2009

Looking at substance use disorders through lenses of self psychology and existential psychotherapy : a theoretical study

Michael E. DiLorenzo

Michael DiLorenzo
Looking at Substance Use Disorders through the Lenses of Self Psychology and Existential Psychotherapy: A Theoretical Study

ABSTRACT

This theoretical study explored the theoretical frameworks of self psychology and existential psychotherapy in the context of their usefulness for clinical social workers in their therapeutic work with clients with substance use disorders (SUDs). The central guiding question of this thesis was, "How can the theoretical lenses of self psychology and existential psychotherapy help clinical social workers and other mental health professionals to better understand SUDs and inform clinicians' work with addicted clients?"

In this theoretical study, self psychology and existential psychotherapy were examined and employed as a means of understanding the nature of SUDs. In addition, these two theories were used to analyze and interpret the underlying psychological and existential factors that may contribute to the development and persistence of SUDs in some individuals. This study concluded that both self psychology and existential psychotherapy can be useful—separately and even more so together—to clinicians in their work with clients with SUDs.

Both of these theories, despite their many differences, share a number of important similarities that make them useful for clinical social work. These include an optimistic view of the potential for growth and healing through treatment; the importance of imperfect attunement and empathic failures between therapist and client during the

course of therapy; an emphasis on trying to understand the client's subjective experience; and a genuinely humane and respectful view of all clients, including those struggling with SUDs.

LOOKING AT SUBSTANCE USE DISORDERS

THROUGH THE LENSES OF SELF PSYCHOLOGY

AND EXISTENTIAL PSYCHOTHERAPY:

A THEORETICAL STUDY

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Michael DiLorenzo

Smith College School for Social Work
Northampton, Massachusetts, 01063

2009

ACKNOWLEDGMENTS

I want to thank my thesis advisor, Luba Falk Feigenberg, for her patience and guidance throughout the entire thesis process. I also want to thank Kevin for his camaraderie and for being a true friend. And much thanks and all my love to my wife, Aya, for her love and support.

TABLE OF CONTENTS

CHAPTER I

INTRODUCTION

In the latest National Survey on Drug Use and Health, it was estimated that today in the United States there are more than 22 million people over the age of 12 who have been classified as having a substance use disorder (SUD) (Substance Abuse and Mental Health Services Administration [SAMHSA], 2008). While many of the individuals who are in need of substance abuse treatment never actually receive any, SUDs remain a common precipitating factor for individuals who seek or are mandated for treatment at facilities where they are likely to encounter clinical social workers and other mental health clinicians. Moreover, since drug and alcohol problems are so common among clinical populations, every mental health clinician is, at one time or another, likely to have clients with SUDs in his or her caseload, whether or not an SUD was the "presenting problem" that led a particular client to seek treatment initially (Washton & Zweben, 2006**).**

Given the scope of the problem, it is important for all mental health clinicians to be familiar with SUD symptomatology and treatment approaches that are useful when working with clients with SUDs. Further, it is particularly important for clinicians to be aware of the possible underlying or co-occurring psychological and existential factors that may initially lead individuals to abuse and/or become dependent on substances, and that contribute to the persistence of these patterns of substance abuse and dependence

over time. A guiding premise of this project is that both of the two selected theories—self psychology and existential psychotherapy—can be useful (separately and, even more so, together) to clinicians in their work with clients with SUDs, both as a way of understanding the nature of their clients' problems and as a helpful framework on which to base their clinical interventions.

The subject of SUDs has been examined extensively over a fairly long period of time from a variety of theoretical standpoints. A number of early psychoanalytic thinkers, including Freud and those that followed, began to consider and examine the phenomenon of addiction in the early part of the 20th Century. Many of the early psychoanalytic writings dealing with the subject of alcohol and drug addiction were steeped in the idea that problems involving innate sexual and aggressive drives were what led certain individuals to abuse and become dependent on alcohol or drugs (Freud, 1897; Abraham, 1908/1926; Glover, 1932; Radó, 1933). Later writings discussed other factors and viewed the problem of addiction from a number of different perspectives. Some writers focused on the idea of substance use as an artificial means of affect-regulation (Wurmser, 1974; Krystal, 1978; Morgenstern and Leeds, 1993; Washton & Zweben, 2006) or an attempt at self-medication (Khantzian, 1985/1997; Washton and Zweben, 2006) and/or self-regulation (Khantzian, 2007).

