ALCOHOLISM, A.A., AND THE GOVERNANCE OF THE SELF

JOHN E. MACK

Dynamic Approaches to the Understanding and Treatment of Alcoholism

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Alcoholism, A.A., and the Governance of the Self[1]

John E. Mack

> It is idle to say that men are not responsible for their misfortunes. What is responsibility? Surely to be responsible means to be liable to have to give an answer should it be demanded, and all things which live are responsible for their lives and actions should society see fit to question them through the mouth of its authorized agent. [Samuel Butler, *Erewhon*, p. 113]

There has been a relative lack of psychoanalytic attention to alcoholism in recent years (see the chapter by Margaret Bean for a review of the current literature). This is the result not only of therapeutic discouragement, for psychoanalysts have often written persuasively about clinical conditions for which no suitable therapeutic application of analytic formulations had yet been developed. The lack also seems to reflect the failure to discover an appropriate theoretical framework within which to consider the disorder.

The popularity of the "disease concept of alcoholism" (the term, though not the idea, derives from Jellinek's [1960] book by that title) seems to have discouraged efforts to explore the psychological aspects of alcoholism. Jellinek's emphasis upon alcoholism as a disease (he regarded "illness" as a "more felicitous" term [p. 11]) appears to have been motivated by a desire to secure legitimacy for alcoholism within the medical profession, and to help

bring about changes in social attitudes and policies that would permit better care for alcoholic patients and lead to the support of clinical and research activities. The disease concept was, in the words of Robin Room (1972), “a means,” in some ways unsuccessful, “of getting a better deal for the ‘alcoholic’ ” and not “a logical consequence of scholarly work and scientific discoveries” (p. 1056).

Although he felt that research in alcoholism should focus upon the pharmacological process of addiction (p. 154), in considering alcoholism as a disease Jellinek did not intend to exclude psychological factors. He accepted the definition of disease offered by the *Journal of the American Medical Association* in 1957 as “any deviation from a state of health; an illness or sickness” (quoted in Jellinek, 1960, p. 11), which does not specify whether psychosocial or organic factors predominate. After reviewing the relevant literature before 1960, Jellinek pointed to the unsatisfactory nature of existing psychological formulations in explaining any of the phases of alcoholism but seemed to encourage investigations of the psychological aspect. Jellinek's target was not psychology or psychiatry, but traditional views which thought of alcoholism primarily as the consequence of sin, vice, or weakness or character and the alcoholic as a person to be punished rather than understood or treated.

The disease concept has clearly been useful in bringing greater

acceptance of the idea that the alcoholic is a person in need of help, or as a treatment strategy for relieving guilt. Its unwarranted but perhaps inevitable extension has also, however, given rise to a good deal of mischief, as Pattison, Sobell and Sobell point out in their book *Emerging Concepts of Alcohol Dependence* (1977). The narrowly organic connotation of "disease" has led to the espousal of over simplified physiological models and a territorial smugness within the medical profession which disregards the need for careful psychological study, discourages appropriate psychotherapy, and precludes a sophisticated psychodynamic understanding of the problems of the individual alcoholic (see also Robinson, 1972). Finally, the disease concept has produced potential confusion and contradiction about the idea of responsibility, a problem which the inherent sophistication of the A.A. approach has found a way around through holding the individual alcoholic responsible for initiating the steps toward sobriety while relieving him of responsibility for the drinking or the illness. The models of sin and disease do not exhaust the possibilities. "It is time," as Peter Dews wrote, "to move to new attacks" (p. 1047).

As Jellinek pointed out himself, there is a crucial distinction between the mechanisms that lead the gamma alcoholic (his term for the alcoholic who has lost control of his drinking, constituting more than 80 percent of his sample of two thousand A.A. members) to begin a new bout of drinking and those that drive him to continue to drink once the bout has begun. The issue

of responsibility is quite different depending upon whether one is considering the initiation of a new bout of drinking or the ability to bring the drinking under control once an episode is underway. This is consistent with Jellinek's (1960) view that "psychological formulations" were "more satisfactory" than physiopathological ones "as far as the initiating stage of alcohol addiction goes" but that this "does not extend to the later developments" (p. 80).

When psychoanalytic concepts or terms derived from psychoanalysis are employed, they may be used merely as straw men to be blown away in a puff of ridicule. Generally it is a conflict theory, with stress upon the alleged role of unconscious guilt, that is marked for demolition. Or sweeping statements are offered which presume knowledge that we do not yet possess, or seem to equate psychodynamic elements with conscious control. Vaillant, for example, in his chapter in this volume, asserts that "the etiology of alcoholism is uncontrolled drinking" and "uncontrolled drinking is not symptomatic of some underlying disorder," and that "for most alcoholics return to controlled drinking lies outside an appeal to reason or to a dynamic unconscious. Like the hypertensive or the diabetic, the alcoholic cannot usually cure himself by will power or insight alone" (page 37).

Certainly formulations which regard uncontrolled drinking as if it were no more than a psychoneurotic symptom, manifesting itself within a psychic organization that is, by and large, intact and functioning smoothly, will fail to

shed much light upon acute and chronic alcoholism in either its symptomatic or its addiction phase. But there does exist now within psychoanalysis an emerging body of theory relating to drive organization and regulation, personality structure, narcissistic vulnerability, the formation and maintenance of a cohesive self, and a set of ego functions concerned with self-preservation, self-care, and what I call self-governance (see below) that may have relevance for the understanding of addiction in general and alcoholism in particular.

The success of Alcoholics Anonymous in the treatment of alcoholism may not be equaled by any other known therapeutic approach. Traditional forms of insight-oriented psychoanalytic therapy, however valuable in helping the alcoholic to understand various aspects of himself, have not generally been successful in giving him power over his drinking, in enabling him to master the problem (Bales, 1944b, pp. 273-274; Zinberg, 1977, p. 100). The history, organization, and procedures of A.A. have been well described (Alcoholics Anonymous, 1976; Bales, 1944b; Bean, 1975; Leach, 1973; Leach et al., 1969; Stewart, 1955; Tiebout, 1943-1944, 1961; Trice, 1957; Alcoholics Anonymous, 1977; Zinberg, 1977), but A. A. as a psychosocial modality of treatment offers in addition a rich arena of observation that has been underutilized for learning about the psychological aspects of alcoholism. In this chapter I will examine in psychodynamic terms the role of A.A. in the treatment of alcoholism, drawing especially upon the reported experiences of

alcoholics who have attended A. A. meetings. From these observations and other relevant clinical data I will suggest tentative formulations and directions in which further clinical investigation could proceed if a more complete in-depth understanding of the psychology and psychopathology of alcoholism is to be obtained. My comments and observations will have particular relevance to the following aspects of the problem of acute and chronic alcoholism:

1. The initiation of a new bout of drinking in an alcoholic who is sober
2. The ending of a bout of drinking outside of an institution
3. The maintenance of sobriety
4. The vulnerability of the individual to becoming an alcoholic

There will be less discussion offered on the mechanisms which underlie the continued drinking of an addicted alcoholic during an actual bout, as physiological and biochemical factors appear to play a larger role in this phase of the illness. It should be pointed out, however, that many alcoholics in the middle of a drinking episode have been able to muster sufficient control to bring themselves to A.A. and to initiate thereby the chain of events leading toward sobriety.

A.A. and Self-Governance

The psychoanalyst Ernst Simmel (1948), writing a decade after A.A. was formed, asked, "Does our theory, derived from psychoanalytic research, provide any possibility of application to the therapy of groups of patients to meet the universal danger which alcoholism signifies for the mental health of the country?" He answered his own question in the affirmative: "It has already been applied intuitively and successfully in a mass psychological experiment—Alcoholics Anonymous" (p. 28). Simmel went on to point out that the therapeutic principles employed by A. A. corresponded "basically to psychoanalytic findings." He stressed the recognition by A.A. of the overpowering nature of latent drives in the alcoholic and the need for a countervailing power upon which he can rely, a higher power which is embodied in the phrasing of A. A. 's step 3, "God as we understand Him" (Alcoholics Anonymous, 1977, pp. 5, 35). Simmel's paper was published posthumously and was incomplete at the time of his death. Notes written in longhand on the last page of the manuscript indicate that he was thinking about the interrelation of ego psychological, group dynamic, community, and religious dimensions of the understanding of alcoholism that was implicit in A.A. (see also Zinberg & Fraser, 1979, p. 379). The notes concluded with this hope: "possibilities for Alcoholics Anonymous from the collaboration of psychoanalysts" (Simmel, 1948, p. 31). But such collaborations have been quite limited. This chapter may be regarded as one effort to carry forth the hope which Simmel expressed.

