals to residential or intensive outpatient programs, support for participation in 12-step programs, use of toxicology tests, and use of pharmacotherapies designed to counteract or inhibit drug effects (for example, disulfiram for alcoholics, naltrexone for opiate addicts). Purely speaking, then, any treatment of active substance users is, by force, integrative in practice, if, ultimately, psychoanalytic in design. But, if appropriately used, such supplementary therapies do not necessarily compromise the analytic task; in fact, it is my argument that the particular tools summoned during the course of any one patient's treatment are—like his drug use—uniquely customized to fit his relational needs and are therefore best understood within a psychoanalytic framework.

Literature Review

Psychoanalysis has produced a rich, if circumscribed, body of work about addiction, reflecting different schools of thought and their particular persuasions. A selection of these authors, while not complete, is presented here to offer a sampling of the various formulations that shape analytic understanding of addiction today.2

2 Morgenstern and Leeds (1993) provide an excellent, in-depth review of the analytic literature on addiction.

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Wurmser's work (1977, 1978, 1984) offers a contemporary view of addiction that is faithful to the classical tradition by locating the source of chronic drug use in intrapsychic conflict (see also Morgenstern and Leeds, 1993). Specifically, Wurmser places greatest emphasis on superego pathology. While it is impossible to render Wurmser's comprehensive work in a single, formulaic line, it is fair to say that, in his view, the drug user suffers from a crippling superego that is relentlessly on the attack and drives the user to drugs for desperately needed surcease (L. Wurmser, personal communication, January 12, 2000).

Besides offering broad views of the psychopathology of chronic users—which he sees as severe and borderline in nature—Wurmser (1977) breaks down the typical psychodynamics that underlie individual episodes of drug use. In his analysis—itself a classic in the addiction field—the drug user, already weakened by unworthiness and attendant affects like shame, suffers a precipitating narcissistic crisis, causing a drop in self-esteem. He is overwhelmed by feeling, experienced as unbearable tension, which he is driven to escape
through pursuit of drug relief. The climactic act of drug use, with its euphoric effect, serves as a narcissistic triumph, not only because it undoes the initial blow, but also because it entails “abolition of the superego, which gives enormous relief” (L. Wurmser, personal communication, January 12, 2000).


Khantzian feels that drug users suffer from “vulnerabilities” in personality organization, consisting of deficits in ego function, or, subjectively considered, in capacities of the self (see Khantzian, 1981, p. 164, for a discussion of the terms he uses). He identifies four main areas of ego function that are deficient in drug users and that, he believes, they use drugs to redress: affect tolerance, self-care, maintenance of self-esteem, and management of relationships. Khantzian (personal communication, January 19, 1995) gives special weight to the role of affective distress, or poor self-regulation overall.

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in predisposing people to drugs. In fact, Khantzian (1985) coined the so-called self-medication hypothesis, proposing that drug use is essentially an effort at self-cure of painful affect states through addicts' choice of particular drugs for select, sought-after effects. Self-medication is a widely accepted theory in the field, and, because it is so experience-near, it is often used by patients in their efforts at self-understanding.

The narcissistic fragility that is often seen in people who turn to drugs beckons understanding by practitioners of self psychology. Indeed, Kohut (1977) saw the addict as suffering from a central “defect in the self” (p. vii). This gap in “psychic structure” (p. viii), according to Kohut, is the result of inadequate environment and selfobject function early in development. Thus, Kohut reasoned, the addict seeks the drug as a “substitute for a self-object” (p. vii) with which he can symbolically achieve feelings of acceptance and merger.

Krystal (1977), too, identifies a “basic defect” (p. 91) in the personality dynamics underlying addiction, but he differs from Kohut in the way he sees that defect. To Krystal, the drug user labors under prohibitions against exercising certain functions—for example, capacities for comfort or assertiveness—that are associated with the maternal (or paternal) object. So the user does not access capacities that are theoretically within his reach, but that remain unavailable because the user regards them as reserved for the object. The act of taking the drug works, in Krystal's view, not only because of its chemical effect, but because it serves as a “placebo” (p. 93) that allows for “lifting of internal barriers” (p. 92) between self and object representations; thus the user can lay claim to functions, and act in ways, that really are his own. This formulation by Krystal beautifully captures a current in self-other conflicts often seen in drug use and is an important entry in the realm of object relations views of addiction.

These perspectives on addiction—and others representing classical, ego, self-psychological, as well as object relations, schools of thought—each offer valuable insight into the psychodynamics of drug use. The different phenomena they highlight often coexist, making drug use an “overdetermined” problem (Moskovitz, 1993; Levin and Weiss, 1994). Moreover, theorists of different schools seem to share certain common views of the
function of drug use (Morgenstern and Leeds, 1993). All see the drug as an aid in affect regulation and in the maintenance of self-esteem (Morgenstern and Leeds, 1993). And, clearly, it does not

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require access to scholarship to recognize that drug use often fills social and affiliative needs.