Others have been critical of psychoanalytic and psychodynamic perspectives on addiction, including those who believe that they do not give sufficient weight to the impact of an individual's social environment on his or her decision to use alcohol or drugs (Zinberg, 1975). Addiction has also been examined from the perspective of cognitive theory, which holds that certain individuals become dependent on drugs and/or

alcohol largely as the result of a set of dysfunctional beliefs they have about substance use and what it does for them (Beck, Wright, Newman, & Liese, 1993). More recently, some writers have called attention to brain research findings which seem to indicate that addiction is a chemically and biologically based brain disease (Washton & Zweben, 2006). Others have sought to frame addiction not as a something secondary to underlying psychological disturbances, but rather as a separate, primary illness (Brickman, 1988).

The central guiding question of this thesis is, "How can the theoretical lenses of self psychology and existential psychotherapy help clinical social workers and other mental health professionals to better understand SUDs and inform clinicians' work with addicted clients?" In this theoretical study, self psychology and existential psychotherapy are examined and employed as a means of understanding the nature of SUDs. In addition, these two theories are used to analyze and interpret certain underlying psychological and existential factors that may contribute to the development and persistence of SUDs in some individuals.

In this thesis the focus will be on two particular theoretical perspectives—self psychology and existential psychotherapy. Each of these theories has a different perspective regarding the nature of SUDs (and psychopathology in general). From a self psychology perspective, SUDs and other forms of psychopathology are the result of *deficits*—in particular, defects or weakness in the self resulting from problems and disruptions during early self-selfobject relationships (Kohut, 1977a); substance use is an attempt to make up for this deficit (Goldstein, 2001). From the point of view of existential psychotherapy, SUDs and other forms of psychopathology are the result of *conflict*—in this case, conflict brought about by an individual's confrontation with certain

existential realities or ultimate concerns—the "givens of human existence" as Yalom (1980) refers to them (i.e., death, freedom, isolation, and meaninglessness). From an existential perspective, substance use is seen as a maladaptive defense against existential anxiety. One goal of this study is to show that these two theories need not be seen as incompatible with one another when it comes to the issue of understanding and treating SUDs. Rather it will be argued that while each on its own has something valuable to offer to clinicians working with addicted clients, both can also be used in conjunction with one other in a way that will be helpful to the therapeutic work with clients struggling with SUDs.

Before proceeding, it is worth calling attention to areas of potential bias on the part of this writer in relation to the present study. My interest in the topic of SUDs came at least in part as a result of my experience working with clients in an outpatient substance abuse treatment program during the past year. I believe that part of the reason that I was drawn to the two theories that are focused on in the present study is also the result of this experience working with addicted clients, some of whom I worked with for a period of several months, during which time I came to know and respect them and their struggles. I believe that my choice of self psychology and existential psychotherapy as the two theories of focus for the purpose of this study had to do in large part with my belief that both of these theories, despite their many differences, share a number of important similarities. These include an optimistic view of the potential for growth and healing through treatment; an emphasis on trying to understand the client's subjective experience; and what I feel is an especially humane and respectful view of all clients, including those struggling with SUDs.

CHAPTER II

SUBSTANCE USE DISORDERS

Introduction

In this chapter, the reader is presented with an overview of substance use disorders (SUDs). In order to illustrate the ways in which clinical and popular views of SUDs in the US have changed over time, this chapter begins with the evolution of the diagnostic categories and criteria of SUDs, as described in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, from the time of the publishing of the first edition in 1952 through the most recent edition, *DSM-IV-TR* (4th edition, text revision), published in 2000. A description of the extent to which SUDs impact the population of the US today is then presented. This is accomplished by means of a brief summary of the most recently available numbers and demographic information regarding the prevalence of SUDs in the US. Following this description of the affected population, data showing the need—both met and unmet—for treatment among individuals with SUDs is presented. The chapter concludes with a review of the literature in which a variety of theoretical approaches to understanding the nature of SUDs are discussed and summarized. One point of focus throughout this review of the SUD literature will be directed toward possible underlying issues, as well as possible developmental or experiential factors, that might lead individuals with SUDs to begin and/or continue their use and abuse of drugs and alcohol.