In 1978 A.A. estimated that its membership was greater than 1 million in more than thirty thousand groups worldwide (Alcoholics Anonymous, 1976, 1978 printing, p. xxii). The therapeutic success of A.A. is difficult to evaluate, in part because of the self-selected population. But the available data suggest that although A.A. may only reach 5 to 10 percent of alcoholics, for those who attend meetings on a regular basis it is the most effective means of maintaining sobriety currently known (Leach, 1973). This suggests that whatever the forces are which drive the alcoholic to drink, they can be successfully counteracted by a form of treatment that relies entirely on a human mode of intervention. In my opinion this salient fact must dampen the hope that biochemical explanations or forms of treatment alone will be of much help in the preaddiction phases of alcoholism. What I am interested in pursuing are the psychological mechanisms relevant to A. A. 's success and the implications of the fact that any form of group treatment could have such an extraordinary impact upon a disorder which is so difficult to control.

Before proceeding further in this discussion, I wish to introduce a concept that I have found useful in trying to understand alcoholism and other disorders in which a problem of impulse control is involved. I am referring to the notion of self-governance. Self-governance has to do with that aspect of the ego or self which is, in actuality or potentiality, in charge of the personality. Self-governance is a supraordinate function, or group of functions, in the ego system. It is concerned with choosing or deciding, with

directing and controlling. The functions of self-governance are similar to what Hendrick (1943), in relation to the capacity to work, and more recently Bean (1975, p. 25), in discussing the paralysis of the alcoholic's problem-solving capacities by magical thinking, have called ego executant functions. But "executant functioning" connotes a solitary operation of the ego, while "self-governance" is a psychosocial term, intended to leave room for the participation of others in the governance of the individual. Self-governance as a theoretical concept is intended, unlike ego executant functioning, to allow for the sharing of control or responsibility with other individuals or groups. It acknowledges the essential interdependence of the self and others. Psychotherapy always has among its goals extension of the areas over which the individual has sovereignty, his domain of self-governance.

There are many situations in which self-governance is impaired—manic and schizophrenic psychoses and aggressive impulse disorders are obvious examples. The disorders of substance abuse in general and alcoholism in particular, offer other striking examples of such impairment. The powerlessness which the alcoholic experiences in relation to alcohol reflects an impairment of self-governance with respect to the management of this substance. It has not been ascertained whether this powerlessness is specific to the drive to drink or is experienced by alcoholics in relation to certain other strong impulses as well. In the A.A. approach acknowledgment and acceptance of this powerlessness are the *first step* in the path to recovery

("We admitted we were powerless over alcohol—that our lives had become unmanageable").

Self-governance—the sense of being and the power to be in charge of oneself—is one of the most highly valued of human functions. The admission that one cannot manage an aspect of oneself which is expected ordinarily to be under one's own control is experienced as an important failure, a major personal blow. One has only to note how vigorously a friend or colleague who has had a few drinks too many will resist letting someone else drive him home from a party, will cling to the belief that his judgment remains intact and that he is still responsibly in charge of himself. One frequently hears from alcoholics statements like "I can't bear to admit I can't control my drinking." Even though the loss of voluntary control is perhaps never absolute (Pattison et al., 1977, p. 98), it is a far more useful step *therapeutically* for the alcoholic to acknowledge his powerlessness than to have it demonstrated that he still retains an element of control. For even in this early stage in the development of his drinking problem he may not be able to exercise control in any useful or practical way. Therefore any emphasis at this time upon the dimension of control which remains will only give more cause to feel guilt and deepen the sense of failure.

One reason, I believe, why alcoholism is so difficult to treat derives from the general acceptance of drinking in our culture. This acceptance is

accompanied by a high level of expectation that controlled drinking is both possible and desirable together with a deep, though often unconscious, opprobrium attached to the idea that one is unable to manage one's drinking. The profound reluctance of most family members, and even medical and mental health professionals, to confront the problem drinker with the fact, by then usually obvious, that he cannot control his drinking derives, I believe, from the widely internalized belief that it is a shameful and embarrassing failure to admit that this function is no longer within the governing capabilities of the self (DiCicco et al., 1978).

A.A. in its graduated twelve-step program seeks to enlarge progressively the capacity of the chronic drinker to govern *the impulse to drink* in the absence of alcohol. The seemingly single-minded emphasis in A. A. upon sobriety derives from the experience that for the alcoholic this is the essential first step without which nothing else can be achieved. In other words, the management of the impulse to drink when drinking— "controlled drinking"—whether for psychological or physiological reasons, is outside of his capability. The question of nonabstinence as a treatment goal for alcoholics is a highly complex and controversial subject which will not be considered here (see, for example, Pattison, 1976). Perhaps it is sufficient to say only that "alcoholism" embraces a spectrum or continuum, and that many alcohol-abusing individuals may reasonably strive to achieve controlled drinking (Vaillant. 1979).

The success of A.A. is due to its intuitive and subtle grasp of the complex psychosocial and biological nature of self-governance, not only for the control of problem drinking but in a far more general sense. For A.A. recognizes that the self never functions as a solitary entity. It is always participating with others—other persons, the family, neighborhood, social, ethnic, religious, or national groups—in its realization and fulfillment.[2] The psychic representations within the self are not static structures. They are constantly resonating or interacting with the ongoing communications or representations of other individual selves or groups which are continuously being taken in and exerting a strong guiding or moderating impact on the self. A.A. has perceived that certain forms of group activity, especially if placed in the context of religious experience and values, can have a more powerful influence upon the capacity of the individual to govern himself than can any form of individual psychotherapy. Bales (1944b) was referring to this aspect of A.A., I believe, when he wrote, "There is a certain type of control within the individual personality which can have its source only 'outside of the self'—for practical purposes, in the moral principles advocated by a closely knit solidary group—and can only be internalized and made effective against self-centered, satisfaction-directed impulses by an involuntary feeling of belongingness and allegiance to such a group, i.e., a "moral community' " (p. 276).

Many visitors to A.A. meetings who are not alcoholics have an

experience which they describe in such comments as “1 could use this myself,” or “This isn’t just for alcoholics. There is something here which could be valuable for everybody.” What is being referred to is, I believe, the aspect of belonging to which Bales refers, the unembarrassed acknowledgment of the need for participation in a caring community without ulterior motives, one which accepts the individual totally for what he is. At a more theoretical level what is being perceived is the fact that the self cannot exist as a solitary structure, that its survival, governance, and value require participation in a social structure or community.

Alcoholics continue to attend A. A. meetings after they have achieved sobriety and reordered their lives. Some continue to attend even after the group is no longer essential for controlling the impulse to drink. These individuals recognize, I believe, the personal importance of the A.A. community in ways which may have very little to do with their drinking problem. From the standpoint of A. A. itself the policy of a perpetual open door contains an implicit recognition that A.A.’s values, philosophy, and program offer a community of purpose which has a significance beyond the explicit goal of maintaining sobriety or controlling the impulse to drink in chronic alcoholics, a purpose that could have clinical and theoretical relevance for understanding aspects of the self-psychology of nonalcoholics as well.

A.A. and the Psychology of Narcissism

Professional and paraprofessionals who work in the alcohol field are most reluctant to use such terms as “character problem” or “ego defect” in talking about individuals who suffer from chronic alcoholism lest they impose thereby an additional onus upon the patient and reinforce negative attitudes among caregivers. Once again, what began as a well-meaning and useful therapeutic strategy has discouraged systematic exploration of the developmental problems of alcoholics and stands in the way of achieving psychological understanding of the disorder.

A. A. itself has not been as concerned with this sort of protection and does not hesitate to stress the character problems of alcoholic members. Step 6 is the readiness “to have God remove all these defects of character” and step 7 asks “Him to remove our shortcomings. ” But beyond this the authors of *Twelve Steps and Twelve Traditions* (Alcoholics Anonymous, 1977) observe “that character defects based upon shortsighted or unworthy desires are the obstacles that block our path toward the achievement of A.A.’s objectives” (p. 77) and how reluctantly alcoholics “come to grips with those character flaws that made problem drinkers of us in the first place, flaws which must be dealt with to prevent a retreat into alcoholism once again” (p. 74). Perhaps it is the connotation of moral condemnation and inferiority that is attached to the word “character” in its *popular* usage that has led alcohol workers to avoid

the term. But it needs to be emphasized that in psychoanalysis the word has usages which carry no more of a value connotation than do “personality,” “ego,” or “self.”

Although nontechnical, everyday terms are used, A.A. leaves no doubt that it is in the sector of narcissism and narcissistic development of the personality that important clues may be found to the understanding and treatment of alcoholism. Narcissism is defined psychoanalytically as “the libidinal investment of the self.” We may consider it here more simply as the realm of self-love and self-regard. As Heinz Kohut and others have noted, there is with narcissism, as with character, “an understandable tendency to look at it with a negatively toned evaluation as soon as the field of theory is left” (Kohut, 1966, p. 243).

