Self Representation and the Capacity for Self Care

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I. Substance Abuse and Psychoanalytic Theory

Some of the early analysts, especially Abraham (1908, 1924), Simmel (1930, 1948), and Rado (1926, 1933) contributed significant insight into the psychodynamics of alcoholism and drug addiction, and in the process enriched psychoanalysis. As pessimism shrouded over the prospects of individual analytic therapy for these patients, we lost interest in them, and thereby we lost the opportunity to learn from working with them. Symptomatic of this impoverishment of our studies is the absence of a course on problems of alcohol or other drug dependence from the curriculum of all psychoanalytic institutes affiliated with the American Psychoanalytic Association (Handler, 1977). The Board on Professional Standards of the American Psychoanalytic Association does not require or recommend any instruction in the area of the addictions.

Yet I have found this to be a rewarding area to study. Impressed with the vagueness and lack of differentiation of affective states, particularly depression and anxiety in withdrawal states, I pursued a study of affective disturbances in alcoholism and drug dependence (Krystal, 1962). I found an affective disturbance in drug-dependent individuals consisting of affect dedifferentiation, deverbalization, and resomatization (Krystal and Raskin, 1970). These patients showed a severe disturbance in affective forms and function. Their emotions came in vague, undif-

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ferentiated, somatic form, i.e., they experienced sensations and not feelings. They were not able to put their emotions into words, and therefore could not use them as signals to themselves (Krystal, 1974). Wurmser (1974) has also reported that in studies of drug addicts he found the coincidence of impairment of symbolization and affect disturbance. "This curtailed ability, or inability to symbolize, pertains particularly to the patient's inner life, his emotions, his self-references. One example is the inability of most of these patients to articulate feelings. Many if not all relevant affects are translated into somatic complaints . . ." (p. 837).

The disturbance in affectivity involved verbalization and symbolization and had a double impact upon the problem of addiction: an etiological one and a therapeutic one. For with this disturbance and with what I also found to be an impairment in affect tolerance (Krystal, 1975), it was most unlikely that they could bear the added burden of psychotherapy. In struggling with these challenges I came to the following conclusions:

It is possible to prepare some substance-dependent individuals for psychoanalytic psychotherapy by offering them a preliminary stage of the treatment in which the patient's affective functions are dealt with. I have discussed the techniques of dealing with this type of problem and impairment of affect tolerance elsewhere (Krystal, 1973a, 1975). The emotional disturbances found in alcoholic and drug-dependent patients are not unique to them, but can be found in other patients. I found a very high incidence of the same affective-cognitive disturbance in severely traumatized survivors of Nazi persecutions (Krystal, 1971).

The concentration-camp survivors also showed an extremely high rate of psychosomatic diseases. Whereas the over-all incidence of psychophysiological disturbances was 30 percent, among the patients who suffered the persecutions in childhood and adolescence, the incidence reached 75 percent! (Krystal, 1971). The combination of psychosomatic illness and a disturbance in affectivity and cognitive processes was observed early by a group of French psychoanalysts (Marty, de M'Uzan, and David, 1963). Sifneos (1967) has coined the term *alexithymia* for the disturbance of affectivity and verbalization he found in psychosomatic patients. Sifneos and Nemiah have made many observations and careful descriptions of the patients' inability to express their feelings in words and to link them with fantasies (Nemiah, 1977, Nemiah and Sifneos, 1977). Marty and de M'Uzan (1963) observed the same phenomena; they also reported that many psychosomatic patients were unable to produce fantasies, and that their thoughts seemed preoccupied with

mundane details and not suitable for symbolizing drive tensions, a phenomenon they labeled *pensée opératoire*.

Our clinical observations on drug-dependent and alcoholic patients coincide precisely with those of Sifneos, Nemiah, Marty, de M'Uzan, and others who have studied psychosomatic patients. It has, however, been the drug-dependent group, when compared to my observations of traumatized patients, who made it possible for me to realize that I was observing a regression. The resulting working out of the genetic development of affect (Krystal, 1973a, 1974, 1977) permits us to understand psychosomatic conditions as a regression in regard to affect—in that affects are resomatized and dedifferentiated, with a concomitant impairment in verbalization and symbolization.

The observations derived from patients who represent themselves with a problem of substance dependence or psychosomatic illness apply in various ways to a great number of patients. McDougall (1974) has pointed out that, like it or not, the psychoanalyst ". . . finds himself constantly confronted with psychosomatic behavior of a general kind in all of his analysands, [and] he will also discover that a considerable proportion of his patients, whether he wishes it or not suffer from authentic psychosomatic disorders" (p. 438).

Whether the patients show psychosomatic symptoms, or have addictive tendencies, as long as they show alexithymic characteristics, their capacity to utilize and benefit from psychoanalytic work is seriously impaired (Sifneos, 1973, 1975). De M'Uzan (1974) has stressed that patients showing these characteristics include character neuroses and "normals" and has described them as "anti-analysand, analysis proof" (p. 462). As already mentioned, I have been less pessimistic about the applicability of analysis to these patients. I feel, however, that these problems account for a great number of analytic failures, and for an even greater incidence of impairment of effectiveness of analytic work with primarily neurotic patients. The ongoing explorations of the "alexithymic" disturbance in affectivity and symbolization will continue to yield helpful insights toward the handling of these hitherto ignored problems.

Another area in which the study of drug-dependent and alcoholic patients contributes a helpful view of universal interest is the question of object and self representation, especially with regard to the fantasy of "introjection." For the alcoholic and drug-dependent patient, the nature of their transferences and self representations poses an often insuperable barrier to psychoanalytic psychotherapy, as I hope to demonstrate later. It is precisely because this area is such an obstacle

that we must study it. Very likely, our technical weakness stems from a failure to recognize and understand something about those problems.

II. Ambivalence in Object Relations and Transference

Let us consider the difficulties resulting from the ambivalence in object relations so frequently noted in the treatment of these patients. What becomes difficult to weather is the early surfacing of aggressive transference. One view of this difficulty relates to the disturbance in affect tolerance. One is inclined to expect that painful (or "emergency") affects present the greatest challenge to the ego, in terms of the management of pain and secondary anxiety. However, drug-dependent individuals are among those who have difficulties with a type of emotion which is commonly experienced as pleasurable. Rado (1969) has called all of those "welfare affects," since they usually favor the well being of an individual. Out of these, Spitz (1963, p. 55) has singled out the "proleptic" group, i.e., the emotions experienced in the process of expecting gratification. However, these emotions are only pleasurable when accompanied by hope and confidence based on previous good experiences. Unfortunately, with these patients, that is not the case. Because of the nature of their transferences, they expect disappointment and rejection, and proleptic affects may represent a "trauma signal" for them (Krystal, 1975).

When exposed to a potential good object, such patients panic and may have to ward off their yearnings for love and acceptance. Such an untoward reaction represents a fear of the positive transference, and has also been observed in psychotherapy with schizophrenic patients (Sechehaye, 1951). These patterns have been described in great detail by Kernberg (1975) and Boyer (1977) in regard to borderline patients. Of course, borderline patients also frequently manifest dependence on drugs and use them defensively to deal with these types of transferences. Kernberg especially has clearly discussed the need to devaluate, even symbolically destroy, the therapist in order to ward off feelings of envy and the resulting rage.

Whether we consider it a manifestation of the transference, or a defense against it, unconscious, hateful, and destructive impulses toward the analyst frequently appear early, and represent a threat to the establishment of a working alliance. Because of the prevalence of magical thinking, fortified by the wish for magical powers, and in

harmony with a grandiose self representation, alcoholic and drug-dependent patients in psychotherapy become terrified of their death wishes directed toward the therapist. Relatively early in the treatment they are confronted with their extraordinary envy, and have the need to deal with their poorly mastered narcissistic rages. At this point, they flee from the treatment, because they fear that their death wishes will destroy their therapist. Alternately, they tend to turn their aggression against themselves, and act it out in an accidental injury, suicide attempt, or relapse of drug abuse (Simmel, 1948). This may be one of the major reasons why alcoholics and drug abusers do poorly in *individual* therapy. For this type of drug-dependent patient, for whom individual therapy is desirable, treatment works better in a clinic situation, in which auxiliary therapists are made available. As additional contacts are usually readily available in a clinic setup, these may be observed to be spontaneously sought out by some patients with addictive problems.

The idea of using a team to manage the substance-dependent patient is not new. One of the successful psychoanalytic treatment centers was Simmel's Schloss Tegel Clinic. Simmel was concerned with the alcoholic's tendency to self-punishing ideas and suicide attempts after withdrawal. The patient who was being withdrawn from alcohol was permitted to stay in bed, and a special nurse was assigned to look after him, and supervise his diet. This was a conscious attempt to provide the patient with passive gratification, to provide a gentle "weaning," and prepare the patient for his "regular analysis" (Simmel, 1948).