This paper is intended to advance relational formulations of addiction and their utility in guiding clinical practice. While it is true that reliance on a drug may serve as a substitute for other ties in a person's life, that is not my point here. Rather, I am suggesting that chronic drug use, and the individual act that propels it, holds the user in its grip because it captures dynamics that derive from the early relational matrices of his life that remain unresolved. Such a view goes beyond seeing drug use as serving to replace relationship, or as recreating a particular strand in self-other conflict, as some object relations theories suggest (Krystal, 1977; Seinfeld, 1991). A broader relational view of drug use, as I am proposing, allows for the uniqueness of the bonds and patterns of interaction that shape the early psychic lives of drug users and ultimately determine the variability of drug use that is found among them (Mitchell, 1988).

**Case Illustration**

I met Dr. C, a surgeon in her 30s, when she entered a group I was running at an outpatient facility following her stay in a residential drug treatment program. Intensive outpatient groups for substance users are organized around the task of strengthening sobriety by teaching patients concrete skills to manage drug-related situations and urges. Dr. C stood out in this setting for her quick intelligence and composure: she always came to group well-prepared with her plans and spoke calmly and articulately; she was able to mingle easily with others. Her appearance was equally impressive: she was pretty and well-groomed, always stylishly dressed. As both a patient and a woman, she seemed model in her effect.

Who would guess that underneath her exterior looks and poise, Dr. C was a woman with a history of extensive intravenous drug use, entailing injection of opiates, benzodiazepines, and barbiturates in hidden areas of her body; her repeated injection of some veins had left bruises that required makeup to cover them over.

The raw details of drug use often belie appearance, and such was the case with Dr. C to a startling degree. The incongruity of drug use

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and appearance seen in many substance users can be explained, from the standpoint of the law, as a simple result of illegality: people have to go into hiding—on their bodies and in their lives—simply because their use of drugs is illegal. Seen from a psychological perspective, this same incongruity of drug use and appearance can be understood as a function of dissociation. Dissociation, which often figures into the
personality organization of substance users, accounts for the dramatic contradictions encountered in their identities: we have all heard, or sadly read, of junkie cops, alcoholic clergy, lawmakers who get “busted,” and addicted physicians. It is not their drug use alone that makes the lives of drug-addicted people so compelling and therefore easy fodder for sensationalist headlines; it is the polarization of personality in their lives, often seen in stark clashes enacted between forces of good and bad, duty and lawlessness, integrity and dishonor.

In Dr. C's case, the pressure to look good came from several sources. Helena, as I will call her, was the eldest of three children of Greek immigrants, who, in many ways, had realized the American dream. Helena's father was the hardworking owner of a diner; her mother, a homemaker who took care of the children and helped manage the finances. All the children attended college; Helena, exceptionally gifted, went to medical school, her decision to become a doctor a tribute, in some sense, to her parents' sacrifice and efforts.

But her parents' rugged, old-world ways also left their mark on Helena, by her account. She portrayed her father as a dominating man, accustomed to deference as the head of the household, but granted it partly out of the family's fear of his temper. Helena recalled with terror the occasions when her father became furious with his children, and she and her brothers tried to run down the hall as he came after them with his belt.

Helena's mother, a woman of considerable intelligence and love for her children, seemed to have forfeited her own potential to serve her family. Helena felt empathy for the way her mother's capabilities largely went unrealized. It seemed as if caretaking and womanhood were her proven areas of prowess, and there her mother exercised her authority. Helena was filled with a sense of her mother's scrutiny, experienced as a child as omnipotent and penetrating. She evoked the impact of her mother's expectations and attention when she recalled how she was able to sit quietly as a child, for long periods of time, with her hands neatly folded in her lap as she awaited her parents during a family visit to the neighbors. Now an adult, Helena often feared her mother's judgments of her own efforts as a homemaker. According to Helena, her mother could notice traces of dust on the floor. Helena worked hard to eliminate her mistakes or, at least, to ensure that they went unnoticed.

So Helena fashioned a flawless exterior not only in an effort to win others' approval, but also to defend against their attack or against their ability to “detect” her real self at all. She assembled a false self—“the building of a fortress,” she later called it—in various ways. The earliest tool she acquired, by her description, was her ability to lie, which, in time, had become so practiced a part of her personality that, like many substance users, Helena felt as if she herself had at times lost track of the truth. Her drug use was a later addition, which acted as a sealant in her false self, layering on another construction of behavior and deception that ensured that the world would never see, let alone reach, the real person underneath (L. Wurmser, personal communication, December 23, 1996).