Kohut and his followers (Kohut, 1971, 1977b; Kohut & Wolf, 1978; Goldberg et al., 1978) have attempted to separate narcissism, or self- love, from object relations, and have studied its normal and pathological manifestations as separate lines of development. Healthy narcissism is a fundamental aspect of general emotional health and includes a feeling of well-being, a confident sense of one’s worth and potential, and a balanced perspective about one's importance in relation to other persons and groups and in the cosmos (see Vann Spruiell [1975] for his discussion of the “three strands” of narcissistic development). This kind of health is a prerequisite for

satisfying relationships with others and for gratifying and successful work and recreational experiences. Manifestations of pathological narcissism include exaggerated preoccupation with oneself and one's own needs and desires, a diminished sense of one's value or an exaggerated belief in one's worth or importance, described in its extreme expressions as grandiosity. Severe disturbances of narcissism are associated with fragmentation and disorganization of the self as seen in acute schizophrenic psychoses or in the regressive clinical picture sometimes brought about as the result of acute drunkenness or prolonged drinking (one reason why alcoholics are so often misdiagnosed as schizophrenic). Ego disorganization can take place as a result of physiological or psychological causes, or a combination of both, which is one of the reasons why it has been so difficult to determine the basis of many of the states of ego regression that are found in association with alcoholism in its various phases.

We have already seen how one sort of narcissistic disturbance stands in the way of the alcoholic's obtaining help—his inability to acknowledge that his drinking is out of control. This reluctance is the result not only of resistance to giving up the drinking itself, but derives from the degree of investment which, for the alcoholic and for all of us, is attached to the belief that one is in charge of oneself, i.e., has the capacity for autonomous governance of impulses in general and the drive to drink in particular.

A.A. 's literature is filled with descriptions and insights into aspects of healthy and pathological narcissism. A.A.'s founder. Bill W., wrote in his "story" that the achievement of sobriety "meant destruction of self-centeredness" (Alcoholics Anonymous, 1976, p. 14). Though "just underneath there is deadly earnestness," he also found a "vast amount of fun" in the whole recovery process, recognizing the healthy dimension of humor (an aspect of A. A. which has, in my opinion, received insufficient attention) (p. 16). *Twelve Steps and Twelve Traditions* contains many discussions of self-centeredness, of egoism and the need for "ego-puncturing," and of the consequences of injured self-regard.

Harry Tiebout (1943-1944, 1961) was the first to recognize that A. A. 's approach to the treatment of alcoholism was directed primarily at the narcissistic dimension of the disorder. In A.A., Tiebout wrote, the alcoholic came to realize he had always "put himself first" and that effective treatment depended upon recognizing that "he was but a small fraction of a universe peopled by many other individuals" (1943-1944, p. 471). In order for the A.A. experience to work effectively, the alcoholic must "lose the narcissistic element permanently" (p. 472) and replace the "big ego" of infantile narcissism with a more humble self (1961, p. 59). What seems not to be found in Tiebout. in subsequent writings about narcissism and alcoholism or, for that matter in A.A.'s own publications, is a differentiation of the manifestations of pathological narcissistic expression and vulnerability that

are contained in the prealcoholic character of the individual from those which are the regressive consequences of the chronic or addictive drinking itself. Until this is clarified, it is presumptuous to write of the "narcissistic core" of the disorder or of a "fundamental wound of the addict's ego" (Simmel, 1948, p. 27). For the experience of chronic drunkenness contains so many inevitable hurts, so many catastrophic injuries to the self that are a *consequence* of the alcoholic's drinking, that one must be very careful not to conclude without better indications that the narcissistic aspects of the clinical picture antedated the excessive drinking.

It is its recognition of the dangerous egocentric pitfalls of leadership that accounts for the absence of perpetuating offices or positions of directing authority in A.A. (Unterberger, 1978). ''Tradition Two" of A.A. (Alcoholics Anonymous, 1977) states that ''for our group purpose there is but one ultimate authority—a loving God as he may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern" (p. 136). The authors of *Twelve Steps and Twelve Traditions* describe clearly the temptation to grandiosity that may, for example, attach to the experience of having founded a successful A.A. group. "Being on the human side," they observe, "the founder and his friends may bask a little in glory" (p. 137). But if these individuals should try to "run this group forever," they are likely to find themselves "summarily beached" by "the rising tide of democracy" at the election to A.A.'s rotating committee (p. 138). This committee does necessary

chores for the A. A. group, but it does *not* govern or direct the group and is sharply limited in its authority. A defeat of this sort, in which, for example, a founder's status is sharply reduced, can cause a severe sense of injury, a fall in self-esteem. A.A. calls such individuals "bleeding deacons," and some "hemorrhage so badly" that they get drunk. "At times," it is observed, "the A.A. landscape seems to be littered with bleeding forms" (p. 139). But most, A.A. observes, survive their disappointment and become "elder statesmen," valued members of the group who have grown in *wisdom*, one of the cardinal dimensions included by Kohut among his examples of healthy narcissism. These elder statesmen become the "real and permanent leadership of A.A." to whom the group turns for advice. They lead by example and "become the voice of the group conscience" (p. 140). Thus, although A.A. has its heroes, there are no leadership positions.

There is in this aspect of A.A.'s tradition a profound recognition of the artificial inflation of self-regard and the stimulation of archaic- grandiose structures in the self that can occur through holding positions of leadership and authority. Furthermore, from the standpoint of the group, the idealization and investment of limited narcissistic resources in a leader can deplete the sense of self-worth of individual members and increase the risk of further drinking. Inevitable disappointment in a leader on the part of the members would lead to personal criticism of him with the inevitable risks of damage to self-regard for member and leader alike.

It seems that A.A.'s eschewing of authority positions within the organization is based on more than the need for democratic structure that is characteristic of most voluntary self-help groups. This policy may reflect, in addition, the recognition of narcissistic vulnerability as an aspect of alcoholism, and the realization of the likely injuries to self-regard ("hemorrhaging") that would be incurred for member and leader alike if authority positions were to be created.

The monologues of drinking experience, the often humorous "drunkalogues," which are such an important and appreciated part of the program at A. A. meetings, seem at times just a public self-excoriation, an exhibitionistic and self-centered confession. But they are more than this. They are, in addition, a serious effort on the part of individual alcoholics to reinforce the new self-respect they have achieved since becoming sober, the healthy shifts in the economy of their narcissism that have been accomplished since becoming A.A. members. The speaker offers an experience with which the group members can identify in their efforts to consolidate their own personal growth. The group recognizes the familiar elements in the various stories and offers legitimate approval and appreciation of what the speaker has to say. There is an exhibitionistic aspect, but it is in the service of the healthy development of the individual and the group. It is to this group aspect of A.A. that I now wish to turn.

A.A. and the Collective Dimension of Self-Governance

Freud's (1921, 1930) writings about groups related mainly to mass organizations and to institutions, such as an army or a church. He was interested particularly in the psychological importance of the leader and the effect of large groups upon superego and ego ideal structures in the individual. A.A.'s reference to the "group conscience" (see above) is interesting in this connection. More recent studies of group psychology have included a consideration of the need-fulfilling and ego-sustaining aspect of small and large groups (Calder, 1979; Kernberg, 1977; Scheidlinger, 1964, 1974); the regressive and destructive potential of mass organizations (Mitscherlich. 1971); the distinction between mature (work) groups and regressive (basic assumption) groups (Shapiro, 1977); and the relationship of group and organizational structures to the stability of the self (Zaleznik, 1977). Erik Erikson (1959, 1968) has made important contributions to our understanding of the importance of social structures, of groups and institutions, in the formation of ego identity. It remains for others to describe more specifically the ways in which specific groups function in maintaining the structure and stability of the self. A comprehensive theory of group psychology will have to include the part played by family, community, and other group formations in the development, structure, and continuing stability of the self.

AA recognizes the importance of the powerlessness of the individual in relation to alcohol and the drive to drink. Anyone who has worked with alcoholics will appreciate their helplessness in the face of this drive no matter how vigorously and sincerely they may protest that it is now under control. A.A. does not interpret the psychological or biological *basis* or *reason* for this powerlessness within the individual. It does not need to. A.A. simply takes it into account and provides a powerful counterforce to make up for its absence and a series of steps whereby the individual can gain for himself *in part* the power to manage the impulse to drink.

I have noted earlier the essential part played by family, group, and institutional representations in the formation of a cohesive self. I have focused especially upon the executive functioning of the individual, what I have called self-governance. It is my contention that A.A.'s approach *can* be helpfully understood in terms of the functions of self-governance. The association's effectiveness derives from its recognition of the fact that the self is a *social organization* and that self-governance for all individuals is never entirely a solitary activity. It is, rather, a function or set of functions which depend upon the individual's participation in social structures and institutions. A.A. succeeds in enabling the individual with a drinking problem to become sober through providing a network of reliable individual and group relationships that operate powerfully in the governance of the need to drink.