It has been my observation that when highly ambivalent patients have a therapeutic team available they will use it for the purpose of "splitting" of their transferences. In this way they experience their angry and destructive wishes toward one member of the team while presenting a basically loving relationship toward another, preferably the chief therapist (Krystal, 1964). I believe that this development takes place commonly in treatment clinics and groups. However, most of the time the transferences acted out with various clinic employees are lost from the therapeutic process unless a special effort is made to "gather" them. If everyone in the clinic reports to the chief therapist about every contact and communication with the patient, the picture of the nature of the patient's transference may then be put together. It will be found that the patient is not experiencing a simple splitting of the transference into one love and one hate relation. The picture will be quite complex, and quickly changing. At one moment, the chief therapist may be experienced as the idealized mother whose love and admiration the patient yearns for, whereas another staff member may be experienced as a

rejecting, condemning parental image whom the patient dreads, and hates; and still another staff member may be experienced as seductive, intrusive, destructive, or other parental transference object. When the patient feels frustrated by the chief therapist, and needs to experience his rage toward him, instantly he will experience one of the other members of the team as an idealized parent, while he experiences other partial transferences with yet another clinic staff—anybody around, whether they are in a therapeutic role or not. Conversely, when the chief therapist is experienced as kind, concerned, and loving, the patient may be confronted with enormous guilt over his aggressive, envious feelings which may drive him to act out in a self-destructive fashion. He may avert that need if he can justify his feelings by some grievance over a deprivation or slight from someone in the clinic.

In order to demonstrate to the patient the splitting and idealization involved in his transference, it is necessary to bring his projections together, and show that all of these transferences represent various object representations, which he needs to experience toward the *one* therapist. The patient's vacillations and changes in attitudes toward the various staff members can be used to demonstrate his dilemma. Bringing in the ambivalence in the transference is the crucial step in working with such patients, because one of the major forces which propel individuals toward addiction is that they can displace their ambivalence toward the drug in a way which I will discuss in detail later. The very slang names given to alcohol and drugs reflect this ambivalence. Szasz (1958) has emphasized this aspect of drug problems in his paper on the counterphobic attitude in drug dependence.

A special instance of the use of a group of therapists is the situation where the addicted individual is sent to the clinic by a court. The probation officer assigned to the patient becomes an object of transference of a very significant type. The fact that this type of a patient has a characterological disturbance which necessitates that he "externalize" (that is, fail to integrate) his superego function in having others enforce controls for him is a clear indication that these transferences cannot be left out of the treatment (Margolis, Krystal, and Siegel, 1964). Back in 1931, Glover commented that drug-addicted patients are able to give up the drugs up to the very last drop. This "last drop" however, becomes virtually impossible to give up, because it contains the symbolic expression of the fantasy of taking in the love object. The external object which is experienced as containing the indispensable life power that the patient wants to, but cannot, "internalize" illustrated the basic dilemma dominating his psychic reality. This tendency applies to his

conscience as well, so that he is unable to experience it as being a part of himself, but arranges for others to exercise it for him. When antabuse is prescribed for an alcoholic, both the doctor and his patient may share the illusion that the pill will replace or repair the alcoholic's failing impulse control. The drug, however does not constitute an insuperable barrier against drinking, as its affect can be abolished by simply skipping it whenever the patient wants to indulge his impulse to imbibe. We can detect in this operation some of the characteristics of the *placebo effect*. The patient becomes able to exercise his hitherto inhibited function, but he denies his part in it, and attributes the activity to the pill. The ingestion of the pill represents a ritual, or symbolic act, through which one gains access to a function which otherwise remains blocked.

The failure to integrate, to be able to own up to one's own functions and aspects such as conscience, and the need to attribute them to others, such as parents, spouses, or probation officers make the drug-dependent individual experience the world in a paranoid way. This pathology was summed up by Glover (1931) when he said that drug addicts are inverted paranoids, and that they are both persecuting and persecuted. Thus, whether there is a probation officer in the picture, or whether antabuse or similar substances (or procedures) are used by the therapist, the transferences involved in the patient's failure to see the self sameness of his superego have to be brought into the treatment by interpretation—if the patient is ever going to be able to accept himself as a whole person. We should note also that these operations in which a patient needs to "take in" some external factor in order to exercise his own function are a mode of behavior paralleling the use of a placebo. I will return to that point later.

III. Self Representation and Vital and Affective Functions

These observations address themselves to what I consider to be the basic defect and the basic dilemma in the life of a drug-dependent individual such as the alcoholic: He is unable to claim, own up to, and exercise various parts of himself. He experiences some vital parts and functions of his own as being part of the object representation and not self representation. Without being consciously aware of it, he experiences himself unable to carry out these functions because he feels that this is prohibited

for him, and reserved for the parental objects. I have studied this and described the clinical evidence for these views elsewhere (Krystal and Raskin, 1970, Krystal, 1975). At this point I would like to consider what prevents the patient from "internalizing" these functions, and indeed, whether the model of taking in such functions from without is a reflection of the patient's fantasy or whether, in fact, functions are "taken over" from parental and later transference objects. A new source of observations in this area has become available recently in biofeedback studies combined with psychotherapy. I would like to consider a certain difficulty which develops sometimes in that setting.

Just as the drug-dependent individual is unable to exercise certain functions for himself, and/or admit that such is the case, so do we all experience those parts of ourselves which are under the control of the autonomic nervous system as being beyond our volition. However, in the last twenty years, a whole literature has become available demonstrating that through the use of biofeedback devices, control over these areas can be acquired. For the most part the reports are exclusively behaviorally oriented, reporting the degree of success in terms of percentages and the number of trials. The concern is with the apparatus, rewards, and results. Rickles (1976) is a rare exception—a psychoanalyst looking at this work and concerning himself with the psychic reality of the patient, and the patient's mental representations and transferences to the machine, the therapist, and his problem. His patients are in psychoanalysis or psychoanalytic psychotherapy while having their biofeedback training. They are also required to speak for five minutes into a tape recorder after each biofeedback session and relate whatever occurs to them. Perhaps it is because of this unusual setting that he relates about one of his patients that "She soon left biofeedback therapy . . . because she was frightened by the depressive feelings which emerged when she relaxed" (p. 5). I have had occasion to treat a few patients who had been undergoing biofeedback treatment. I advised one of these to get it for his severe hypertension. In a couple of other cases, we were dealing with extremely severe manifestations of anxiety: a patient who had a resting pulse of over 110, and several others who suffered from insomnia or severe headaches which had been intractable by all other previously tried methods. The patients responded rather surprisingly. Although most of them cooperated with the instructions of the psychologist, and achieved some desired results in the sessions with him, they developed much difficulty in practicing at home, and most of all in generalizing their newly acquired skills and applying them to their everyday lives. A number of reasons accounted for this, however, in-

cluding certain of the more usual transference problems. However, one reaction, quite marked in some, and only mild in others, should be highlighted here.

All of the patients showed evidence of guilt and anxiety over gaining control over vital functions and over parts of themselves which they assumed to be beyond their control. Some were conscious of this feeling, and expressed fear that such a Promethean act on their part would be punished severely. Others dreaded that in acquiring such powers they might destroy themselves. Some showed only indications of unconscious reactions in that vein. The patients felt that these major parts of their bodies were proscribed for the incursion of their volition. To assume control over these functions was a forbidden act.

The fact that they did "learn" to exercise a particular action under the direct supervision of the psychologist is consistent with such feelings. While under his tutelage, they were able to do it, as long as they disavowed their responsibility for the act. However, they could not accomplish the same results at home consistently, acting out their denial in various ways, e.g., falling asleep while practicing. Even when they learned to carry out an activity—for example, to lower their blood pressure or relax their muscles while practicing—they had great difficulty in generalizing this act outside of the practice session. To do so would signify a conscious admission that they have taken over the control of the "autonomic" area of their bodies which they felt they were not supposed to do. These feelings are universal, not limited to psychosomatic patients, although they are more problematic to them. A case has been reported, for instance, of a psychoanalyst who learned to relax the spasm of the peripheral blood vessels and thus relieve the symptoms of his Raynaud's disease. After about a year of doing it, he became less successful at it and had to return to the laboratory for "further training" (Schwartz, 1973, p. 672).