Evolving Diagnostic Categories

In 1952, when the first edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* was published, SUDs were grouped under personality disorders rather than being separated out and defined as their own distinct diagnostic category (Saunders, Schuckit, Sirovatka, & Regier, 2007). Within the larger category of personality disorders, the DSM (American Psychiatric Association [APA], 1952) defined *alcoholism* as "cases in which there is well established addiction to alcohol without recognizable underlying disorder" (p. 39) while *drug addiction* was not defined in specific terms, but was viewed as being "usually symptomatic of a personality disorder" (p. 39). One point worth noting here is the way that alcohol and drugs were treated as completely separate types of substances. As described in this edition of the *DSM*, alcoholism was not understood to be indicative of any other sort of psychopathology, whereas drug addiction was seen to be a symptom of some defect in one's personality (APA, 1952).

In the second edition, *DSM-II*, published in 1968, SUDs were again grouped under personality disorders and had very little in the way of specific definitions or diagnostic criteria. *Alcoholism* was described as a condition in which one's alcohol intake has reached a point whereby he or she is damaging his or her physical health or personal or social functioning, or when consuming alcohol is actually necessary in order to reach a point of normal functioning. A diagnosis of *drug dependence* required only that the individual in question show evidence of habitual use or need of the drug; no mention is made of any impairment to one's health or functioning being necessary in the case of drug dependence (APA, 1968). Here again, as with the previous edition of the *DSM* (1952), we see the way that alcohol and drugs were viewed differently. A diagnosis of

alcoholism required that one's health or functioning was impaired to some degree, while a diagnosis of drug dependence seemed only to look at whether or not one exhibited habitual use or need; impairment was not considered to be a criterion (APA, 1968).

The third edition, *DSM-III*, published in 1980, represented a major change in the way that SUDs were categorized and described. Unlike in the previous two editions, in *DSM-III* SUDs were identified as a distinct diagnostic category containing the two separate diagnoses of substance *abuse* and substance *dependence*, each with its own set of diagnostic criteria. For substance abuse, there were three criteria distinguishing abuse from normal use: a pattern of pathological use, impairment in social or occupational functioning, and duration of at least one month. The two criteria for substance dependence, only one of which had to be present for a diagnosis of dependence to be indicated—except for alcohol and cannabis dependence, which required evidence of social or occupational impairment as well—were tolerance and withdrawal (APA, 1980). Another significant change seen in this edition is the similar treatment of alcohol and drugs, unlike in the previous two editions where *alcoholism* and *drug addiction*, while grouped together under the larger category of personality disorders, were viewed quite differently with regard to their respective diagnostic criteria.

Today, as defined in the current *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, the category of SUDs is used as an umbrella term that includes the two separate diagnoses of substance dependence and substance abuse (APA, 2000). In *DSM-IV*, substance dependence is viewed as a more serious condition than substance abuse, and an individual cannot be diagnosed with both conditions during the same time

period; a diagnosis of dependence would preempt an earlier diagnosis of abuse (Saunders et al., 2007).

According to the definition found in *DSM-IV*, substance dependence refers to a "maladaptive pattern of substance use, leading to clinically significant impairment or distress" (APA, 2000, p. 199) and which is evidenced by the occurrence of any three (or more) of the following symptoms within a twelve month period: tolerance; withdrawal; taking the substance in larger amounts or over a longer period of time than originally intended; persistent unsuccessful attempts to cut down or stop use of the substance; spending a great deal of time obtaining the substance, using the substance, or recovering from its effects; reducing or giving up important social, occupational, and/or recreational activities because of substance use; continuing use of the substance despite recognizing that such use is causing serious psychological and/or physical problems for the user.

Substance abuse is indicated by the occurrence of any one (or more) of the following symptoms within a twelve month period: failure to fulfill major obligations at home, school, or work because of substance use; use of the substance even in situations where it might be physically dangerous to do so (e.g., driving when intoxicated); legal problems related to substance use; continuing use of the substance despite recognizing that such use is causing social or interpersonal problems for the user. Substance abuse, unlike substance dependence, does not include tolerance, withdrawal or compulsive use as diagnostic criteria (APA, 2000).