It might be useful at this point to note how little we know about how individuals who do *not* have drinking problems govern their desire to drink. Clearly in addition to internalized ego controls there are powerful social attitudes, pressures, institutions, and structures which operate subtly within the self-system to enable persons who might otherwise become problem drinkers to control their drinking. Zinberg and Fraser (1979) have shown, for example, how much more of a problem alcoholism was in the nineteenth century than in the colonial period in the United States. They hypothesize that this was due to the breakdown of family social structures which had restricted drinking to ritualized and ceremonial occasions, and to the increased availability of taverns and barrooms to which men, who were already experiencing social dislocation as a result of industrialization and urbanization, flocked in large numbers. In societies such as France, where there is an institutionalized tolerance of large daily amounts of alcohol intake, paradoxes arise with regard to alcoholism. There seems to be rather widespread addiction and low-level impairment of functioning due to the presence of alcohol in the tissues. But at the same time the socialization patterns seem to prevent the occurrence of as much uncontrolled drunkenness as is found in societies, such as the United States, which have a relatively low level of acceptance of large daily amounts of alcohol. (See Jellinek, 1960, pp. 25-32, for a more detailed discussion of the relationship of drinking patterns to cultural attitudes.) The increase in alcoholism among

some American Indian tribes and in certain African countries needs also to be studied in terms of the impact upon the individual of the destruction of tribal structures which have served essential functions in the ongoing governance of the self.

A comprehensive consideration of why some individuals lose the capacity to govern their drinking cannot be limited to an examination of the development or breakdown of drive and ego structures within the individual. We need also to consider losses or shifts in the role of essential social and community structures that have heretofore helped individuals who are biologically and psychologically vulnerable to alcoholism, to govern their drinking. Personal loss, which frequently precedes the onset of excessive drinking, is generally looked at from the affective standpoint. In terms of my argument, we must also consider a meaningful loss or losses as the removal of an important presence, or of a stabilizing force or social structure, which has aided in governing the impulse to drink. Many individuals who become problem drinkers seem recently to have lost family members or other sources of social stability that have been part of their self-governing system.

Whatever theory may be espoused, workers in this field seem for the most part to agree that alcoholics need to substitute people for alcohol. For those who choose it, A.A. does this in abundance but without the evident risks which often seem to attend the intense relationships of individual

psychotherapy. As Vaillant points out in his chapter in this volume (page 53), some alcoholics have suffered from early maternal neglect which may impair their capacity to care for themselves. This neglect, or other troubling developmental experiences, may have left the alcoholic acutely vulnerable to further hurt or humiliation. Certainly once alcoholism has developed, the individual will suffer many personal wounds and failures and become vulnerable to further injury. Such disappointment can occur in the course of individual psychotherapy. The time may come when the patient will call his therapist drunk, perhaps on a Sunday or other inconvenient time, and the therapist will have insufficient time or patience to meet his needs or to make the arrangements for hospitalization. Hurt and disappointment with the therapist, to whom exalted expectations may have become attached, can follow with the result that the sense of injury in the self can be deepened.

A.A. groups offer many individuals who care, who have similar stories and do not tire of hearing new ones. Because of this caring and support. AA members individually and in group meetings may be able to do a good deal more confronting of the alcoholic with his maladaptive defenses of denial, rationalization, and magical thinking (see Bean, 1975, and in this volume) without inflicting new wounds upon the self. The alcohol-controlling capacity of these other individuals is gradually internalized and becomes a part of the self-governing structure of the individual. The A.A. group itself, as a caring object, also may be internalized. A twenty-six-year-old young man, sober for

several months, when asked what it was in the A.A. experience which enabled him to get on top of his drinking, replied, “It’s the fellowship. It’s the companionship. It's the love within our program. That’s why it’s more successful than any other program with alcoholics. ... I got to know many fine people and it still continues. My circle continues to grow. Very good people, who were loving, caring and understood, and *still do understand* [my italics]. That's probably one of the greatest reasons why it works so well—because it's a fellowship. ” There is in this statement the recognition of the need-filling aspect of the A. A. group and also of the importance of its ongoing nature.[3] A.A. remains an important part of this man’s self- governing structure. The twelve-step program of A. A. is another way in which the association provides order, a system, even ritual, which can be utilized by the alcoholic in the development of internalized self-governing structures, although complete autonomy of the self with respect to alcoholism is not an explicit or reasonable goal for A.A.

A.A., Narcissism, and the Religious Dimension

It has frequently been noted that A.A. functions more like a religious organization than a medical one. Many alcoholics, including A.A.’s founder. Bill W., achieved sobriety through conversion-like spiritual experiences (Simmel. 1948; Tiebout, 1961). Rituals analogous to confession, penance, and absolution are found in A.A. (Bean, 1975). The language of salvation is often

heard at A. A. meetings and the war against alcoholism sometimes takes on the shape of a holy crusade against an evil demon, embodied by alcohol itself. Bill W. wrote, “If there was a Devil, he seemed the Boss Universal, and he certainly had me” (Alcoholics Anonymous, 1976, p. 11). Harry Tiebout, who wrote astutely of the religious aspect of A.A., observed that A.A. achieves its result through a spiritual awakening. A.A.’s “Big Book.” *Alcoholics Anonymous*, states bluntly, “The great fact is just this, and nothing less; that we have had deep and effective spiritual experiences which have revolutionized our whole attitude toward life, toward our fellows and toward God's universe” (Alcoholics Anonymous, 1976, p. 25). It has been noted that a “parallel to the A. A. experience occurs within Fundamentalist Protestant experience” (Bean. 1975, p. 54), although the sacramental elements are more typical of Catholicism. I have also heard aspects of A. A. likened to Eastern religions, and the religious conversion of A.A.’s cofounder has been compared to the Buddha’s experience of Satori (Shimano, Douglas, 1975).

Much of this is. I believe, misleading. The phrase “God as we understand Him” in A.A.’s step 3 has provided a flexibility that allows for a vast range of spiritual concepts and attitudes. A. A. states explicitly that not all spiritual experience that leads to change in A.A. is the result of sudden or spectacular conversion. Personal development that A.A. calls spiritual may occur gradually over a period of many months or years. Most A.A. members find “that they have tapped an unsuspected inner resource which they presently

identify with their own conception of a power greater than themselves" (Alcoholics Anonymous, 1976, Appendix II, pp. 569-570). The concept of a greater power may have little or no necessary relationship to any of the ideas of God that occur in the world's formal religions. Many alcoholics resist attending A.A. meetings on the grounds of their inability to accept the religious aspect. Yet A. A. includes among its members many people who consider themselves agnostic or even atheist (Stewart. 1955, p. 255). A number of A.A. members interpret the idea of a greater power in humanistic terms, expressed as the belief in something of value larger than themselves. The central point is that for an alcoholic to recover in A. A. a significant psychological shift in what seems universally to be called a spiritual dimension must take place within the self.

There is a paradox with respect to the psychology of narcissism inherent in Judeo-Christian religious attitudes. On the one hand certain religious ideas and emotions are profoundly egocentric and childish. As Freud pointed out in *The Future of an Illusion* (1972), the only one of his books concerned primarily with the psychology of religion, man attributes caretaking functions and omnipotence to a superior being whose activity replaces the parents that formerly protected him in his childish weakness and helplessness (p. 24). Death need not be an ending, "a return to inorganic lifelessness. " There is a superior and judging being in the universe who, far from being indifferent to our fate, has a special interest in us and reviews our

conduct like a conscientious parent. Our sufferings and terrors are not in vain, but will be compensated in a hereafter, and our good and evil deeds will be rewarded or punished as they deserve. Freud thought that men should admit the "full extent of their helplessness and their insignificance in the machinery of the universe." He urged the abandonment of egocentric illusions, remarking that "men cannot remain children forever; they must in the end go out into 'hostile life' " (p. 49).

But the paradox is this. Throughout the history of civilization human beings have had great difficulty managing their childish desires, their self-oriented drives and grandiose wishes, their narcissism, without reference to a greater power in the universe, someone or something they call God. One may argue that the cultural development of the ego, or the universal internalization of humanistic values, may ultimately lead us to triumph over our aggressive narcissistic aims. But from a historical perspective, no reference to moral values, even if incorporated in a shared group ego ideal, that is not *perceived* as deriving from a force in the universe greater than man himself has generally proved powerful enough to prevail in the face of man's egoistic desires. One reason men have formed religions has been to bring order out of the chaos of the primitive rapaciousness which they exhibit when left to their own moral devices.

There is a state of mind which might be called a primary religious

attitude, an experience of awe in the face of the universe and its wonder, which is not at root narcissistic in an infantile sense. It is an attitude of humility in the face of existence and an awareness of vastness and of unlimited forces in the cosmos, of eternity. This perspective may in itself help to subvert an egoistic orientation. Heinz Loewald (1978) has written of the ways in which we may grasp eternity through a kind of fundamental awareness, closer to primary- than to secondary-process thinking. If it makes any sense at all to discuss these attitudes of awe and humility in terms of narcissism, they would have to come under the category of "mature" narcissism. As Leowald wrote, "Freud did not recognize (or refused to recognize) that religious life, as anything else in human life, is capable of evolving more mature forms of functioning and expression, no less than human love, for example" (pp. 71-72). (See also Meissner, 1978, for discussion of mature aspects of narcissism in relation to religious faith.)