Lest we get distracted from our observation that we are dealing with an emotional block to the exercise of our potential functions, let me re-emphasize that we are not dealing with peculiarities of the autonomic nervous system. As I mentioned, for some of the patients who suffered from muscle-tension states or tension headaches, the aim was to relax their muscles. Thus, the area of the body excluded from the self representation does not necessarily coincide with that of the visceral or archipalial areas, but is an individual matter. Frequently, however, it involves all those parts of the body which are importantly involved in a given individual's *affective responses*. When a patient is referred for biofeedback treatment, a significant psychosomatic element is in the

picture. Unlike experimental animals or subjects, they are addressing themselves to symptoms of their affective, if not symbolic, disorder.

IV. Body Image and Maternal Transference

The reason the patients had such guilt and anxiety about learning to control their viscera, or even to relax their muscles, was because their unconscious belief was that organs such as their hearts were under the special care of God (or fate, doctor, hospital, and the like), which guaranteed their survival. This is illustrated in the commonly held theory of sleep—namely, that God causes it by taking away the soul, which He may, by His grace return to us the next morning. This theory of sleep is a transference of the maternal image for whom life-giving powers, as well as nursing, are reserved. This theory is universally shared and incorporated into law. What it means, in effect, is that we do not own our lives, and therefore do not have the right to commit suicide. All basic life-assuring functions are carried out under a franchise, as it were.

This experience has its roots in infancy, and even phylogeny, for certain new-born mammals will not void, but die, unless licked by the mother on the perineum (Lehman, 1961). Abandoned young mammals die, sometimes even when a maternal substitute becomes available, if a personal attachment (object constancy) has been accomplished (Van Lawick-Goodall, 1973). Vulnerability of the human infant is, of course, the greatest, and we could say that the newborn will destroy himself unless rescued by the mother. Much of Melanie Klein's theorizing about the early destructive impulses of the child can be understood in this light. The early mothering is experienced as a *permission* to live. When the biofeedback patients were told that they could learn to control their autonomic functions, some experienced fears that taking over such maternal prerogatives would cause them to destroy themselves. Of course, even dying is experienced as being regulated by the primal mother who takes back her child (e.g., Mother Earth, or the Pieta theme).

It is relevant to remind ourselves again that this area is involved in the "expressive" aspect of affects, because the emotions are similarly experienced as emanating from the object, and the idea of "managing" them, and using them as signals in the patients we are considering, is also experienced as forbidden by many of them (Krystal, 1975). Thus the two areas of disturbance—one in the sphere of affects,

and the other in the sphere of self and object and self representations – have their common denominator in the historical sources mentioned. The connection goes even deeper. These patients often have the following definition of love based on the addictive fantasy: "If you love me, you will take care of me, and make me feel good." Therefore, they not only experience their feelings as emanating from the object who carries the whole responsibility for them, but even further compound this construction. Whenever they feel badly, they conclude that they are unloved and rejected by the love object. They become convinced that either the object is bad and dangerous, or they are bad and being punished. Their rage about the "unfair" state of affairs appears to turn either against the object or against themselves. These problems, of course, contribute to the problems of early aggressive transferences mentioned above. Most of all, however, since all the patient's bad feelings are the fault and responsibility of the object, it is up to the love object, and not permissible to the patient, to make themselves feel better.

Behaviorists have overlooked this problem, since it represents, for the most part, unconscious fantasies demonstrable through the analysis of transferences and characterological patterns. They have emphasized that one handicap in acquiring conscious volitional control over viscera lies in the lack of proprioception, which is remedied by the biofeedback apparatus (Stoyva, 1970; DiCara, 1972). But to their credit, behaviorists have questioned the limits of the voluntary control of our selves, as well as the very concept of volition. In a thoughtful review of the problem of volition, Kimble and Perlmuter (1970) pointed out the narrowness and inadequacy of the view of the academic psychologists that volition is equal to conscious intentionality, and proposed to explore the development, initiation, and control of voluntary acts. Implicit in operant conditioning is the conception that an organism will tend to repeat actions that bring it pleasurable consequences (rewards), thus suggesting a broader concept of motivation which goes beyond consciousness or reason.[1]

Their views, however, ignore the psychoanalytic concept of the mind functioning in a state of conflict, and therefore they miss the main point of interest to us: *that volition, intention, or motivation may be opposed by like forces in the opposite direction.* That is the reason why they have not observed the difficulties that subjects encounter within themselves in

[1] There is a corresponding effort to review the psychoanalytic conceptions of volition and motivation, notably in the work of Klein (1970) and Holt (1976). For a review see Santostefano (1977).

expanding the limits of their acknowledged function, that is to say, in trying to integrate alienated parts of themselves.

Behaviorists exploring the area of voluntary control of internal states have produced a wealth of evidence that the commonly accepted limits of conscious control of automatic function are not due to absolute anatomic limitations. The following is a good review of their position on these issues:

> It is not possible to define in an operational way the meaning of the word "voluntary," but all of us have a *feeling* of voluntary control, at least part of the time, regardless of the psychophysical and metaphysical implications of that feeling. Few people realize, however, that that feeling or intuition of freedom has unusual significance in respect to the autonomic nervous system, the so-called involuntary nervous system, nor do they realize that the "psychophysiological principle" when coupled with volition makes it possible to regulate a number of important involuntary functions, and at least theoretically to regulate in some degree every psychological and physiological function of one's being.
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> The psychophysiological principle, as we hypothesize it, affirms that "Every change in the physiological state is accompanied by an appropriate change in the mental-emotional state, conscious or unconscious, and conversely, every change in the mental-emotional state, conscious or unconscious, is accompanied by an appropriate change in the physiological state" [Green, Green, and Walters, 1970, p. 5].

Now, what are some examples which indicate that our inability to control our physiological states is functionally, and not anatomically determined? To start with, some individuals naturally possess the ability to control various viscera. Some people have been found to have conscious control over their heartbeat and blood pressure. One man was even observed to be able to bring his heart to a complete stop for a few seconds, and resume normal function at will (Ogden and Shock, 1939; McClure, 1959). Yogis have also been watched in the exercise of control of various functions through volition alone (Green, Green, and Walters, 1970). Of course, we all exercise control over viscera, but usually we deny it by giving credit to the various devices we use. When, for instance, we select a certain kind of music, in order to calm ourselves, or otherwise modify our affective state, we tend to minimize our own responsibility in this, attributing it to the "external" implements.

The functions so laboriously acquired, apparently through learning, may be gained instantly through the use of hypnosis (Shor, 1962; Maslach, Marshall, and Zimbardo, 1972). Barber (1970) has done a critical review of many reports in this area and concluded: ". . . a wide variety of physiological functions can be influenced directly or indirectly by suggesting to either hypnotic or awake subjects that certain physiological effects are forthcoming" (p. 243). Among these effects were the production of vestibular nystagmus, the production and blocking of pain, the induction and inhibition of labor contractions, modification of vasomotor function in the skin, i.e., blood-vessel dilatation or constriction, cardiac acceleration and deceleration, and the modification of a variety of metabolic and gastrointestinal functions. Another group of researchers concluded: "These experimental results free us from the shackles of viewing the autonomic nervous system with contempt. They force us to think of the behavior of the internal, visceral organs in the same way that we think of the externally observable behavior of the skeletal musculature" (Miller et al., 1970, p. 358).

Beyond the evidence of the potential for the control of physiological states derived from hypnosis and suggestion, the placebo phenomenon should be considered (Krystal and Raskin, 1970). The history of medicine is in essence the history of the placebo, since effective drugs have been a rare and recent development (Shapiro, 1960). As is well known, under the influence of the placebo, patients are capable of exercising a multiplicity of functions in the sphere of their selves over which they usually feel no control (Beecher, 1961). These effects are not necessarily beneficial. A variety of untoward reactions have also been reported—from transient sleepiness, nausea, skin rashes, diarrhea, to urticaria, angioneurotic edema, and others (Roueché, 1960; Beecher, 1956; Wolf and Pinskey, 1942). Why is it, then, that we are unable to exercise control over the parts of our bodies ordinarily controlled by the autonomic nervous system but do so under the influence of biofeedback training, hypnosis, or placebo?

I must address that question by making the outrageous claim that *the usual state of Man in regard to the autonomically controlled part of his body is analogous to a hysterical paralysis.* Since we have the potential to exercise these functions but are prevented from doing it by a psychological cause, we are dealing with a functional or conversion-derived block. This "normal" inhibition of the exercise of volition over the autonomic or affective aspect of ourselves is, like any conversion paralysis, the symbolic representation of a fantasy. The fantasy, however, pertains not to our genital or phallic conflicts, but to the vital

functions. In the "normal" state, we dramatize the fantasy that the control of our lives and feelings does not belong to us, and is not a part of the self representation, but is under the sovereignty of mother, doctor, or God—and thus part of the primal object representation.