There was a haunting quality to Helena's polished presentation, given the seriousness of the circumstances in her life. The setting of a large group did not offer much chance to address this effect. But Helena eventually had another crisis that brought about changes in her life and led to my long-term individual work with her. Following a lengthy leave to secure her sobriety, Helena tried to resume her work as a surgeon. Not long after, she relapsed to drug use; this time, she resigned her position.
Individual psychotherapy permitted a new depth and direction to Helena's treatment. The early stages of our work together entailed education to redirect Helena's focus from the external events of her life to her own thoughts and feelings, a step important to take in any drug treatment to help patients make the connection between drug urges and inner experience; exploration into Helena's relationship to her family; and inquiry into the history of her drug use. Regarding this last, and central, thrust to our work, Helena was like many substance users in professing little understanding of her drug use. Her relative ignorance and dread of her inner life—dubbed “psychophobia” by Wurmser (1977, 1978), who found this a common trait in substance users—was itself a condition that fed her addiction by keeping her in blind thrall to the power of drugs. Broadly speaking, then, it can be said that the disarming of addiction begins with the emergence of psychological-mindedness.3 More specifically, with Helena, as with any substance user, dynamic treatment of addiction rested on reaching an understanding of the unique meaning and function of drug use in her life, with the hope of helping her find healthier ways of meeting essential needs.

Why was Helena using drugs in the way that she was using them? In our inquiry into this question, it became clear that Helena's use was multiply determined, illustrating several theories discussed earlier in this paper. From the standpoint of environment, as a physician Helena had both access and supply, conditions necessary for any repeated drug use. Helena often attributed the escalation of her drug use to her early training as a surgeon, where not only were drugs available to her, but conditions were so demanding that use of drugs seemed to offer the only means of quick relief.4 Illustrating Khantzian's ideas, Helena also used drugs to medicate other intolerable feelings, especially for her, states of agitated distress or outright rage. Additionally, Helena's use of drugs demonstrated Wurmser's central thesis—Helena seemed to use drugs in an effort to escape a constant sense of doing wrong, originally acquired from her parents, now reawakened by her training and other relationships in her life. In this respect, her use of drugs proved, at best, a compromise solution (Wurmser, 1977), offering her as it did immediate relief, but assuring that she realize “defectiveness” all the same.

In other ways that drew our attention, Helena's drug use did not conform to prevailing theories. During her peak period of use, Helena drew from a wide range of drugs, including benzodiazepines, barbiturates, and opiates. This was unlike the tendency of most substance users to gravitate to a single, specific drug—a pattern first named the “drug-of-choice” phenomenon by Wieder and Kaplan (1969), who understood it as the discovery of a “match” between a chosen drug's chemical effects and an individual's preferred style of conflict solution. In Helena's case, while she clearly favored drugs drawn generally from the sedative-depressant class (and avoided stimulants, for example), the drugs she used produced a wide array of

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3 Morgenstern and Leeds (1993) make a similar point, using the same term, in their discussion of substance users’ difficulties with introspection.

4 One reason Helena granted permission to use her story, in disguised form, was to communicate the point that physicians are not immune from serious problems like addiction; because of their profession, they may even be more susceptible to them.
effects, ranging from states of euphoria to quiet calm, wakeful dissociation to actual sleep. As she reviewed her use, it seemed that she had ruled out drugs if they had adverse effects on her work as a surgeon—say, of nausea or lingering sedation—as opposed to having chosen them for a particular form of mood alteration.

What all her drugs delivered, regardless of high, was an effect that overpowered her; her experience with all of them was of “giving way” to something “taking over,” a sensation that was heighted and conveyed in visceral form by her method of intravenous injection. She could feel the drug advancing in her system and her body inexorably succumbing. Whether the drug delivered a state of elation or a blunter plunge into unconsciousness, the effect she sought was one of submission, at times accompanied by a feeling of defeat, at other times sublime. This was also seen in the state she sometimes achieved, of passing out from the administration of her drug.

The interplay of force and capitulation figured in several relationships in Helena's life. Beyond her obedience to her parents, Helena often spoke sadly of her parents' ties to one another. While her father seemed ostensibly to dominate her mother and to discourage her from activity outside the home, to Helena, her mother won a stealthier triumph by making herself so indispensable to her husband that he was helpless without her. There was little intimacy between them, or even shared enjoyment, in Helena's eyes. It was as if mutual subjugation had taken the place of love in their life, her parents acting more as “wardens” of each other than as loving husband and wife. Helena herself had had similar relationships. She often found herself drawn to men who exuded a surface strength, only to find herself later taken advantage of in ways that left her feeling subservient and trapped.

To return to her psychotherapy: a number of momentous events shaped Helena's life at this time. First, there was her professional crisis. Simply put, Helena did not know whether or not she could ever practice surgery again, because it granted her access to powerful drugs. This grave question hung over her life, and she remained unemployed for a long time as she tried to face the implications of her drug use on her chosen career. This was not a matter of private soul-searching alone. Hospital administrators had reported Helena to a state agency that monitors the professional practices of health professionals and permits physicians who have been identified as impaired to undergo treatment in lieu of facing disciplinary charges (for example, loss of license). Helena asked me, as she had all previous treating professionals, to report on her compliance with treatment to this state agency, so that she could maintain her contract with them and preserve her professional standing; I agreed.