There is nothing inherently childish in acknowledging a powerful authority, a power greater than ourselves. To ask an alcoholic to surrender his will and his life to a greater power is to acknowledge a fundamental truth, that when it comes to his drive to drink he has no authority *within* his body or personality capable of managing. The idea of God, or of a greater power, becomes a powerful governing force within the self, a force as strong and fulfilling as the powers attributed to alcohol. Just how a problem drinker is enabled to gain mastery of his drive to drink through this surrender and

through the experience of a holding, caring group is a subject that deserves much further study. What seems clear from the "mass psychological experiment" (Simmel, 1948, p. 28) of A.A. is that the experience of relating to a power greater than oneself can start an alcoholic on the road away from the self-ministration of drinking and begin to move him in the direction of object love. Vann Spruiell (1975) has identified three strands of narcissism in childhood and adult development: self-love, omnipotence, and self-esteem. The second strand, omnipotence. has to do with feelings of power or weakness, and begins in the second year with the toddler's sense that he can make things happen. Spruiell relates the beginnings of the psychology of power (or, I expect, also of its converse, powerlessness) to this period of childhood. The idea of God, of a power greater than oneself, may represent one of the steps in the transformation of infantile omnipotence. The small child's recognition of the limits of his power may also represent an intermediate stage in the establishment of object relations. The love of God may thus be a transitional step (as in A.A.) between infantile narcissistic omnipotence and object love.[4] The fulsome and mechanical quality which often attaches to talk of love in religious groups may have to do with the failure to achieve this transition in a genuine sense.

It is in this area of "mature narcissism," or more accurately through its work in the maturing of narcissism, that much of A. A. 's success in the treatment of alcoholism may lie. If I am correct in this thought, our

understanding of the religious aspect of A. A. may have importance for the mental health field beyond the treatment of alcoholism. A. A. strikes at the heart of the infantile egoistic aspect of chronic drinking and provides an antidote to it. It confronts directly the denial, rationalization, and make-believe which would perpetuate the addictive and destructive use of alcohol. To the self-serving activity of chronic drinking, and the wallowing self-pity that is its regressive by-product, A.A. opposes directly an attitude of religious humility, a narcissistically demoting perspective of self-in-the-universe.

The admission of powerlessness and the surrender of self to a greater power which are in A.A.'s early steps—the steps are offered as suggestions only—have been misunderstood as an abnegation of responsibility. They represent, on the contrary, a breaching of the narcissistic defensive structure which maintained twin illusions: on the one hand the illusion that the drinking could be controlled and on the other hand the illusion of self-autonomy or self-sufficiency. The admission of powerlessness over alcohol represents the first defeat of infantile egoism, a first step in the assumption of responsibility (Kaiser, 1955). At the same time, acknowledgment of a basic dependence upon others, and upon some power greater than oneself, begins the abandonment of a grandiose posture. The child's idea of God, based as it is on omnipotent and idealized fantasy structures, is a logical first step in the transition from narcissism to object love. God may be loved on the model of a dependent, anaclitic relationship. but it is a relationship which replicates

archaic, grandiose self-structures. God is all-loving, omniscient, all-powerful. He accepts and may forgive all. In Kohut's terminology He might be thought of as the perfect mirroring parent. But He, like a good parent or psychoanalyst, is not just a projection of infantile narcissism. He is—again using Kohut's (1971) terminology—a self-object, an intermediate figure between self- love and object love, a being who can provide or represent much needed authority and structure within the self.

For individuals who conceive of a greater power in more personal terms God can, of course, be experienced as a literal being or presence. It is sometimes possible to see in such instances the way in which the relationship to God may seem to fulfill the same functions that the individuals were seeking to provide themselves with alcohol. A forty-six year-old woman (Rizzuto, 1976), who was hospitalized for gastritis and fatty liver complicating chronic alcoholism, had been drinking from her late teens. For fifteen years alcohol had severely complicated her life. When she attended A.A. regularly, she was able to stay sober. She was clear about the fact that whether in A. A. or outside of it she felt no need to drink when she felt God's intoxicating presence. This presence she described as like a bright light of hallucinatory intensity, with her and within her. For this patient God was experienced as an omnipresent, all-powerful person who was always there and who gratified her craving for affection, peace, understanding, and comfort. God, she said, knew just what her needs were and could take care of

all of them, already knowing what they were without her having to tell him. He also accepted her totally and uncritically. God for this woman also served a self-regulatory function, guiding her and, together with the church, providing structure and direction. For her, Christ, ministers, and A. A. seemed to serve as mediators or intermediaries between herself and her idea of God. The childish roots of this patient's image of God are obvious, yet her religious experience allowed her to give up her drinking, to achieve some satisfaction of intense emotional hunger and self-esteem, and to govern her life on a daily basis in a less self-destructive manner.

The relationship with God can have its own ups and downs. These vicissitudes can be approached in object-relations terms and may have a direct bearing on the drinking problem. A fifty-year-old Catholic woman, hospitalized in a state institution because of her alcoholism, was clearly struggling with her relationship with God. Feeling overstressed in her life, she began to feel annoyed with God for giving her a "burden" larger than her "back could carry." "Foolishly," she said, "I questioned His wisdom, that He thought perhaps I was stronger than I really am. " As the patient felt more distant from God, she felt less able to use His help to control her drinking. Part of the job of the mental health professionals responsible for her care was to help her repair her relationship with God so that she could resume her participation in A.A. and her steps toward achieving sobriety.

Each of A.A.'s suggested steps after step 3 represents further potential movement away from narcissistic postures and toward caring for others. I am anticipating here the objection that narcissism, at least in the writings of analysts who follow Kohut, should be considered as a separate line of development rather than be set in opposition to object love. I would reply that this may be true if one is focusing upon the development of capacities such as humor and creativity which represent healthy expressions of narcissism. But the antagonism recognized by Freud and other psychoanalysts between immature narcissism and the capacity for unselfish love of others still remains valid. Mature object love cannot occur without an abandonment of a large amount of infantile egoism.

The later steps of A. A.—self-examination, making amends to others, continued "personal inventory," and carrying A.A.'s "message" to other alcoholics—may all be conceived of as movement in the direction of greater concern and love for others. Step 12 is essentially a prescription for full human maturity, for "love that has no price tag on it"(Alcoholics Anonymous, 1977, p. 109) and "devoted service to family, friends, business or community" (p. 128). It means giving up the childish, overly sensitive and grandiose aspects of personality (p. 127), enjoying the ordinary "give and take" of relationships (p. 119), accepting the limitations of ambition (pp. 126-127), and settling for the "permanent and legitimate satisfactions" of a useful life (p. 129). If it could be shown through careful research that A.A.'s methods

achieve permanent structural change in the narcissistic sector of the personality, this would be a finding of considerable theoretical significance.

Implications of A.A.'s Approach

In most of the remaining pages of this chapter I will discuss what I believe are some of the theoretical implications of A.A.'s approach and effectiveness. No effort will be made to provide a complete psychodynamic formulation of alcoholism. Rather, I will suggest what seem to me to be some of the directions in which clinicians and theoreticians who are interested in applying psychoanalytic concepts and approaches might proceed, the areas to look at, in their efforts to understand and help patients with drinking problems.

ALCOHOLISM AS A TOTAL SOLUTION AND THE PRINCIPLE OF MULTIPLE FUNCTION

I know of no patterns of behavior that better illustrate Robert Waelder's (1936) principle of multiple function than those associated with alcoholism. Waelder, it will be recalled, noted that every psychic act is overdetermined, serving simultaneously instinctual gratification, the tendencies of the ego—including its own inclination to repeat—the superego, and the requirements of the outside world. Every act is, in this sense, an attempt to solve a problem or "a *group* of problems" (p. 48). Thus behavior, or a pattern of behavior,

which may seem to be maladaptive, or even relentlessly self-destructive, may at the same time be solving other problems which, from the standpoint of the "central steering" of the organism or executant functioning of the ego, have a higher priority. Such a priority might include the eradication of overwhelming anxiety, fulfillment of grandiose fantasies, or the avoidance of an intolerable reality. But, as Waelder points out, each attempted solution creates "a new piece of reality." Through the attempted solution itself "everything is changed, so that now new problems approach the ego and the attempted solution fundamentally is such no more" (p. 60).