When one functions under the influence of the doctor's placebo, the behaviorist's biofeedback machine, the hypnotist's suggestion, the shaman's or curandero's magical incantations, one gains access to the functions previously reserved for the object. It is because the needed functions are experienced as part of the object representation that in the ritual of reclaiming them the fantasy of devouring or "introjecting" the object is symbolically acted out. When the symbol of the object is "taken in," whether it is a prescription medicine, alcohol, or illicit drug, or even the ritual of Holy Communion, the evidence of the ambivalence toward the object may become noticeable. Wieder and Kaplan (1969) have pointed out that "drugs" and "potion" both denote at once medicine or poison. They explain: "The earliest prototypes of 'druglike' experiences probably are of milk, breast and mother. In the argot of the addict, his supplies are often called 'Mother' and his supplies 'mood food.'. . . The image of the drug may be 'good' or 'bad' regardless of whether they used pharmaceuticals, caresses, food, laxatives or enemas. Severely or chronically ill children, such as diabetics and asthmatics, relate to their medication as to magic potions, especially during periods of remission" (Wieder and Kaplan, 1969, p. 401).

The ambivalence in terms of ill effects from drugs is not limited to "junkies," but is a universal phenomenon. Better than half of all patients never fill their prescriptions. However, this failure to do so is not just a matter of the splitting of the object and taking in of a poisonous object, i.e., "witch-mother." The point which is especially made clear in religious beliefs is that the Host is always good, and it is only the taking it by the undeserving which is punishable. Thus it is the transgression of taking in the object for the purpose of acquiring the walled-off, self-soothing, and comforting function which is forbidden and punishable. That is why, if one is still "supposed" to suffer, taking the medicine will cause one to become even more ill (become poisoned or cursed), as we noted above among the adverse reactions to the placebo. This is the reason why psychosomatic patients respond differently to biofeedback than experimental subjects.

What we are confronting, then, are barriers within one's self representation, in which the most basic life-maintaining functions and affective functions are experienced as outside the self representation, and as part of the object representation. The usurping of maternal (God's)

privileges is the feared transgression of what is experienced as the "natural" order of things.

What happens, then, under the influence of the placebo or one of the other conveyances is that there is a temporary lifting of internal barriers between the self representation and the object representation, thereby permitting access to, and control of, parts of oneself that were previously "walled off." What are these intrapsychic schisms made of? They represent repressed parts of one's self, repressed by *depriving them of the conscious recognition of selfhood.* This does not pertain only to parts of one's body, but much more so to the spheres of functions.[2]

V. The Blocking of Self-Caring Functions in Drug-Dependent Individuals

Alcoholics and drug addicts are among those people who have a great inhibition in carrying out a multitude of "mothering" or self-comforting functions. In studying their difficulties, we gain a chance to observe that we are dealing with an intrapsychic block which prevents them from the consciously exercised use of these functions. They act as if they were forced to repress (alienate) their potential for self care.

These repressions take place at various times in childhood in connection with the various conflicts centered in the psychosexual development. As analysts, we are very familiar with these conflicts and the inhibitions which the neurotic patients show. On the phallic level of development it is very common for us to find the very same kind of structure which I have described in regard to the autonomically controlled-affective part of the body. The neurotic patients often believe that their genitals are not part of their self representation, but belong to their parents, for whom their use is reserved.

A boy finds himself frightened of his competitive strivings with his father because of his fantasies and theories of destroying his father and taking his place; i.e., unconscious identification fantasies related to his theory of becoming *the* father may repress these wishes and fantasies. Thereafter, he sees himself as a boy permanently, with adult masculine

[2] Just what kinds of functions may be among those alienated has long puzzled philosophers and scientists. The view commonly held at present that Laetril represents a placebo which permits some people to mobilize their healing and life-preserving forces renews the question of the extent of these potential powers and the ways to mobilize them.

modes of action reserved for the father. Unless he finds some way to overcome or get around these repressions, he may never be able to fulfill his masculine ambitions, or consciously own up to, or exercise his masculinity. This may lead to the kind of inhibition in the occupational and sexual goals, with a rise to prominence of homosexual striving, which the early psychoanalytic writers describe so many times in their observations of alcoholics (Abraham, 1908; Simmel, 1930, 1948; Rado, 1926, 1933; Juliusberger, 1913; and Hartmann, 1925). In some homosexuals, the fantasy is that through the sexual act one will regain one's alienated masculinity through the symbolic introjection.

However, in some drug-dependent individuals there is a specific disturbance consisting of the "walling off" of the *maternal* object representation, and within it the self-helping and comforting modes. Thereby, such a person loses his capacity to take care of himself, to attend to his needs, to "baby" or nurse himself when tired, ill, or hurt narcissistically. We have described the resulting deficits in the drug-dependent patient in terms of the impaired ability to comfort and soothe himself (Krystal and Raskin, 1970). I have stressed that one reason the addict yearns for the "nods," or uses drugs to obtain relief from distressing feelings or gain "good" feelings is because he is not able to exercise comforting, mothering functions. Consequently, he may not be able to do the kinds of things that an ordinary person does in order to soothe himself, relax, and go to sleep. In my discussion of the uses of the placebo and other devices, I have also stressed repeatedly that many patients, beyond the group of drug-dependent individuals in whom this is so conspicuous, do not feel free to comfort themselves when they feel bad. In other words, their affect tolerance is impaired because they do not feel free to exercise the kind of comforting, gratifying care that a mother gives to a distressed child. In brief, I have found an inhibition in the substance-dependent patient's ability to take care of themselves physically and emotionally, in the literal sense of that word (Krystal, 1975).

Recently, Khantzian has expanded on these observations, pointing out that they have even wider implications. He showed that the drug-dependent individual had "a type of self-disregard associated with impairments of a multitude of functions related to proper *self-care* and *self-regulation*" (Khantzian, 1977). Khantzian reminds us that many drug-dependent individuals do not take care of their nutrition or general medical and dental care, and that they fail to exercise the usual care and caution to avoid the multiplicity of troubles and tribulations which "befall them." These patients fail to exercise the welfare func-

tions in such a consistent way that we must conclude that they have an inhibition in this essential area. Zinberg (1975) has also commented on the drug addicts' severe impairment in self care. He pointed out that they are not only self destructive, but also "manage almost never to do well for themselves in the simplest life transactions. They lose laundry slips and money, choose the wrong alternative at each instance, and are invariably being gypped at the very moment they think they are the slyest" (p. 374).

Since we have already observed similarities between substance-dependent and psychosomatic patients in regard to affective function, it is relevant to note that psychosomatic patients also frequently fail to take care of themselves, especially in regard to the symptoms of their diseases. McDougall (1974) has commented on this phenomenon, noting that the illness progresses silently:

> When once the symptoms break the bounds of silence they still fail to receive much attention in the analytic discourse. Either they are ignored or are referred to in ways which appear to attach little importance to them. This is frequently accompanied by an attitude of blithe disregard for one's physical welfare as though the body were a decathected object even in the face of evident disfunction and physical pain. "I have been having these pains for two years. I didn't know what caused them but I contrived a way of walking which made them bearable. This went on up until the ulcer perforated," reported one patient [p. 458].

The example of the peptic ulcer brings to mind that I found 40 percent of patients admitted for delirium tremens to have peptic ulcer or gastritis (Krystal, 1959). The alcoholic who ignores his ulcer or treats it with more liquor unites these apparently disparate groups for us and helps to emphasize the common denominator.

VI. The Placebo as a Means of Overcoming Internal Blocking

The placebo effect is an important element in the development of drug dependence. This was the aspect of addiction we were referring to when we called it "an extreme form of transference" (Krystal and Raskin, 1970, p. 71). Drug-dependent patients are not free to take care of

themselves except under the "order" of transference objects or under the influence of a placebo. Again, this is a phenomenon observable in psychosomatic patients as well. McDougall (1974) observed that her psychosomatic patients were extremely dependent on their love object for feelings of "being alive" and that they "tend to fall physically ill when abandoned" (p. 451). But their love objects were "highly *interchangeable*": "The central demand being that someone must be there. This someone is cast in the role of a 'security blanket' and thus fulfills the function as a transitional object" (McDougall, 1974, p. 451). McDougall refers to such object relations in psychosomatic patients as "addictive" and relates how one of her patients with the loss of her mate "lost everything: her sexuality, her narcissistic self-image, her capacity to sleep and her ability to metabolize her food" (p. 452).

In her discussion of the use of objects by psychosomatic patients to enable them to take care of themselves, the same author also stresses that "these patients attempt to make an external object behave like a symbolic one and thus repair a *psychic* gap. The object or situation will then be sought addictively. Basically all addictions from alcoholism and boulimia to the taking of sleeping pills, are attempts to make an external agent do duty for a missing symbolic dimension" (McDougall, 1974, p. 455).