A few comments are in order about the nature of this reporting obligation. The agency that oversees the treatment of impaired physicians in this state requests reports from treating clinicians on the physicians' attendance and overall “progress.” Where drug use is involved, inquiries into progress usually entail inquiries into the stability of sobriety. Broadly speaking, the agency is seeking a gauge of the physician's overall safety.
so as to protect the citizens of the state. However, in this case, just as clearly, considerations of the public good are at odds with those of the individual patient, for whom confidentiality is necessary if his treatment is to be therapeutically sound. Even in cases where relapse does not actually occur, substance-using patients need to express drug urges freely, without fear of professional threat or therapeutic betrayal. In Helena's case, to complicate matters, there was no denying her request that I report, without declining to treat her altogether; for the only initial incentive for her to seek treatment—as is often the case for physicians in her circumstances—was to satisfy the mandate of the state.

A solution to this bind would be to separate the treatment process from the reporting apparatus. To do this, the regulatory agency involved, in this state and others that operate in kind, would have to create a separate position in its protocol for a “recovery coordinator” (see Gabbard and Lester, 1995). The “recovery coordinator” would be another clinician, whose only role would be to monitor the physician's efforts at recovery by meeting regularly with the patient and collecting other data, such as urine-test results. If verification of the patient's treatment is required, the therapist's report could then be confined to attendance alone. Although such a design could pose practical problems in some states, it would have far-reaching clinical value for its protection of treatment confidentiality, and promotion of honesty and trust.

To resume Helena's narrative: the potential loss of her identity as a surgeon was a devastating blow. Helena's rise in the field of medicine had been double edged. On one hand, Helena felt that it was the autocratic stamp of her training itself that had contributed to her feelings of enslavement, which, in turn, had fed her use of drugs. On the other hand, Helena freely acknowledged the pleasure she achieved from her work and special status as a surgeon. Grandiosity aside, Helena enjoyed true feelings of mastery as a surgeon; the work relied on a set of skills that she knew she had—information retention, resourceful problem solving, task performance. Although she would later recognize that her own unconscious conflicts about success had figured into her professional undoing, for now, the loss of surgery left a huge narcissistic void.

Partly to fill this void, and to defend against the larger crisis around her, Helena proceeded to adopt a child. During an earlier interlude of sobriety, she had made arrangements, through a foreign country, that were final when she first entered my group. Knowing nothing about her at the time, except the circumstances that had brought her into treatment and that she lacked a partner, I reacted to her plans to raise a child with feelings of bewilderment and impotence. Impotence is a mainstay of countertransference in psychotherapy with substance users, not only in response to their incidents of drug use but, on a deeper level, in response to the omnipotence that is at the heart of many of their actions. One often finds oneself standing on the sidelines with these patients, watching helplessly as they act boldly and broadly in ways that may irrevocably change their lives.

“I wouldn't be alive if it weren't for my child,” Helena said on one of the countless occasions, later in our work, when she tried to make sense of her choice to bring a child into her life, when she did. It didn't even qualify as a “decision,” Helena admitted, so much as it was a desperate act of survival to fend off the shame and depression she suffered at the loss of her career. Yuri, a spirited boy of three by the time Helena started individual psychotherapy, gave her a reason to live, filling her life with a sense of purpose she had lost with her professional suspension. But Yuri, brought into her world to save her, soon posed a threat to her sobriety...
in a number of ways.

Helena's choice to bring a child into her home opened the door to her parents to reenter her life. As a single parent, she needed their help but was unprepared for the other effects of their involvement. To Helena, her mother often seemed critical: she disapproved of Helena's permissiveness, for example, if she allowed Yuri full rein to his exuberance, as he ran around the house; or she chided Helena for her carelessness if she let Yuri go out with a cold. To Helena, her mother's stance of superior knowledge had the effect of “stealing her identity,” in this case of a competent new mother.

Moreover, as a single parent, Helena found she had a new oppressor in her life: her own son. Helena soon began describing herself as her son's “slave,” subject to his constant demands. She especially experienced her son's naptimes as a “trap”: when Yuri was asleep, she was not even free to leave the house. More and more, it seemed, single parenthood approached a state of “solitary confinement” to Helena.

Finally, in this recounting of the impact of events on Helena's fragile mental status at the time, there was also the “event” of her involvement in psychotherapy. Helena responded uncertainly, at first, to the intimate format of psychotherapy as if she were deliberating how to approach an alien medium and task: she often recited portions of her drug history as if she were uttering the kinds of testimonials she had grown familiar with at A.A.; or she detailed her activities to me in busy speech, a style of communication that we later came to call “chattering.” When she gradually allowed herself to enter into a relationship with me, it was clear that the therapeutic alliance offered her support in modulating painful affect. As earlier noted, drug-dependent people lack a capacity for affect tolerance; early in sobriety, when denied recourse to drugs, they can derive critical benefit from this holding function of the treatment relationship (Krystal and Raskin, 1970; Wurmser, 1977, 1978; Khantzian, 1981). As Helena was contending with depression and shame that felt “barely bearable” to her, she was helped by reliance on therapeutic contact. (At this and other times, she also tried antidepressants, which provided some, albeit insufficient, relief.)