This describes very well the situation of many alcoholics. They may tell us that they began to drink as an attempt to satisfy a craving, to comfort themselves, to feel more complete, to deal with depression, or to ease anxiety experienced with other people. One tends too hastily to label these explanations entirely as "rationalizations." These they may be in part, but in addition, these observations can be true though incomplete accounts. If one looks further, it turns out that drinking was used as a total solution, a multidetermined form of adaptation (including the satisfaction of a physiological craving), serving all of the functions which Waelder described. As one patient put it, "for me alcohol was a total personality orientation."[5]

A forty-one-year-old man, for example, described how drinking was an antidote for loneliness, gave a feeling of warmth, substituted for people, and

"washed out" all painful as well as all pleasurable affects. It also brought him in contact in fantasy with his dead father and other family members who had also been alcoholic. A forty-year-old separated mother of five children, whose life had been destroyed by her drinking, still found it difficult to give up alcohol. When this was explored with her, she said that when she was drinking, she had the feeling that all problems, all painful realities, even the shattered dream that her husband would return, were obliterated. When drinking she felt more at ease and less guilty, and had the sense of being totally taken care of and at peace. In the face of her utter inability to manage her life, and her troubling affects, the self-destructive pattern seemed to her of little weight. A thirty-five-year-old married woman who knew that drinking "in the long run makes it all worse" was quite candid about the fact that alcohol simultaneously took away painful feelings and memories, substituted for the closeness she missed with others, and punished her for her sins through its inevitable consequences.

It may be argued that any or all of these statements occurred after the fact and may, therefore, rationalize a more fundamental reality—that for these individuals drinking is out of control. It will require prospective and longitudinal studies, attention to the stage of the illness, careful observations made in advance of a bout of drinking, and detailed examination of the context in which drinking occurs to sort out the relative role of biological and psychosocial factors in chronic alcoholism. Part of A.A.'s effectiveness surely

derives from its comprehensiveness. Its approach considers human beings in their totality. As Zinberg and Fraser (1979) have recently pointed out, A.A.'s "prescription" for recovery includes "every aspect of human functioning: spiritual, mental, emotional-communal and physical" (p. 27).

SELF-PSYCHOLOGY

I have indicated the ways in which A. A. explicitly addresses infantile regressive attitudes among alcoholics and have suggested that its effectiveness may derive in part from its success in helping the alcoholic to abandon certain maladaptive defensive positions for more object-related orientations. We have also seen how the caring and supportive A.A. community and the relationships to a "greater power" (mediated through the structure provided by the group) help to overcome the powerlessness that the alcoholic feels in relation to his drinking. A.A. helps an alcoholic to reverse this state of powerlessness, initially by acknowledging that it exists in relation to his drinking, implicitly recognizes the shared or psychosocial nature of self-governance, and enables the problem drinker to govern his drive to drink through the nonjudgmental interdependent experience of the group.

There is a growing literature, inspired especially by the work of Heinz Kohut (1971, 1977b), which seeks to understand the development of a cohesive sense of self through the study of archaic narcissistic structures that

are regarded as precursors of the mature self. These include especially what Kohut calls the grandiose self and the transitional idealized “self-object” or parental imago. Kohut suggests that in persons who may become addicts early disappointments, especially in relation to the mother, act as traumatic experiences which interfere with the normal development of these precursor mental structures. In treatment the early structural defects are repaired, according to Kohut, by means of an empathic “mirroring” transference in which the analyst mirrors, i.e.. accepts fully, the patient's exhibitionistic display. Kohut writes, “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” (1971, p. 46).

James Gustafson (1976) has applied Kohut’s theory and approach (and also Michael Balint’s views on “benign regression”) in the psychoanalytic psychotherapy of an alcoholic with a “narcissistic personality disorder.” It is clear in the report that Gustafson's mirroring, caring approach helped his patient to reduce bodily tensions and to give up the need for alcohol. But at the end of treatment unanalyzed aspects of the man’s narcissistic

transference persisted and continued to be acted out in self-destructive "mirror transference relationships" (p. 83). Although Gustafson has used Kohut's formulation, there is no specific mention of alcoholism by Kohut. In fact, the hypothesis seems to apply more accurately to certain drug addicts than to alcoholics, among whom a vulnerability to ego regression, especially under the influence of the substance itself, seems better to describe the more frequent pathology than a structural defect in the self. Similarly, Leon Wurmser (1978) has observed that "alcoholics are in general far more socialized, have much better inner structures (controls, capabilities to adapt) than most compulsive drug users" (p. 221).

Although many alcoholics seem to have narcissistic problems and conflicts—many occurring as a *result* of their drinking—I do not believe that most would be correctly diagnosed as "narcissistic personality disorders" in Kohut's sense, especially prior to the onset of the drinking problem (see also Wurmser, 1978, p. 221). What seems to me useful in this theoretical approach is the emphasis it places upon the cohesive self and its vulnerabilities. In order to search for areas of vulnerability in the development of the self, it is not necessary to assume basic defects in early infantile psychic structures. We are concerned here with elements in the developing personality which might make the individual *susceptible* to alcohol addiction. These vulnerabilities are most likely both biologically and psychologically rooted and may have to do with difficulties in quite specific areas of drive regulation, body tension, or

affect management—inadequate functions which alcohol is later expected to serve.

If these formulations are correct, in alcoholism we are more concerned with poorly developed functions (precursors of what I have called self-governance), i.e., *specific susceptibilities to regression,* than with a pervasive structural defect in the development of a cohesive self such as Kohut postulates is the basic pathology in the immature individuals whom he calls narcissistic personality disorders. These susceptibilities could well be present in spite of a history of early accomplishments, retrospectively good childhood relationships in the manifest sense, and even a successful prealcoholic adult adjustment. In fact, many alcoholics seem to have had a relatively good earlier capacity for object relationships, and are sometimes able to undo the harm they have caused others and "make amends" (A.A. steps 8 and 9) quite readily once they are able to become and remain sober. A.A., when it is effective, seems more to supply certain *functions* for the self, or to offer a gratifying and supportive set of object relationships, than to repair structural vulnerabilities within the ego organization. A.A. members, and others who work clinically with alcoholics, recognize that professional help is needed in addition to A.A. for patients with severe "self pathology"—some character problems, such as are found among poly-drug abusers (Vaillant, 1979) for example, and borderline or schizophrenic alcoholics.

PROBLEMS IN SELF-CARE AND SELF-PRESERVATION

Because the effects of chronic drinking can be so disorganizing, it is difficult at times to appreciate the global extent to which alcoholics may depend on alcohol to manage their lives. Destructive as alcohol may be in reality, many patients leave little doubt that they use it, nevertheless, to help them survive, that drinking is employed by the ego for problem-solving purposes. Such expressions as "I drink to get a grip on myself" or "It helps me to keep hanging together" are frequently heard. In many cases patients successfully escape from decisions, even trivial ones, by getting drunk.

Until the end of his life Freud discussed the functions related to taking care of oneself, of self-preservation (or what he called the ego instincts), largely in terms of the vicissitudes of libido. Freud (1913, p. 182; 1915, pp. 124-126; 1916-1917. p. 430; 1925, pp. 56-57) saw self-preservation as the activity of narcissistic libido, a reflection of the instinct to preserve the life of the individual in contrast to object libido, which served to perpetuate the species. Only in one of his last works (1940) did he place self-preservation explicitly among the functions of the ego when he wrote. "The ego has set itself the task of self-preservation, which the id appears to neglect" (p. 199). Freud thus left it to later investigators to explore how the ego develops the capacity to accomplish this task.

Part of learning to take care of oneself has to do with the ability to plan

and to anticipate the consequences of any given action, to foresee danger to the self. Freud's concept of signal anxiety bears directly on this point. Small amounts of anxiety are experienced by the ego as a signal to mobilize psychic defenses and to forestall the occurrence of a more serious danger. “The individual will have made an important advance in his capacity for self-preservation,” Freud (1926) wrote, “if he can foresee and expect a traumatic situation of this kind which entails helplessness, instead of simply waiting for it to happen” (p. 166).

Alcoholic patients often will, as we know, tell us with seeming conviction that they do not intend to drink again, that the experience of their last hospitalization has persuaded them it would be folly to do so. I have heard such assertions frequently enough myself to be convinced that the patients are often quite sincere in these statements, and may not be aware of the denial and rationalizations involved. Naturally, once they are released from the hospital, it is often not long before they are drinking again. What is striking in such situations is the absence of any anticipatory or signal anxiety which can mobilize effective defenses against the impulse or desire to drink. The anticipation of danger is merely intellectual, without real conviction, and the trauma of drunkenness recurs. One professional man, for example, who had been sober for several months, knew that if he drank again, it could severely jeopardize his marriage and his entire career. He became drunk, nevertheless, with disastrous consequences. When asked how he understood

the fact that he had gotten drunk once more, he replied candidly, ”1 missed having a drink at the bar with the guys on the way home.” This man remained unable to anticipate that if he were to drink at all, he would surely become drunk.

There is a problem in the functioning of the ego with respect to self-care or self-preservation in cases such as this, a difficulty made worse perhaps by biological factors as yet unknown. What is not understood, and is a problem for future research, is whether self-preservative or self- care functions have failed to develop adequately in childhood or have been obliterated by the alcoholic disorder. The above patient favored the latter view, commenting that “the strength of the urge to drink enables one to rather gently set aside a rational evaluation of consequences. ” But this too may be a rationalization to explain the impairment of an ego function which never developed adequately.