Population

In the latest National Survey on Drug Use and Health, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that today in the United States there are 22.3 million people aged 12 and older—9% of that population—who have been classified as having a SUD related to their use of alcohol and/or illicit drugs. Of these, 3.2 million were classified with an SUD involving both alcohol and illicit drugs, 3.7 million were classified with an SUD involving illicit drugs only, and 15.5 million were classified with an SUD involving alcohol only. The use of the term "illicit drugs" is meant here to include cannabis (e.g., marijuana, hashish); cocaine, including crack; heroin; hallucinogens; inhalants; and the non-medical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives (SAMHSA, 2008)

Among the 22.3 million people who were classified as having an SUD in 2007, the rate of SUDs was about twice as high for males (12.5%) as it was for females (5.7%) among those aged 12 and over. However, rates were similar among males (7.7%) and females (7.7%) between the ages of 12 and 17. With regard to race and ethnicity, the rate of SUDs was lowest among Asians (4.7%) and highest among Native Americans (13.4%). Other reported racial/ethnic group rates included individuals reporting two or more races (10.8%), Hawaiians/ Pacific Islanders (9.9%), Whites (9.4%), Blacks (8.5%), and Hispanics (8.3%). These numbers remained similar during the years 2002 through 2007 (SAMHSA, 2008).

Need for Treatment

SAMHSA (2008) estimated that of the 22.3 million individuals aged 12 and older who were in need of treatment for SUDs in 2007, approximately 2.4 million (10.4% of those in need) received treatment at a specialty facility such as a hospital (inpatient only), a drug or alcohol rehabilitation facility (inpatient or outpatient), or a mental health center. The remaining 20.8 million people needed treatment for an SUD but did not receive treatment at a specialty substance abuse facility. However, some of the 22.3 million people who were in need of treatment did receive treatment at places other than facilities specializing in drug or alcohol treatment, including, emergency rooms, private doctor's offices, prisons/jails, and self-help groups such as Alcoholics Anonymous and Narcotics Anonymous.

Despite the fact that many individuals who are in need of treatment do not receive it, SUDs remain a common precipitating factor for individuals who seek or are mandated for treatment at facilities where they are likely to encounter clinical social workers and other mental health professionals. Moreover, since drug and alcohol problems are so common among clinical populations, every mental health clinician is, at one time or another, likely to have clients with SUDs in his or her caseload (Washton & Zweben, 2006**).**

Given the scope of the problem and the large numbers of individuals who are in need of and/or who seek treatment as a result of SUDs, it is important for all mental health professionals to be familiar with SUD symptomatology and treatment options. Further, it is particularly important that they be aware of the possible underlying or co-occurring psychological and existential factors that may initially lead individuals to abuse

and/or become dependent on substances, and/or perpetuate these patterns of substance abuse and dependence over time. The following section discusses a number of theoretical approaches to understanding SUDs; issues of underlying psychological and existential factors as it has been addressed by several different authors is discussed.

Understanding Substance Use Disorders: Theoretical Approaches

Early Psychoanalytic Writings

Psychoanalysis has been cited by one author as "the first modern discipline to study addiction" (Yalisove, 1997). Much of the early psychoanalytic writings dealing with the subject of drug and alcohol dependence were steeped in the idea that innate sexual and aggressive drives are what lead some individuals to abuse and become dependent on drugs or alcohol (Freud, 1897; Abraham, 1908/1926; Glover, 1932; Radó, 1933). As early as 1897, in a letter to his friend, Wilhelm Fliess, Freud (1897) wrote of his realization that masturbation was the "primal addiction" (p. 272) for which all other addictions (e.g., drug and alcohol dependence) were merely substitutes or replacements (Freud, 1897). This realization of Freud's occurred at a time when he had begun to believe that the sexual drive was at the root of all psychic conflict and psychopathology (Mitchell & Black, 1995).

In what is likely the first psychoanalytic article devoted entirely to the subject of addiction, Abraham (1908/1926) wrote of alcoholism as a kind of sexual perversion, one that interacts with the sexual instinct and which results in the removal of inhibitions and an increase in sexual activity. Abraham also saw a connection between drinking and homosexuality. He believed that in normal individuals, "the homosexual component of

the sexual instinct yields to sublimation" (i.e., it is contained, redirected, and released in the form of more socially acceptable behavior) but that in the case of the alcoholic, "the homosexual component-instincts … reappear in no veiled form under the influence of alcohol" (p. 4).

Glover (1932) saw a connection between drug addiction and the psychoses and believed that aggressive drives were important in the etiology of drug addiction (Khantzian, 2003). He described the defensive function of drug addiction, which he saw as a means of controlling aggressive impulses and a means of preventing psychotic reactions to situations when an individual is in a state of regression (Glover, 1932). In a paper in which he examined the psychodynamics of alcoholism, Knight (1937/1997) referred to the excessive drinking of the alcoholic as a symptom of a serious, underlying personality disorder. He believed that alcoholics drink in an attempt to manage their difficult feelings and emotions and he argued that abstinence from alcohol would not solve the alcoholic's problem, but would only make the nature of the underlying personality disorder more apparent.