She also turned to the therapeutic relationship to find refuge from the state of parental “surveillance” she felt she was living under. One can imagine the concern of Helena's parents, given her history of chemical dependency and circumstances of unemployment; yet it felt to Helena as if they were using her misfortune to “insinuate” themselves into her life, “under the guise of helpfulness.” She often came to session bearing painful accounts of perceived intrusiveness on their part that left her feeling “defective”; communication with me served to restore validation. “I'm so glad I can talk to you,” she would say. In this way, the unfolding of the therapeutic relationship offered Helena chances at authentic expressions of self, a basis for intimations of trust, and the beginnings of a new sense of competence built out of her growing command of psychotherapy itself.

At the same time, however, the process of drawing closer to me inevitably stirred the very feelings of danger from which Helena was
seeking protection. Who was I, and what could I do to her? she wondered with wary precision, as she told me of her efforts to size me up. Alongside our emerging alliance, there was also, in the transference, Helena's growing fear of me as a powerful and possibly duplicitous caretaker who could be profiting from her misfortune to secure a position of advantage over her through my help and expertise. Whereas Yuri afforded her parents leverage, in my case, it was her very psyche that was up for grabs—and there was an ever-present risk that Helena could hear my observations as superior pronouncements on the “defective” state of her functioning. I, too, could “steal her identity” as a capable person by proving her to have failed yet again in her life, in this case, at her own psychology. Moreover, Helena's concern that I could “do” something to her was not a mere paranoid perception; it was based in fact, designed into the very contract between us, as she had engaged me not only to provide psychotherapy but to report on her treatment status to a state agency. In the face of all this, another indignity, to Helena, was that psychotherapy had denied her use of the very tools she had resorted to in the past to protect herself from authority, namely, dissembling and drug use. “You took away my lies, and that was how I was powerful,” she said in one of the many angry accusations she directed against me and the treatment process for stripping her of the means to defend herself, which left her in danger of feeling exposed and overmatched.

Transference is the enemy of sobriety: so say many adherents of a traditional approach to alcoholism treatment, which maintains a strong, early focus on behavior and steers clear of deeper exploration (see, e.g., Vaillant, 1981). To such practitioners, a patient in early recovery is believed to have so tenuous a hold on his sober functioning that all “uncovering” approaches to psychotherapy are viewed as dangerous, and to be avoided, or, at least, significantly delayed, and treatment kept to a tightly structured course. It is true that the therapeutic relationship poses a possible threat to sobriety. This is so not only because the affective intensity of transference challenges a patient's sobriety—as it does any patient's equanimity, outside of the issue of drug use—but because the treatment relationship mobilizes the selfsame hopes and threats that occasion the solution of drug use everywhere else in the patient's object world. This development is not only impossible to avoid—as it is impossible to “shelve” transference in any treatment relationship—it may be misguided to try to do so, even when the task of addressing transference is as weighty.

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as it is in cases of serious use. For the patient's warring responses to significant objects, and corresponding experiences of self, are the heart of his drug problem, and the phenomena to be treated and addressed.

So, for Helena, I was both potential new ally and persecutory threat; empathic listener and seer equipped with the evil eye (Wurmser, 1995); facilitator of her growth and oppressor intent on her enslavement. That psychotherapy itself becomes the carrier of the patient's problem, as well as of its potential solution, is seen as inevitable in psychoanalysis proper and as the basis for therapeutic change (Mitchell, 1993, 1997). It is no different in analytic work with substance users, notwithstanding that their response to distress, or even the more benign state of ambivalence, includes the possible impulse to use drugs. To be clear: one never undertakes work with substance users blind to the likelihood of relapse, including that occasioned by the treatment process itself. One anticipates it always and joins forces with the patient to identify the unique set of personal conditions—in or outside treatment—that prompt drug thoughts and usage, in the knowledge that this set of conditions constitutes the core of his addiction; tackling it is the point of the treatment process. One
can, and must, manage drug phenomena as they arise, but one cannot tactically foreclose them, any more than one would banish tearfulness or suicidal thoughts in a patient seeking help for depression (Rothschild, 1998).

To return once again to Helena: it was against the backdrop of the loss of Helena's job, challenge of parenthood, and experience of psychotherapy that I began to suspect that she was drinking. As with her drug use, Helena did not drink in moderation; she had used alcohol to excess on various occasions in her life and realized states of drunken indisposal. It was for this reason that she had made a commitment to total abstinence; it was also one of the terms of her contract with the state agency that was upholding her license. Nonetheless, signs of her possible drinking appeared: she missed appointments to undergo the urine tests that were required of her by the state; a brother contacted me to relay his own belief that she was drinking. To every direct question I ever asked Helena about whether or not she was drinking or engaging in any other form of drug use, she always, and without exception, denied it.

How does one describe the effects of the doubt and disbelief that arise in work with certain substance users? In such cases, suspicion enters the room like a fine spray that seeps into therapeutic awareness and silently heralds the likely presence of drug behavior. Ultimately,

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Helena engaged in an episode of excessive drinking that involved her family, who reported it to me themselves. Helena drank a pint of vodka one night and phoned members of her family, who converged on her home, found her impaired, and “took over” the job of tending to her and her son. Though she experienced a blackout that evening, when I confronted her with this account, Helena admitted that she had returned to drinking, often heavily at night, and on occasion in ways that interfered with her care for her son. As a result, I rereferred her to an inpatient drug facility, where she restabilized her sobriety. When she was discharged I referred her to a psychiatrist to start her on the preventive step of taking Antabuse. I also referred her and her son to a child psychologist to give Helena support in her caretaking responsibilities and to provide added supervision of Yuri. I spoke to Helena about her need to meet a high standard of sobriety as a single mother of a young child. I reminded her of my reporting responsibilities in this area, of which she was already aware as a health professional herself.