This behavior on the part of the patient represents the dealing with *their fantasy* of a deficiency, or defect, to be repaired by the incorporation of the object. As psychoanalysts, we quite regularly "take over" the patient's fantasies and make them part of our theories, as I have done in a recent paper: "It may be said with Kohut . . . , that the defect in the above patient represented a failure to successfully establish the kind of transmuted internalization that would make it possible for her to exercise certain adult functions" (Krystal, 1975, p. 200).

However, the placebo does not lend the taker the *function,* only the freedom to exercise it. If a drug-dependent, a psychosomatic, or a "normal" individual can exercise a function under the influence of the placebo, drug, hypnosis, love, or inspiration, then he demonstrates that his freedom to exercise it has been blocked by a fantasy. That is why we may conclude that substance-dependent and psychosomatic patients alike experience their self-caring functions as reserved for the maternal object representation, and psychologically "walled off"—inaccessible to them.

It is the child's construction that the mother provides all the comfort for him, and all the good feelings emanate from her, and that when he provides such sensations for himself he is "taking over" her function.

This is patently an incorrect perception, for no matter what she did he always "*created*" all his feelings and sensations, including his perceptions and mental representations of her. Based on this childhood theory of the world are many of the difficulties resulting from the attribution of part and function to the object representation.

Here, we are observing the late consequences of the theory that self-comforting and self-soothing functions belong to and are reserved for the primal love object. There is evidence that this fantasy is ubiquitous—notably in the universal blocking of our autonomously controlled parts of the body which I have reviewed above. But drug-dependent individuals and psychosomatic patients have an even broader and more severe proscription of the acknowledged self-directed exercise of self-caring functions. Are there any direct observations of settings in which a child might be likely to develop such attitudes?

VII. The Child's Mental Representation of the Mother and Its Relation to the Exercise of Vital Functions

In the introduction to a paper "On the Beginnings of a Cohesive Self," M. Tolpin (1971) explained that it was necessary to study minutely the processes by which autonomous functions are acquired. She used observations on the transitional object to explore the development by the child of self-soothing functions. We are concerned with the problems in this process, particularly since we are concentrating on two groups of patients who show serious psychopathology in this area. We are particularly concerned with the nature of infantile experiences that interfere with the child's gradual development of a freedom for self soothing—in other words, with those situations which retrospectively appear as if a permission for self care was not felt, or a prohibition of it was even experienced.

Our first question involves the kind of mother who, for a number of possible reasons, may act to punish or discourage any self gratification or autonomy on the part of the child. One thinks, offhand, of a mother whose need for a narcissistic unity with the child is so great that she is jealous of other objects, even a transitional object, and prevents the use of it.

I want to stress, however, that I do not imply that such direct causation is a necessary condition for the child to obtain "a message" that his

conscious self caring is prohibited. A variety of situations might conspire to give the same result. For whereas some mothers may not favor the child's self integration, and we will discuss some of these types, what concerns us is the child's *psychic reality*. It is the child's mental representation of the object which will cause him to attribute various fantasies and theories to his construction of the object and himself. Thus the child will fuse his perceptions of his mother and his own illness or other distress and come up with a construct of "bad mother" or "bad self being punished" or a myriad of other fantasies. This point has been made previously by Brierly (1945), Angel (1973), and Beres and Joseph (1970).

We find illustrations in Spitz's (1962) observation that where the mother-child relationship is not satisfactory (for the child, we assume) autoerotism is diminished or disappears altogether. But in discussing the kinds of unsatisfactory mother-child relationships, Spitz clearly approaches the issue from the point of the child's experience, as he considers a variety of examples, including Harlow's monkeys. Particularly in our work as adult analysts, it is clear that we are sharing with the patient a reconstruction of his original fantasies regarding his mother and her messages to him.

From her work with adult analysands who only incidently to their main (neurotic) problems were found to also have psychosomatic ones, as well as from direct observations, especially by Fain (1971), McDougall (1974) concluded:

> . . . there are two predominant trends in disturbed baby-mother relationships which are apt to create a predisposition to psychosomatic pathology. The first is unusually severe prohibition of every attempt on the baby's part to create autoerotic substitutes for the maternal relationship, thus initiating the nodal point for the creation of inner object representations and the nascent elements of fantasy life. The second trend is the antithesis of this, namely a continual offering of herself on the mother's part as the only object of satisfaction and psychic viability [p. 447].

Fain and Kreisler (1970) have directly observed children who cannot go off to sleep. One group of infants was unable to sleep unless continually rocked in their mother's arms. These babies, McDougall concluded, were unable to exercise for themselves the psychic activity necessary for sleep, but required the mother to be "the guardian of sleep" (p. 446). Fain (1971) theorized that these babies did not have a

Mère satisfaisante ("satisfying Mother") but a *Mère calmante* ("tranquilizing Mother"). "The latter, because of her own problems, cannot permit her baby to create a primary identification which will enable him to sleep without continual contact with her" (McDougall, 1974, p. 446). These children can be said to be suffering from a psychosomatic problem as well as an addictive problem. We have here the common root to the affective disturbances and inhibition in self caring which these two groups share.

The child's ability to maintain sleep is the first achievement in regard to exercising the kind of self-caring functions with which we are concerned. In studying sleep disturbances in infants, Fain (1971) describes three patterns: the baby who sleeps with small sucking movements, the baby who sleeps with the thumb in his mouth, and the baby who sucks frenetically and does not sleep. Whereas the first child accomplishes the necessary relaxation by a dream or hallucinatory wish fulfillment, the second infant requires a concrete representation of the breast. The need for the *concrete* external object substitute may be either due to the absence of an internal symbolic "good object," as McDougall (1974) suggested, or it may be the necessary prop which, like the placebo, permits the exercising of functions of "loving" reserved for the object and prohibited to the self. In this sense the placebo like the fetish serves to deny something. For the third child, there is a failure to accomplish relaxation regardless of the continuing sucking. Fain (1971) has explained all of these disturbances by an inability on the part of the mother to grant the child its autonomy. Conceivably, however, the child's inability to gain comfort derives from some inner disturbance, as has been reported by Chethik (1977) from his studies of borderline children.

Fain (1971) also describes the opposite end of the spectrum, where the child engages in a type of autoeroticism which seems to eliminate the mother as an object. This extreme, McDougall (1974) concludes, demonstrates that "instinctual aims and autoerotic activity then run the risk of becoming literally *autonomous,* detached from any *mental representation of an object*" (p. 447; author's italics). However, it may be that in the above cases, babies suffering from merycism, where they constantly regurgitate and swallow the contents of their stomachs, we may see the precursor of an inability to retain the yearned-for supplies which we see in drug-dependent individuals, to which I will return shortly. At this point, I would like to once more quote the conclusions of McDougall (1974) which are so much more impressive when we keep in mind that she was trying to understand the disturbance in psychosomatic patients:

> I do not think it would be a misrepresentation of Fain's work to describe the mother of his observational research as performing *an addictive function.* The baby comes to need the mother as an addict needs his drug—i.e. total dependence on an external object—to deal with situations which should be handled by self-regulatory psychological means. In my clinical work I have found similar imagos in patients showing "acting out" behavior other than addictions and psychosomatic symptoms, notably in perversions and in character patterns marked by discharge reactions [p. 448].

The interpretation which McDougall gives to all of these observations implies an absence of good object representations on a symbolic level, which has to be substituted for by the *concrete* supplies. That is, for her, the paradigm for the failure of symbolization that is manifest later in the "operational thinking" which Marty and de M'Uzan (1963) described in psychosomatic patients. McDougall's explanation is attractive as a way of understanding the phenomena of alexithymia. However, it has certain weaknesses. In the first place, I have reported the same findings not only in psychosomatic and addictive patients, but in posttraumatic ones as well, and in this last group it is evident that we are dealing with a regression, rather than with an absence of a symbolic object. Secondly, if we consider the concomitant inhibition in self-caring functions, we cannot relegate it to pure psychopathology. It is in this connection that we need to recall the universal phenomenon of the "hysterical paralysis" of our autonomically controlled parts. The occurrence of this universal inhibition, and the use of the placebo to get around it, forces us to study these problems in terms of the nature of self and object representation. When we say that the transitional object represents the object, we are really saying that, like the placebo, it permits the exercise of functions which, even at an early age, are already experienced as part of the object representation. The impoverishment of the self of self-helping resources and the "walling off" of these as part of the object representation is a most severe form of psychic crippling.