DRIVE AND AFFECT MODULATION AND REGULATION

Drive theory is somewhat out of fashion nowadays in psychoanalysis, and reference, for example, to the “orality” of alcoholics or to their oral eroticism is considered in poor taste. Yet if we follow Schur (1966) in considering drives or instincts in the psychoanalytic sense as energies having their source ultimately in the soma but exerting pressure upon the executive apparatus of the ego, any comprehensive theory of alcoholism will need to

give some consideration to the drive or motivational aspect of normal and problem drinking. In discussions of alcoholism this drive is usually referred to as a craving or "compulsion" to drink.

Experimental studies have shown that the sense of powerlessness which alcoholics experience in relation to their problem cannot be attributed simply to the strength of the craving they feel for alcohol per se (see Gottheil et al., 1973; Pattison et al., 1977, Chapter 4; and Mathew et al., 1979). Ludwig (1972), for example, showed that among 176 patients who resumed drinking during an eighteen-month follow-up period only 1 percent attributed their resumption of drinking to subjective feelings of craving or the "need to drink." Instead, most attributed their resumption of drinking to some form of psychological distress, family problems, or a variety of other reasons and rationalizations (which may or may not have been actual determining factors). There is experimental evidence which suggests that even among alcoholics who have resumed drinking, situational variables—drinking, for example, associated with pleasant expectations and behaviors recalled from previous drinking episodes or activity—interact with the effect of the alcohol itself in determining further alcohol intake. The craving is by no means absolute or constant. Psychoanalysts might be able to contribute further to the understanding of the psychological and contextual elements which affect the intensity of the craving, to a clearer appreciation of the drive's subjective quality, and to further appreciation of the factors which determine the

capacity to control or modify it.

As Pattison et al. (1977) and others have demonstrated, and has been discussed earlier in relation to the effectiveness of A.A., the "loss of control" (defined by Jellinek [1960] as loss of the ability to control the quantity of alcohol ingested once one has started to drink) which alcoholics experience is also far from absolute. Mello and Mendelson (1972), for example, have shown that alcoholics placed in a situation with unrestricted access to alcohol do not drink all the alcohol available to them. That A. A. can enable an alcoholic to interrupt a drinking episode is itself evidence of the less than absolute nature of the loss of control. One of the purposes of this chapter has been to provide a framework in which the psychological, social, situational, and even biological factors which affect the ability to control the drive to drink may be studied and understood. Control is always a relative concept. The ego always participates in the *decision* to drink or not to drink.

The psychologist Silvan Tomkins (1962) has noted that drives have a rigid and unmodifiable character, and that even if they activate the affect system, it is primarily feelings or affects which we experience and which determine actual behavior.[6] Affects have a flexibility which drives do not possess. "It is affects, not the drives, which are transformable," he notes (p. 143). Tomkins has demonstrated that "most of the characteristics which Freud attributed to the unconscious and to the Id are in fact salient aspects of

the affect system" (p. 130). I have found this point of view valuable in trying to understand the way in which alcoholics handle affects.

Anyone who has worked with alcoholics has frequently been told that a given episode of drinking started when the patient felt sad, anxious, or even joyous, that a bout began after a painful failure or an unexpected success, etc. These remarks tend to be treated as rationalizations, as excuses par excellence. They may indeed be used in this way, but they also indicate, I believe, a deeper truth. For alcoholics seem, at least once they are in an active period of the disorder, unable to deal with intense feelings, to modify or transform them. It is precisely the flexibility to which Tomkins refers that they seem to lack, and this deficiency may antedate the onset of problem drinking. Many alcoholics will say how helpless they feel when experiencing disturbing or intense feelings in the face of the most ordinary life situation. The alcohol may be sought to make more manageable guilt, sadness, ordinary anguish or pain, even joy.

Vaillant, in his chapter in this volume (page 40), seeks to refute the argument that the alcoholic drinks to relieve emotional distress on the grounds that if this were so, "it should raise self-esteem, alleviate depression, reduce social isolation, and abolish anxiety." He cites a study by Tamerin and Mendelson (1969) which he states "suggests that despite what alcoholics say, objective observation of drinking reveals that chronic use of alcohol makes

alcoholics more withdrawn, less self-confident. more depressed, and often more anxious" (page 40). This is true but somewhat misleading. Alcoholics are generally ready to acknowledge that the drinking ultimately made them feel worse. What they make clear, however, is that at times they drank to obtain *immediate relief* of emotional pain and that to a degree the alcohol achieved this result on a temporary basis. They were not anticipating the long-term destructive effects, or, if they could, were willing to risk them for the short-term result. But that is a different problem. What Tamerin and Mendelson (1969) found among the male alcoholics in their study of experimental alcohol administration was that for all four of their subjects "the initial effect was uniformly experienced as pleasurable. Subjects felt more relaxed, less inhibited, and generally elated." After this initial phase, however, "the subsequent experience was frequently painful as drinking persisted over a period of days and weeks" (p. 889). These findings are consistent with the observations made in a case reported in detail by Wurmser (1978). "All forms of pain: physical and emotional, including anxiety, guilt and shame, are at first mitigated, but subsequently deepened by alcohol, *her* drug" (p. 227).

The relationship of chronic alcoholism to fundamental disturbances in the psychology of affects constitutes, in my opinion, a particularly fertile field for psychoanalytic investigation. One alcoholic man in psychotherapy made clear that without alcohol he felt himself to be utterly without inner resources with which to deal with emotional pain. Although in many ways he was a

competent man, when he experienced ordinary sad feelings and tearfulness in his therapist's office, he said it seemed like he was "coming apart." In the light of such vulnerability it is quite understandable that A.A. would discourage the experience of strong or troubling emotions, such as resentment, or that psychotherapy which elicits in alcoholic patients disturbing affects before new ego resources are developed to manage them could be of more harm than help (Vaillant, this volume). Once again, what is not known, and will require careful prospective studies to establish, is whether these ego capacities were never present or were lost as a result of the regression associated with alcoholism.

For many alcoholics their psychopathology in the affective realm seems to be more complex than simply the problem of bearing or dealing with painful emotions. It has to do with varying degrees of impairment in a sequence of functions which begin early in a child's development with the differentiation or recognition of specific affects. Other elements in the sequence include learning to name feelings, to bear them oneself (Zetzel, 1949, 1965), to communicate or share the experience of them with others (Basch, 1976), to transform or modify them, and ultimately to take responsibility for the full experience of the feelings themselves. One alcoholic woman of thirty-five told her psychiatrist that she had great difficulty even identifying within herself painful feelings such as loneliness. She would turn to alcohol for relief of distresses that she could only vaguely apprehend. Once

she was sober and the damage caused by her drinking was reversed, an essential first step in learning to manage her drinking problem was helping her become aware of the quality of specific feelings, to find words by which to name and recognize them, and a means thereby to talk to others about them before they became overwhelming. Only then did words such as "taking responsibility for managing one's own feelings" take on any real meaning. Again, the extent to which these ego functions have never developed in certain alcoholic patients, or, instead, are lost by regression as a result of the illness, is a problem requiring much further research.

EGO DEFENSE AND STRUCTURE

A complete discussion of the ego defense system of alcoholic patients is beyond the scope of this chapter. I wish to stress two points only, the significance of rationalization and of certain identification processes. The great importance of denial in maintaining symptomatic and addictive drinking is discussed by Dr. Bean in her chapter. Equally important in my opinion is the use of rationalization by alcoholics, a defense so extensively employed as to seem almost pathognomonic for this disorder. Again, it will be important to investigate the degree to which the powerful presence of this defense mechanism or personality style is the result of childhood ego fixations as opposed to regressive processes resulting from drinking itself which bring these defensive modes into prominence.

We have seen in numerous clinical instances how powerfully rationalization operates in alcoholics to explain to others, and probably to themselves as well, a psychophysiological process in whose grip they experience helplessness and whose cause they really are unable to identify. Rationalization operates to defend the alcoholic patient against the painful blow to his self-regard that full acknowledgment of his bewilderment and helplessness would present. Like denial, rationalization prevents the acknowledgment of alcoholism. It precludes true understanding of the motives for drinking and thus works in the service of perpetuating the addictive process.

Incorporation and identification are fundamental processes in the development of ego defensive and adaptive mechanisms. The anamnesis of many alcoholics reveals that family members have been alcoholics over several generations. This fact has an importance over and above whatever evidence of genetic loading or of the role of "environmental influences" it may provide. A number of alcoholics have powerful memories of family closeness achieved *only* when they were drinking together with their fathers or mothers. The classic Chaplin film *City Lights* shows the little tramp befriended and accepted by the millionaire only when the latter is drunk. When sober, his benefactor rejects him abruptly. Alcohol may facilitate certain kinds of object ties. It is a vehicle through which the chronic drinker seeks to recapture in adult life, sometimes in social drinking before symptomatic and addictive

phases occur, the memories and associations of a lost past. The use of alcohol in this way by individuals may be more likely to occur in ethnic groups for which alcohol is a culturally sanctioned vehicle for the facilitation of closeness within the family or community.