What was going on? As Helena and I explored her drinking, she related that, at the height of her use, captured in events, she felt as if she were saying, “I give up! Go ahead! Take over my life.” To her, she was merely conceding the inadequacy that the world expected. An air of defeat accompanied her relinquishment—of responsibility, as others assumed control, and of consciousness, as she herself gave way to the effects of her drugs.

Yet this relapse, like all others in its endpoint of weary failure, had happened just as she and I were making gains in forging a therapeutic relationship, and she herself was achieving success as a sober person and newcomer to self-awareness. Why damage that? It was precisely because she and I were creating an environment that could invite genuine expressions of her self and loving connections to others that she seemed moved to destroy it. It was as if, on a deeper level, the
5 When heavy drinking interferes with memory function, the effect is called a blackout.

6 Antabuse (generic name: disulfiram) is a medication that interferes with the body's metabolic breakdown of alcohol, causing a person to become sick if he or she drinks. Strictly speaking, prescribing Antabuse to a person with a drinking problem is an example of aversion therapy. The medication is widely used in alcoholism treatment and is sought by some patients as a device that helps them reinforce their own motivation not to drink.

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prospect of uncovering her true self and allowing herself to be known were an experience she both wished for and feared, the latter response serving to mobilize defense, which, in the case of drug use, ensures certain defeat.

Emmanuel Ghent (1990) has written of the wish to surrender—that is, the wish to be known and reached in one's undefended nature—as a longing that is often opposed by its perverted “lookalike,” submission. In Ghent's theory, the wish to give up one's “defensive superstructure” and give oneself over to the unmediated recognition of the other is a universal need that evokes both desire and dread, because of the original threat it revives. Masochism appears, in Ghent's view, when the wish for surrender miscarries and one settles for an exciting, but mistaken substitute, giving oneself over to the certainty of others' control rather than to the possibility of their trust.

This formulation fit Helena: on the threshold of new possibilities in her life, she faced an unconscious choice between opposing expressions of self and their differing relational ends. She could embrace the moment and make a leap of faith (Eigen, 1981; Ghent, 1990) by yielding to the unknown and entrusting herself to the safety of others; or she could falter and fall back on defense, to fulfill her wish in part by delivering herself into the hands of others. For Helena, relapse was an act of renunciation, a giving up and giving herself over to the familiar dynamics of submission, as seen in her interactions with personal and professional caretakers and encapsulated in the act of her drug use itself.

Of course, for Helena, submission had a ready home, given its antecedents in her early ties. In the context of her family, to capitulate brought a clear benefit in the form of guaranteed care. Her family rushed in, and Helena admitted feeling “embraced” by their swift and certain response. This experience was reproduced in her treatment, as her hastening drug use pulled for, and necessitated, an ever-more aggressive response. At this moment in her treatment, the number of compulsory monitors and measures in her life continued to mount and now included me, the state, a psychiatrist, a child psychologist, urine tests, and Antabuse. In short, Helena seemed to solicit force and an environmental response that bordered on brute management.

It is important to note that this bid for force is characteristic of many substance users. In fact, the practice of addiction treatment is marked by its reliance on intrusive surveillance (e.g., urine tests) and other aggressive measures, ranging from the routine use of

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confrontation to the outright step of incarceration. The imposition of restraint, standard in drug treatment, is justified as a necessary response to addicts' loss of control. In light of this discussion, it is interesting to consider if forceful intervention plays another possible role with substance users: does it satisfy the need for a sadistic response, evoked by some of these patients in their recourse to masochism, underlying their drug use, in the manner suggested by Ghent? Ghent, borrowing from Winnicott, also suggests that such patients' need for sadistic objects may stem from their early exposure to impingement, which serves as a model for all their subsequent experiences of care. In this way, the institutional use of external controls, common in drug treatment, may, at least in some cases, serve as a quasi-sadistic apparatus, satisfying some patients' need for contact in the form of abrasiveness and force, rather than in terms of tenderness and love.

I certainly found myself entering into states of grim resignation, as Helena's escalating use drew me into an ever-firmer stance. At such times, any possibility of our using our knowledge of her history and our own shared experience in treatment to make events meaningful, gave way before the drivenness of her drinking. This is what distinguishes analytic work with substance users from other kinds of patients: the pace and use of understanding, or negotiation, simply cannot keep up with the press of drug use once the addictive process sets in. That is partly the point of drug use. Drug use—and, some would say, the masochism it serves—is an instrument of omnipotence, giving people the power to dictate the terms of object relations in their lives (Stolorow and Lachmann, 1980; Novick and Novick, 1991, 1996; L. Wurmser, personal communication, December 23, 1996). So, while I was the one ostensibly taking charge, issuing Helena a series of behavioral decrees (go to rehab, take Antabuse), I felt very much as if she were controlling my every move, forcing me to forgo my analytic function and assume the position of peremptory boss. Even making this interpretation, in the face of her mounting relapse, felt like flailing at a train. The truth was, Helena was never more in command than when she was using, constraining each of us in her life into preordained roles.