Therein is the source of the need of the oral character to use the drug both as a pharmacological means to manipulate his affective states and as a placebo: to gain surcease from his feelings of depletion which result from the repression[3] of self-helping attributes and functions of his own,

[3] I have discussed elsewhere (1973b) the concept of repression as referred to in this context. It extends the definition of elements repressed from those rendered unconscious, to include those alienated: not consciously recognizable as part of one's self and one's own living.

making them part of a rigidly "walled-off" object representation. We must recognize them and acknowledge that the kind of person who is likely to become drug-dependent is one who uses the drug to help him carry out basic survival functions which he otherwise cannot perform. People who drink in order to be able to continue to work thus gain access to their assertive, masculine paternal modes of behavior. People who drink for the purpose of surcease and comfort obtain their goal, in addition to the pharmacological effects, by gaining access and ability to exercise their maternal functions. The longing to regain alienated parts of oneself is the real meaning behind the fantasies of fusion with the good mother so clearly discernible in drug-dependent individuals (Chessick, 1960; Savitt, 1963; Krystal and Raskin, 1970).

These yearnings make their appearance in the transference in the analysis of alcoholics and other drug-dependent individuals, and this phase of the treatment, as well as the phenomenon itself, has been termed by Fenichel (1945) "object addiction." This transference needs to be interpreted in the analysis for the very same reason that all transferences are interpreted: so that the patient will discover that the characteristics that he attributes to the analyst are actually his own mental representations, which he first perceived as being part of his mother, and now re-experiences as alienated. The healing principle of psychoanalysis consists of the patient's claiming of his own mind, restoring the *conscious recognition* of his own self.

But, as we know only too well, patients do not feel free to do this. They fight it with all the means at their disposal, as if their lives depended on maintaining the repressions. The drug-dependent individuals often have a terrible struggle with this part of treatment. When we try to understand the nature of their psychic reality which makes the removal of repression from their maternal object representations so difficult for them, we discover that it leads us to the core of the emotional problems that are represented by their infantile trauma.

It is this kind of resistance against establishing the benign object representation, and taking over self-caring functions, which makes me take exception to the view of McDougall and de M'Uzan that in such patients the symbolic function in regard to primary object representations is absent. I will review some findings that suggested to us that drug-dependent individuals have to repress their rage and destructive wishes toward their maternal love object. This need manifests itself in a rigid "walling off" of the maternal love-object representation, together with an idealization of it, and an attribution to it of most life-supporting and nurturing functions. By doing this, the patient

manages (in his fantasy) to protect the love object from his fantasied destructive powers, and to assure that "someone *out there*" loves him and will take care of him (Krystal and Raskin, 1970).

VIII. The Addict's Problems in Retaining a "Good Introject"

Probably the most conspicuous indication of the difficulties of the substance-dependent individual has been overlooked because it is too obvious. I am referring to the fact that drug abuse consists in fact, not only of taking drugs, but equally important, of being deprived of drug effect. All the drugs which are addicting are short acting. The longer acting the drug, the greater the likelihood of the user panicking and developing a "bum trip" (Krystal and Raskin, 1970).

The formal withdrawal from drugs is an integral part of the process of addiction (Krystal, 1962). The development of ever-increasing tolerance for the drug is greater and faster in drug-dependent individuals because they have the need to deprive the drug of its power (Krystal, 1966); and at the same time, the moment it does lose its force, they panic (Rado, 1933; Krystal, 1959).

What is the meaning of all these apparent contradictions? It is that *while the drug-dependent yearns for the union with his maternal love object (representation) he also dreads it.* He really can't stand it either way. Schizophrenic patients and some borderline individuals yearn for union with their love object (representation), and once they achieve it (in fantasy), they cling to it passionately, giving up conscious registration of all perceptions or ideas that spoil this delusional fusion.

Drug-dependent individuals are very busy getting the drug, but can feel themselves reunited with the idealized love object only rarely for short periods of time, and only at moments when they are virtually totally anesthetized. Even then, one finds with amazement that many of them – at the very moment of the climactic action of the drug – indulge in acts of riddance, such as moving bowels, vomiting, cleaning their bodies, cutting their nails, or even house cleaning (Chessick, 1960). It may be said that they are *addicted to the process of taking in and losing the drug rather than to having it.* The seemingly bizarre behavior of the drug addict who plays with the drug by "regurgitating" it back and forth between the syringe and vein suddenly falls into place here. And isn't this another version of the "psychosomatic" child with mery-

cism who keeps regurgitating and swallowing the contents of his stomach?

Drug-dependent individuals dread fusion with the love-object representations because of the way they experienced them in the formative period of their lives. The explanations of these difficulties are linked to the problems of aggression, or ambivalence toward the love-object, which we have noted in the beginning of this paper. The ambivalence toward the therapist in the transference is matched by the ambivalence toward the drug, and that in turn is a reliving of the particularly severe ambivalence toward the maternal object representation. Our substance-dependent patients are just like the ones who get very sick upon ingesting the placebo. They even get sick upon hearing an interpretation which is "right on target" in content, form, and timing.[4]

We have previously pointed out that the "hangover phenomenon" was identical with the untoward reactions to the placebo. We explained that these were caused by "[The] inordinate guilt about oral indulgence, related to cannibalistic problems" (Krystal and Raskin, 1970, p. 47). In other words, when the substance-dependent patient tries to regain his alienated functions by swallowing the symbol of the object representation to whom he attributed these powers, he is confronted with his infantile fantasies that caused him the problems originally.

Another clinical observation well known to every worker in this field supports the accuracy of these constructions: that these patients are unable to accomplish normally the work of mourning and the feeling of "introjecting" the lost love-object. The introjection fantasy is a form of partial union of the self representation and object representation, at which most people arrive at the end of mourning. It is a clinical commonplace to say that alcoholics and other drug-dependent individuals cannot tolerate object losses (and that includes therapists) without being so threatened with their affects that they have virtually unavoidable relapse to self-destructive drug use.

This is a dimension of the problem of ambivalence which makes its appearance in the analysis of the drug-dependent individual. In the early stages of the therapy, the very availability of an object creates serious challenges to him. He also suffers from the above-mentioned fear of aggressive impulses and wishes. In addition, as Vaillant (1973)

[4] For the purpose of emphasizing a certain view of these patients' reactions, I have avoided discussing the nature of their "introjects" or "internal objects." Although these concepts are useful clinically, we can do without discussing them for present purposes.

has stressed, when these patients idealize their therapists in the transference, they experience themselves as worthless and bad.

But these are just preliminaries. The greatest difficulties arise because the effective work in the psychoanalytic therapy by which one can give up his attachment to one's infantile object representation and the infantile view of oneself is accomplished by "effective grieving," a process analogous to mourning (Wetmore, 1963).

IX. Grieving and the Extension of the Limits of Acknowledged Self Sameness

The very process of mourning spells trouble for the drug-dependent patient, who tends to dread being overwhelmed with depression; he also has a dread of all affects which he experiences as a trauma screen (Krystal, 1977). Raskin and I have found it necessary to postulate, in order to explain this phenomenon, that this type of an individual has had a nearly lethal childhood trauma experience, which he fears may return, and which he experiences as a "fate worse than death" (Krystal and Raskin, 1970). Elsewhere (Krystal, 1974, 1975), I have discussed the technical modifications made necessary by the regression in the nature of the affects and the impairment of affect tolerance. If even that obstacle is overcome, the patient is able to grieve effectively, and he then faces the ultimate challenge: the conscious acceptance of his object representations as his own mental creations.

At the end of a successful analysis one is in the same position as at the end of the hypothetical completely successful mourning. The bereaved person discovers that though the lost person is dead and gone, his love-object continues to exist in the survivor's mind. This gives him the opportunity to discover that as far as he is concerned, that is where the object had been all along—in his mind as an object representation of his own creation. And so one has to face the "return of the repressed." All the "bad" persecutory aspects of the object represent projections. Projections are fantasies, impulses, wishes and feelings that are not integrated. The process of integration of ego-alien wishes represent a loss and has to be accomplished by grieving. Until the grieving, and diminution of the idealized self representation is completed, depression is experienced, or needs to be experienced. There were originally two reasons for the failure to own up to one's death wishes toward the

object: the fear of loss of love, and the fear of destroying the object. "Walling off" the object representation as being "external" and "real" provided a protection for it. Attributing all the "goodness" to this "external object" was a bargain in which dependency and helplessness were accepted as preferable to destruction. Thus, the giving up of the repressions, the owning up to the self sameness of one's object representations, confronts one with the aggression that caused one to "wall off" his object representation so rigidly, and subsequently to develop that tragic yearning and dread of the love object.