Also of importance may be the incorporation of, and identification with what might be described as an alcoholic style of dealing with conflict and the outside world. One man in his mid-forties had been unable to manage his drinking for over a decade, with ensuing destruction of family life and deterioration of his professional situation. His history revealed that from early childhood his father had drunk heavily. The father seemed to be able to manage, nevertheless, and the mother never treated her husband's drinking as a problem. The patient became aware in psychotherapy of how deeply he had internalized his father's style, his pattern of using alcohol to manage feelings and to deal with human relations. But forty years later the father was still drinking and had not gotten into serious physical difficulty, nor had he developed the severe psychosocial problems which afflicted his son. It would be valuable for us to know what factors determine whether an individual can employ alcohol as a successful form of defense or adaptation, or cause him to be at risk for pathological regression and addiction as a result of psychological and/or biological vulnerabilities.

THE SOCIOCULTURAL DIMENSION AND SELF-GOVERNANCE

Norman Zinberg has provided in his chapter a comprehensive examination of the sociocultural dimensions of alcoholic and nonalcoholic drinking, an aspect of the problem which has received insufficient attention by psychiatrists. I will not review here his data or arguments. I wish, rather, to point out that if we accept the importance of social factors in determining either the *ability* or the *failure* to drink in a controlled manner, there remains the problem of determining the psychological mechanisms whereby social or cultural elements are incorporated and put into effect within the individual.

I have used the term "self-governance," which implies that the decision-making functions of the individual are themselves shared or socially interdependent, in order to develop a model that may enable us to understand how social and cultural factors operate within the self. A.A. represents a new social context for the problem drinker, one which has a powerful impact in enabling him to become and remain sober. It thus provides a valuable natural experimental context for studying how a particular social institution or group may affect specific aspects of choosing with respect to alcohol, beginning with the initial decision to go to A.A. The early parts of this chapter are concerned with this question. I would hope that the concept of self-governance might prove of value in trying to understand how a variety of other social contexts—families, groups of friends, neighborhoods, ethnic groups—and *changes* within social structures affect the ability of an individual to manage his or her desire to drink. I wish, finally,

to point out that even the choice of what social context to *be in*, as, for example, the decision to go to A.A., may be one in which the individual himself participates, although with varying degrees of freedom. Again, the various determinants of this "freedom," and the factors which increase or limit it. relate to what I have in mind in the idea of self-governance.

Implications for Treatment

What implications for the treatment of chronic alcoholism are contained in these thoughts? To begin with, it is clear that one must pay attention to the stage of the illness, whether the individual is drinking symptomatically, is alcoholic but not physiologically dependent, or is physiologically dependent. For even if we may agree that the "loss of control" is never absolute, the power the drinker experiences in relation to his problem will depend a great deal upon the phase of his alcoholism. The idea of "responsibility" should not be used inappropriately, i.e., to expect of the individual management capabilities in relation to his drinking which are not consistent with the stage of his problem, or to burden the patient uselessly with its moral implications. In asking the alcoholic to take responsibility *initially* only for acknowledging his powerlessness in relation to alcohol, A.A. is gauging the ability to be in control during the early period of treatment.

The point of view described here does not argue against the value of

appropriate individual or group psychoanalytically informed psychotherapy. Rather, my emphasis upon the decision-making functions in the self implies that the model or theory of psychotherapy to be applied cannot be based on the transference neuroses. As indicated by Vaillant in his chapter, an approach which mobilizes in the therapeutic relationship powerful needs and expectations which cannot be fulfilled in the transference (or anywhere else in the patient's life) may lead to intolerable frustration and aggravation of the drinking problem.

The therapeutic approach should, therefore, be consistent with the felt limitations of the patient in bearing strong or painful affects in the context of his intrapsychic and external resources. Continuing drinking undermines obviously the patient's ego integrative and self-governing capacities, alienates others, and painfully erodes self-regard. Sobriety must, of necessity, be the only initial goal. The psychotherapist during this stage of the illness functions as an agent of change, confronting skillfully the denial, rationalization, and other defenses which protect the patient from the narcissistic injury of recognizing his powerlessness in the face of alcohol. The therapist should recognize early the probable limits of his own power to help the alcoholic become sober and act to get the patient to go to a detoxification center, to A. A., or to whatever institution or group may be needed to provide the self-governing function which may not be within the patient's own capacities, even with the enabling efforts of the therapist.

The further stages of psychotherapy must be conducted with these same principles in mind. The very great limitations of autonomous self-governance in individuals susceptible to alcoholism must continue to be appreciated. The adjunctive power of A.A. or its equivalent ("adjunctive" refers here to our vantage point—1 am focusing in these paragraphs on psychotherapy—not to relative value, as A.A. may remain the more important modality of treatment) in providing essential enabling or self- governing capability for the individual may constitute an essential part of the treatment for many years. A collaborative, noncompetitive approach between the psychotherapist and A.A. can be helpful. A.A. provides an altered social context and directly addresses the egoistic defenses and the burdens and vulnerabilities in the self, meeting directly through its group supportive and spiritual approach the functional deficiencies in self- governance from which the patient suffers in relation to alcohol. A.A. furnishes a series of graded tasks which provide initial relief of pain, trauma and conflict, followed by the expectation of continuing shift away from pathological self-love in the direction of object love and altruism.

Psychotherapy needs to incorporate the insight implicit in A.A.'s approach. The therapist needs to recognize the burden of failure and pain which the alcoholic carries within him (deepened greatly by the humiliations of his problem and his inability to manage it), the use of alcohol as a form of self-ministration and self-caring, the evident limited capability of the

alcoholic to deal with many if not all strong or painful affects, and the importance of the reality or social context in the vicissitudes of the drinking problem. The therapist needs to recognize the complexly overdetermined meaning of alcohol and its physiological, psychological, and social functions in the patient's total self-management, meanings in which ego- syntonic and ego-alien elements are intertwined. The therapist should realize that in some cases, because of the peculiar susceptibility of his patient to the addictive use of alcohol, the internalization of new self- governing capabilities in relation to the drive to drink may be of limited power. The therapist's own vanity should not be injured or challenged by having to acknowledge that some patients may always need the help of A.A., or of an equivalent collective power, in the management of alcoholism. Perhaps the therapist's self-regard will be less affected if he can realize that self-governance is never entirely an individual matter, is to a degree for everyone always a shared or collective responsibility.

Summary

For an alcoholic, as for a person who does not have a drinking problem, the determination to take a drink, especially an initial drink when sober, involves a kind of decision, however difficult it may be for the individual to choose otherwise. What Ernst Simmel (1948) called the "mass psychological experiment'' that is A.A. has demonstrated that if the social circumstances are

altered in specific ways, the balance for many individuals can be shifted so that they are able more consistently to choose *no*. By introducing the psychosocial concept of self-governance, I am trying to develop a theoretical framework within which it may be possible to consider all of the factors—biological, psychological, and sociocultural—which affect this decision.

The examination of A.A.'s approach to the treatment of alcoholism reveals that this institution or association (what we call it depends upon which of its multiple functions is being considered) embodies most if not all of the elements—psychological, biological, social, and spiritual— which go into successful self-governance not just for alcoholics but for all human beings. In the later parts of this chapter I have considered certain implications which I believe A.A.'s approach contains for the psychoanalytic understanding of alcoholism. In particular, I have considered how the psychoanalytic psychology of narcissism and the self, aspects of drive and affect theory, self-care and self-preservation, ego defenses and identification, if considered from the psychosocial perspective which I am suggesting, may be found to shed more light on the problem of alcoholism than they have heretofore. I have pointed to areas which might be explored if we are to understand more fully how the decision to drink is governed and what accounts for this failure of self-governance in certain individuals.

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Notes

[1] In his article. “The Cybernetics of 'Self': A Theory of Alcoholism,” Gregory Bateson, employing different language and another theoretical model, anticipated some of the concepts I have introduced here.

[2] Bateson regards the “self” as “a false reification of an improperly delimited part of this much larger field of interlocking processes” (1972, p. 331).

[3] H. Grunebaum and L. F. Solomon (1980) are developing a peer theory of group psychotherapy which may have particular relevance for understanding the effectiveness of a fellowship such as A.A

[4] I am indebted to Dr. Ana-Maria Rizzuto and Sister Nancy Kehoe for helping me to think about the possible relationships to God in terms of the psychoanalytic theory of object relations.

[5] Bateson wrote “the total personality of the alcoholic is an alcoholic personality which cannot conceivably fight alcoholism” (1972. p. 312).

[6] For reviews of psychoanalytic conceptions of affect see Green (1977) and Brenner (1974).