Sadly, it did not seem possible to interrupt this dynamic, in the hope of unpacking it, until its terms were complete. Shortly after Helena returned from rehab, I began getting phone calls that she was drinking again. Family members reported seeing her intoxicated and expressed renewed concern for her son. As these calls came in, to me...
child protective services. Though others working with her volunteered to take this step, I knew the report had to come from me. I felt the assigned obligation because of my place in Helena's life: I had to be willing to be the bad object for her, to knowingly invite her anger and hate, to be a new object for Helena. In fact, both my caretaking roles lined up alongside her in the act of making the report—for not only was I the one to report her inadequate caretaking during instances of her drinking, I also advocated on Helena's behalf to ensure that she retain custody of her child and remain in treatment where she was.

Helena was distraught when I informed her of my intention to report. I did not know if she could continue with me. Her distress gave way to rage and defeat, both of which gave her a target and, perhaps, some reason for her return. “I have to hate you,” she stated in the aftermath of the report, “so that I don't hate myself so much, I kill myself.” Periods of icy anger were replaced at other times by lifeless acquiescence, now fully realized to me: to ensure her sobriety, I now required Helena to undergo observed urine screens and Antabuse administration several times a week. And, while I had succeeded in convincing child welfare authorities to preserve her custody of Yuri, that disposition was contingent on her continued treatment with me. In short, I seemed to be in total control of her life. But who wanted to be, and who was really sovereign? I now wielded an authority I felt I had had no say in

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assuming. And, while Helena was mortified by her display of maternal “failure,” what did it say about me as a psychologist that it was during her work with me that she had been driven to such an end? Although I realized that Helena, by her use of alcohol, had succumbed to relational forces now also at play between us, I was filled with questions about my own efforts, given the results she had achieved.

There we were, then: both brought to our knees, singed alike by feelings of exposure, and now seemingly bound together by decree.

How did we extricate ourselves? Helena and I were able to work our way out of our fated bind (Levenson, 1972; Mitchell, 1997). But that was not the only determinant of change. Several other experiences contributed to her growth, not least of which were her own openness and courage.

Sobriety itself was most instrumental. Volumes have been written about the effects of sobriety; discussion of its therapeutic properties overall goes beyond the scope of this paper. But, for the purposes of this discussion, one aspect of Helena's move into sobriety needs to be singled out for its far-reaching effects on her dynamics. “We admitted we were powerless over alcohol,” state A.A. members in the first of the 12 steps. This admission, which guides people into sobriety, also initiates them into the dynamics of acceptance and positions them to accept other truths beyond the fact of their own addiction. Ghent (1990) spoke of acceptance as another way that people face the opportunity to surrender—if they can “surrender to ‘what is’” (p. 127), that is, to the realities of their own perceptions of themselves and the significant objects in their lives.

Helena was not, in truth, “defective.” As she came to see this, she grew able to “take in” (Ghent, 1990, p. 128) a different view of her parents' lifelong admonitions as actual assaults on the integrity of her self. This truth, which she had warded off with false self-compliance (Ghent, 1990) and obliterating acts of drug use, was never more apparent than when Helena's efforts at growth drew her parents' customary objections. For
example, her mother chided her for “orphaning” her child, as Helena increased her A.A. and other sober involvements. Seeing her parents' detractions for what they really were permitted Helena to see her own drug use as fuel, and, along with getting sober, she asserted a new strength in her dealings with her family. “Don't correct my parenting in front of Yuri,” she said to her parents on one such occasion. Honest perception of her parents, in turn, fed truthful self-awareness. In particular, Helena faced the truth of the danger she had caused her own child. It was immensely poignant to work with Helena in this period, as she evidenced depressive guilt and experienced feelings of deep regret.

Competence, too, played a role in her strengthened sense of self. Shortly after getting sober, Helena responded to an opening in a corporation that was seeking a physician for its in-house medical staff. As the company provided general medical services, no critical care medications—potentially still threatening to Helena—were kept on site. Soon after she started the job, it was clear that Helena excelled at primary care. Novick and Novick (1996), who have written of the part that omnipotence plays in masochistic dynamics, stated that “the greatest threat to the omnipotent system is the experience of competence and pleasure” (p. 62). As Helena achieved skill and widespread recognition as a physician, she had less need of omnipotence to root her self-esteem. With the erosion of omnipotence, drug use, too, lost some of its grip.

What about the interplay of force and domination that overtook the therapeutic tie? It was only as she grew in strength that Helena was able to see that she may have sought monitoring, and the imposition of restraint, as a delivery system for a form of care: one that allowed her passive reception of provision, albeit while she was held captive, without the need for humiliating request.