Earlier I said that the rigid "walling off" of the maternal object representation took place in the face of extreme aggressive impulses toward it. The evidence for that came from this stage of the psychotherapeutic work with drug-dependent individuals. The intensity of the narcissistic rages, the persistence of the aggressive impulses make one wonder if all addiction is, at the bottom, a "hate addiction." The problem of aggression and its apparent threat to the safety and integrity of the self representation and/or object representation sets the limits to the kinds and numbers of drug-dependent patients who can be carried to a completion of analytic work. Along the way, most such patients, when confronted with their aggression, will relapse again and again into the use of the drug and self-destructive activities. Others will be driven to prove that their childhood misfortunes were real, by getting the analyst angry, and provoking abuse. Still others become so terrified of the dangerous, poisonous transference object, that they set out on a panicked, frantic search for the *ideal mother,* in some form—such as drink, love, or gambling.

If the therapist is otherwise equipped to bear the disappointments, provocations, and failures entailed in working with these patients, and if he has the time and patience to permit the patient to do this work by minute steps, then the most helpful thing to keep in mind is that the patient is confronted with problems of aggression that make him experience the transference as a life-and-death struggle. Care and caution must be exercised that the patient not be overwhelmed with his aggressive feelings, or guilt. Emergencies in which the patient's life hangs in the balance will occur, for that may be the way the patient may have to test the therapist.

When Simmel reviewed his lifetime experience with alcoholics in a paper that he never completed, he was very clear about the problems of aggression in the treatment of these patients. He said: ". . . during a state of abstinence under psychoanalysis in a hospital, substituting the addiction to alcohol or drugs was an overt suicidal addiction or an overt

addiction to homicide. During this stage the addict's only compulsion is to kill: himself or others. Usually he does not rationalize this urge; he just wants to die or at other times he just wants to kill" (Simmel, 1948, p. 24).

The aggression observable in the self-destructive life style of the drug-dependent individual is, in the process of psychotherapy, traced to its ultimate sources and meanings. In order to do so, the patient has to be able to experience with the therapist that which he has never dared to face—his hatred. Instead of seeing himself as a victim, and claiming *innocence,* now he is confronted with his murderous aggression. To do so, however, requires giving up the treasured view of oneself as the innocent victim, which again, has to be mourned. And so, it can be said that an unavoidable step in the treatment of a certain type of substance-dependent individual in intensive therapy is that he has to go through a depressive stage. During this phase of the treatment the dependence upon the therapist is extreme, and no substitutes are acceptable. Whereas early in the treatment many patients do best in a clinic with multiple therapists, for the few who will be carried to this type of therapeutic completion, the chief therapist has to be the one who will be stationary and available to the very end. The extreme difficulties resulting from the nature of the object representation of addictive personalities determine that those among them treated by psychoanalytic psychotherapy will continue to be the exception, mainly of research interest.

X. The Common Root of Impairment in Capacity for Self Care and Alexithymia

Among the problems shared by substance-dependent and psychosomatic patients reviewed in this essay is an impairment in their capacity to take care of themselves. This deficit brings them into the realm of those patients who have deficiencies in strategic functions. This point was made by Kohut (1971), who felt that addicts had an impaired development of "the basic capacity of the psyche to maintain, on its own, the narcissistic equilibrium of the personality." He explained:

> The trauma which they suffered is most frequently the severe disappointment in a mother who, because of her defective empathy with

> the child's needs (or for some other reasons), did not appropriately fulfill the functions (as a stimulus barrier; as an optimal provider of needed stimuli; or a supplier of tension relieving gratification, etc.) which the mature psychic apparatus should later be able to perform (or initiate) predominantly on its own. Traumatic disappointments suffered during these archaic stages of the development of the idealized self object deprive the child of the gradual internalization of early experiences of being optimally soothed, or of being aided in going to sleep. Such individuals remain thus fixated on aspects of archaic objects and they find them, for example, in the form of drugs. The drug, however, serves not as a substitute for loved or loving objects, or for a relationship with them, but as a replacement for a defect in the psychological structure [Kohut, 1971, p. 46].[5]

Kohut goes on to stress that, in the transference, the analysand expects to "have his analyst perform the functions which the patient's own psyche is incapable to provide" (p. 47). In connection with the consideration of these patients, Kohut goes on to discuss the process of *"transmuting internalization."* In it, he spells out the "breaking up of those aspects of the object image that are being internalized" (p. 49), and the depersonalizing of the introjected function, so that an effective internalization can be accomplished which leads to the formation of a psychic structure.

Here we have the basic theory of impairment in function based on deficiency in a psychic structure, due to a failure to appropriately introject an aspect of the maternal image which was the carrier for these functions. The weight of the evidence of the observations on both drug-dependent and psychosomatic patients is that this is the patients' own theory of their problem. The idea that they suffer from a deficiency disease, and that the analyst must supply to them the loving care of which they were cheated is often and despairingly proclaimed by these patients. If only the deficiency can be supplied to them they will love themselves and take good care of themselves. In truth, the patient wants not only his deficiency made up to him, but also wants the analyst to roll back the calendar and "fix" everything that happened to him which was "bad," and even then he would have a grudge left that things did not work perfectly the first time. We see the caricature of our fuzzy

[5] McDougall (1974) would insist, however, that in psychosomatic and addictive patients there is a lack of the symbolic representation of the good object (breast) too. She sees such a patient as one who "cannot internalize the breast, who cannot create within himself his mother's image to deal with his pain. . ." (p. 458).

thinking when it becomes the rationale of various nonanalytic therapists who do try to supply to their patients the love they had missed.

As psychoanalysts, we deal with distortions in self representation and object (world) representation. So it is a good thing that our patients do not, in truth, suffer from deficiency diseases, or have a deficiency in their ego apparatus.

We have made observations of substance-dependent, psychosomatic and "normal" individuals which suggest that the "deficiency-resulting-from-a-failure-in-internalization" is not the most helpful model to explain the problems:

1. Although the patients are ordinarily not able to perform self-soothing and general self-caring functions, we have observed that they are able to perform them under the influence of placebo, suggestion, or any situation in which they can disavow their doing it. Moreover, the impairments in function are spotty and fluctuating in scope and intensity—and not total and constant as they would have to be if there was a true deficiency.

2. Whereas drug addicts crave to "introject the object" and acquire the function, they have a great deal of difficulty in doing it, often negate the act instantly, and cannot maintain the fantasy of fusion.

3. The frightening and "sickening" effects of introjected objects suggest that the problem of ambivalence toward the object representation is what prevents them from fulfilling the cannibalistically tinged fantasies.

4. In our perusal of reactions to placebo, biofeedback, and other procedures, we found that psychosomatic patients and other people shared the drug addict's attitudes, albeit in a less severe degree. These were based on the infantile fantasy that one's vital functions were part of the object representation, and that the taking over of them would imply an introjection of the maternal object representation which was prohibited.

I have suggested that the child's attribution of soothing and life-giving functions to the maternal object representation becomes firmly established and reinforced as a defensive operation. The greater the problem of aggression resulting from the infantile trauma, the greater the rigidity of "walling off" of the maternal object representation, and the greater the scope of life-maintaining functions attributed to it. The placebo is a means of going around these intrapsychic prohibitions.

My conclusion is that these patients do not have a deficit in either the capacity for self-caring functions or in psychic structures necessary to exercise them. *They have a psychic block; an inhibition in regard to*

their function of self-soothing, self-caring as well as others. They are in the same position in regard to these functions as we all are in regard to our life-maintaining and affect-related parts of our bodies. We have the capacity to influence our state, but we dare not, unless we have a placebo-like device handy which makes possible the denial of our usurping these "forbidden" areas.

Although the "internalization-of-maternal-functions" idea has serious weaknesses theoretically (besides my difficulties with it, see also Schafer 1972), it is one of the most important fantasies of mankind, and as such represents important analytic material. But we must deal with it for the purpose of understanding and interpretation that this is the fantasy that caused these patients to develop their inhibitions. It may be recalled, from my early material in this paper, that substance-dependent individuals have a tendency to *"externalize"* their functions in general. I illustrated the difficulties they have in exercising their impulse control, and referred to the use of a team which includes a probation officer of antabuse to deal with that problem. In this context, antabuse may be considered a "superego placebo," as it enables the patient to exercise these alienated functions. In a forthcoming book on drug dependence, Wurmser (1978) puts great emphasis on the tendency of such patients to externalization as the most characteristic and important defensive pattern underlying substance dependence.

Rather than limiting ourselves exclusively to the model of acquisition of function by the infant through internalization of his perception of his mother's performance, other models may be more applicable in regard to certain aspects of development. Gedo and Goldberg (1973) have demonstrated the advantage of matching the models to developmental lines and types of experiences.

In regard to the problems of life-maintaining and self-caring functions, a Chomskian model of development appears more useful. Just as the innate capacity for the use of language unfolds in every human, so do most of these functions. The favorable environment provided by the mother permits an optimal maturation of these capacities. The problem is not truly with *acquiring* patterns of behavior or structures from outside, but the freedom to extend the boundaries of one's selfhood, and to minimize the areas alienated and turned over to "nonself." If we direct our attention to the process of development of affects as an example, we find that they evolve out of two basic states; those of tranquility and distress, respectively, which are affect precursors. The process of affect development has been worked out through the contributions of a number of authors which, along with my own, I have reviewed in some detail

(Krystal, 1974, 1977). The process goes on throughout childhood and adolescence. The developmental lines of affect are verbalization, desomatization, and differentiation out of the common precursor patterns into refined forms of specific emotions.

The development of affects takes place in the context of all the important object relations, and in all phases of psychosexual and psychosocial development. At present, however, I want to focus only on the earliest ones. When the child becomes disturbed, he experiences totally somatic reactions of mounting excitation. As the mother attends to the child's needs, she also becomes attuned to evolving variations in the child's responses and, according to her empathic capacity, recognizes the child's wants and responds to them specifically. This is the beginning of a long process of upbringing in which the children are encouraged to verbalize their affective states as precisely as possible, rather than continuing the mass reaction. Thus a good mother is very attentive to the budding differentiation in the child's affective responses and takes pleasure in guessing their meaning. Every increment in differentiation in affective signals produces more precise responses. This situation favors a continuing differentiation in affective patterns, and the start of the process of desomatization and verbalization. The child has, of course, an innate capacity for it, and as with language in general, unfolds it in response to his love objects. However, in regard to affects there is a hazard which the mother strives to prevent: if she cannot relieve the child's distress, and help him to feel content, he may become flooded with the primitive affect precursors. As long as this possibility is prevented, the child's success with increasingly letting his affective states be known promotes the dawning awareness of a variety of needs, emotions, and signals. If we focus our attention on the *process* of affect differentiation and verbalization—we can observe that the symbolic representation of the child's *needs* goes hand in hand with his ability to experience his narcissistic omnipotence in terms of fulfillment of his wishes. The availability of a good self object not only permits the grandiosity of the child to unfold appropriately but also permits the feeling that it is proper for him to "take care of himself." In other words, the infantile omnipotence permits the fantasy of self-care when the actual capacity for it is nil. In this fashion, because affective expressions are the only form of communication available, the mother's responsiveness and "fine ear" for the evolving nuances of the child's feelings become a crucial aspect of the early developmental milieu. The prompt and gratifying responses on the part of the mother permit the infant to claim credit for the parent's beneficent actions. The early

"paradise" of infantile omnipotence, however, is based on the failure to recognize mother as a separate, "external," and hence poorly controlled individual. But this period provides one the conviction that it is all right to will one's gratification and obtain it.

Only when distressed is the child confronted with the external and separate source of his vital supplies. But as one corrects the earlier error and forms the maternal object representation, there is a fatal tendency to confuse the supplies with the *experience of gratification.* The mother feeds the baby, but the baby must suckle, swallow, absorb, digest, metabolize, eliminate, form mental representations of the whole experience, but most of all *enjoy* the food for himself. To lose sight and control of one's authorship of all of his experiences of gratifying, affective and life-preserving functions, and to attribute these to the object representation sets the stage for future proscription of their use. As we have observed earlier, the "hysterical paralysis" of our autonomically innervated organs is virtually universal. We have, to date, no knowledge about influences upon the extent or severity of these inhibitions as related to early experiences.

However, in regard to the capacity for self care, especially for self soothing and obtaining gratification in one's life, there is strong evidence of the influence of the nature of early gratifications and frustrations. Under the experience of "good-enough mothering" the crucial feeling develops that it is *permissible* for the child to exercise a certain measure of self regulation in regard to his affective and hedonic states. One gains the feeling that it is permissible for one to comfort or soothe one's self. Withal, when it is necessary to "baby" one's self, the unconscious fantasy may become manifest that the "benign introject" is doing it, or lending the permission to do it. At times, when "nursing" a sick organ, the identification with the mother taking care of a baby is acted out. All of these are evidences that even in fortunate circumstances of childhood, one grows up with the tendency to attribute these functions to the primal love object. And yet, the principle of psychic reality dictates that from the beginning one had to create for himself, in his mind, all he has ever experienced of comfort or pleasure.

Our observations indicate that *serious frustrations* result in a premature confrontation with the child's helplessness and dependence. The mother is discovered to be the holder of all external supplies, so that sight is lost of the child's active participation in his soothing and comforting. When frustrated or exposed to pain or painful affects, the child becomes dependent upon the mothering parent to protect him from the onslaught of these responses.

The most difficult task of mothering is the recognition of the intensity of affect precursors which the child is able to bear without becoming overwhelmed by them. An essential aspect of mothering related to the affect maturation consists of the gradual allowing of increasing intensity of affects to build up. It is the mother's empathy which directs her judgment as to when she must step in and comfort the child. The failure to interrupt the mounting intensity of affects may lead to the onset of infantile psychic trauma (Krystal, 1975, 1978).

Infantile psychic trauma has serious aftereffects in both spheres which we have identified above:

1. There may be an arrest or regression in the genetic development of affects. This produces the picture of alexithymia, with an impairment in symbolization, and frequently an anhedonia, and a general fear of affects as trauma screens.

2. The premature disruption of the symbiotic unity confronts the child with a dangerous, all powerful external object—that cannot be satisfactorily controlled.

Among the many problems that result from this disruption is the attempt to magically control the object by splitting, idealization, and masochistic modifications of the self representations. It is in this predicament that affective and self-caring functions are relegated to the object representation. The problems of envy and ambivalence prevent the coveted regaining of one's own functions by incorporation. Dorsey (1971) summarized poetically: "In a traumatic living it is my loss of my sense of personal identity that is truly disabling" (p. 125). Khan (1963) described a variety of possible "breaches in the mother's role as a protective shield" (p. 290), which made the child precautiously aware of his dependence upon her. To Khan, this development was one of the most harmful aspects of "cumulative trauma."

To recapitulate, then, the interaction between mother and child in the sphere of early affective function vitally affects two areas:

1. Appropriate responses on the part of the mother favor the normal development of affects in the direction of their desomatization and differentiation. They also promote the progressive development of differentiated affective responses, modulated in their intensity with increasing vocalization, verbalization, and symbolization. This also involves the development of reflective self awareness, and the use of symbols and fantasy for progressive intrapsychic structure formation.

2. The continuation of the symbiotic relationship without traumatic disruption promotes the attribution of self caring and affective functions to the self representation. With it comes a sense of security and permissibility of striving to attain gratification and comfort.

It follows that disturbances in this process can produce the two problems which we have identified in drug-dependent and psychosomatic patients: (1) an arrest or regression in the disturbance of affect which I have reviewed early in this paper and which Sifneos termed "alexithymia," and (2) an inhibition in the ability to exercise self-caring functions.

Both of these problems represent a serious handicap in regard to the patient's ability to utilize psychoanalytic psychotherapy. In regard to the inhibition in self-caring functions, we have to deal with the fantasies that underlie the distortions in self and object representations. It follows that *the goal of therapy is not to supply to the patients their missing functions or psychic structures, but to enable them to exercise functions blocked by inhibitions.* In the process of therapy one has to work through the transferences as reviewed above, in order to enable the patient to renounce his childhood theory of the world and of himself.

XI. Summary

The nature of the object relations of the drug-dependent patient are such that he craves to be united with his ideal object, but at the same time dreads it. He thus becomes addicted to acting out the drama of fantasy introjection and separation from the drug. There is a corresponding intrapsychic defect; certain essential functions related to nurturance are reserved for the object representation. The objective of the therapy is to permit the patient to extend his conscious self regulation to all of himself, thereby freeing him from the need for the placebo effect of the drug as a measure of gaining access to his alienated parts and function.

Psychosomatic patients show the same kind of inhibition in self-caring functions, especially in regard to their illness. They also share with addictive patients a disturbance in affectivity and symbolization termed "alexithymia." The "operational thinking" characteristic of them shows an impoverishment of imagination, and a blocking of drive-oriented cognition.

Both types of problems seem to have common roots in certain disturbances in object relations that relate to affective communications. These problems are most conspicuous in the lives of substance-dependent and psychosomatic patients, but are present in lesser degrees in every analysand. Our awareness of these problems allows us to address our-

selves to these difficulties which otherwise tend to seriously diminish the effectiveness of all of the other therapeutic interventions.

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