Antabuse—the pill that promises to help by potentiating toxicity—furthered our understanding. Continued recovery brought a reduction in Helena's use of Antabuse, which she had taken daily. Helena expressed concern when her weekly regimen allowed for more days off Antabuse than she was on it. I observed, “It is now more you than it,” overseeing sobriety. To this, she said she could hear her mother's voice “whispering in her ear, ‘You can't do it.’” As noted by Krystal (1977), and as was the case for Helena, Antabuse served as a maternal evocation in much the same way as the drugs it had replaced. Whether they delivered states of calm release or precautionary dread, Helena deferred to her drugs and medications not only as a function of their chemical effects, but as a condition of attachment in her object world. Even heeding her own inherent strivings towards growth felt like a treasonous act because they threatened to dethrone objects and dissolve essential ties.

These interpretive efforts to help Helena find a way out of her habitual enslavement were not the only means of therapeutic action. Helena and I were creating a new bond; one function I served was to recognize her growth, in fact, to welcome it as a basis for connection. So, when Helena stopped her Antabuse
altogether, we marked the occasion as if it were, in her words, a “diploma.” When it came time to reduce her sessions with me, we embraced that development, too. With her strength came a new-found vulnerability, for as Helena found that her dire “need” of me shrank, she said that her feelings of “missing” me grew and she could express these openly.

Ultimately, she and I survived destruction. This perspective, which adds to an understanding of the new relationship between us, is taken from Winnicott's (1969) ideas about the developmental passage from the experience of object relating to object usage. According to Winnicott, at this juncture in mother-infant life, the baby stands ready to move beyond the experience of object relating, where the self is able to perceive the object only in subjective terms, to object usage, which entails the self's “perception of the object as an external phenomenon” (p. 89). To Winnicott, it is aggression that drives this change—that is, the baby's need to “destroy” the object in subjective terms—that results in its placement in external reality, outside omnipotent control (pp. 89-91). But the object must “survive” destruction (pp. 90-91), in order for this transition to occur.

In this light, the mounting danger and coercion that Helena brought to bear on us at the height of her drug crisis could be seen as a ruthless developmental force, testing my durability as her therapist and my openness to her change. That we survived—I by preserving my analytic function, she by availing herself of her love for her child—permitted us to enter into a new relationship, grounded in mutuality. There we both existed as subjects—I now as a person, no longer drug, with a life in reality, not merely subject to her fantasized control (Ghent, 1990, 1992; Benjamin, 1990).

When Helena completed her contract with the state agency that had been monitoring her status (long after child protective services had closed her case), she reflected on her progress. It was remarkable to witness her achievement, in view of how close she had come to her own death, and how frankly she herself had assumed it as a likely

7 Ghent (1990) provides a valuable account of Winnicott's ideas about this developmental passage, which I also draw upon here.

8 Ghent (1992) coined the term object probing to describe the kind of penetrating contact that the self subjects the object to in the course of seeking the capacity for object usage.

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outcome of her use. She expressed a rich and complex set of feelings, among which were these: “I'm so proud of my recovery and of walking that path, and part of walking it has been walking it with you.”

Conclusion

When a chronic drug user initially tells his story in the process of seeking help from a therapist, the details of his use, heard in the quiet of the consulting room, can seem almost exotic. Secret locations, illicit exchanges,
and the raw facts of drug use sound like the rumble of a distant “front” in the person's life—dark, at times dangerous, but far, far away.

However, any therapist who thinks relationally will be listening to such accounts and wondering how their dynamics will materialize in the treatment, not only in the patient's continuing behavior, but in his relationship with the therapist. For it is when things go right in the treatment that the patient is able to enact and, it is hoped, at some point resolve, his central relational conflicts in the relationship with the therapist, which were formerly diverted into his use of drugs.

For the therapist who works with substance users, this means expecting, and bearing, experiences of power, control, and destructiveness, seen elsewhere in their use of drugs. Certainly, in my work with Helena it was important that I be willing to engage, and endure, her hate, to help her integrate loving and hateful feelings in her object relations, rather than direct her hostility against herself or into split-off expression through drugs.

Since it is the therapist's task to be “used” by these patients in this manner (Black, accepted), countertransference will be strong. Reaction need not be blatantly aggressive to warrant exploration into countertransference. For example, given the role of domination in my work with Helena, I was concerned that I might be enacting this dynamic in my thoughts about writing about the work in such a paper. For this reason, I sought professional consultation, and in my discussions with the patient followed guidelines of informed consent and sought to explore her independent motivation for participating in the effort (Gabbard, 2000; see also this article, fn4).

Substance users have historically been shut out from psychoanalysis, and the model of treatment presented here, clear-eyed in its

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Substance users have historically been shut out from psychoanalysis, and the model of treatment presented here, clear-eyed in its implications, may seem only to substantiate that status. However, given recent trends in analytic practice and the value of a relational perspective in understanding drug use, the skills of psychoanalysts, augmented by knowledge of addiction, could be of greatest benefit to them.

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