In keeping with the themes discussed by many of his psychoanalytic colleagues, Radó, in his 1933 paper, *The Psychoanalysis of Pharmacothymia (Drug Addiction),* described the pleasure-seeking aspects of drug use, referring to the "stimulant and euphoria-producing effects" (p. 4) of drugs. However, in the same paper, Radó also called attention to the pain-removing qualities of certain drugs and how these drugs may be used by certain individuals in order to manage their emotions and alleviate psychic distress. He asserted that both of these aspects—the pleasure-seeking and the pain-removing effects of drugs—are rooted in the pleasure principle and together "constitute

what may be called the 'pharmacogenic pleasure-effect'" (p. 4). Radó's attention to the ways that individuals attempt, through their use of drugs, to alleviate distress and manage their emotional states moved psychoanalysis beyond a purely drive-oriented interpretation of addiction and toward an understanding of drug use as an individual's attempt at adaptation and self-regulation (Yalisove, 1997).

Radó's 1933 paper has been cited by at least one author as the work that launched "the modern psychoanalytic understanding of addiction" (Yalisove, 1997, p. 2). In addition, an earlier paper by Radó (1928) described how drugs and alcohol may serve to strengthen ego functions—e.g., impulse control, modulation of affect, self-esteem regulation (Berzoff, Flanagan, & Hertz, 2002)—and serve to manage and regulate internal tension and feelings of distress. These ideas presented by Radó (1928), as well as some of those presented by Glover (1933) regarding the defensive functions of drug use, acknowledged the adaptive role of addictive substances and marked "the beginning influence of ego psychology on the understanding of addiction" (Yalisove, 1997, p. 2). A number of more recent authors have taken up the theme of SUDs as an individual's attempt to shore up ego functions and manage difficult emotions. Several of these are discussed in the following section.

Evolving Psychodynamic Perspectives

Affect Regulation. Krystal (1978) looked closely at affective disturbances and described how individuals with SUDs find it difficult, or completely lack the ability, to clearly identify or differentiate among the various affective states they experience. Krystal (1978) and Washton and Zweben (2006) have argued that individuals with SUDs

experience an affective disturbance known as *alexithymia*, a condition in which emotions come as vague, undifferentiated sensations and individuals don't really know what they are feeling at any given moment. Krystal believed that alexithymic individuals experience affects in a somatic fashion, so affects come over them as physical sensations rather than feelings. Krystal (1978) has also argued that, due to problems during early development which resulted in disturbed object relations, individuals with SUDs experience a great deal of ambivalence in their feelings toward other people. They also exhibit impairments in autonomous functioning, especially with regard to functions such as self-control and self-care. Such impairments cause individuals with SUDs to feel that they need to rely on something external—e.g., substances or other people—in order to take care of themselves and maintain a sense of stability (Krystal, 1978, as cited in Morgenstern & Leeds, 1993).

Wurmser (1974) described drug addiction as a symptom of an underlying disturbance rather than an illness in and of itself. He saw the use of drugs as an effort at self-treatment and, echoing a number of earlier psychoanalytic thinkers, he argued that drugs were employed as "an artificial or surrogate defense against overwhelming affects" (p. 829). Wurmser also believed that there is significance to the particular drug that is selected by an individual, since different drugs have different effects, and drug users will tend eventually to settle on those substances that help them best to cope with the particular affects that cause them the most distress. Wurmser attributes the initiation of compulsive drug use in most cases to an acute *narcissistic crisis*, often occurring during adolescence and precipitated by one or more events in which an individual experiences intense feelings of disappointment, either toward others or toward him- or herself. In such a crisis, the individual is overwhelmed with difficult feelings and is unable to cope

without some kind of artificial defense (Wurmser, 1974). Morgenstern and Leeds (1993), in their discussion of the work of several contemporary psychoanalytic thinkers, assert that there is unanimity among all of them that affect tolerance is a key factor in the experience of substance abusers. Furthermore, they observe that, while there may be differing opinions regarding the underlying cause of substance abuse, all psychoanalytic thinkers agree that the abuse of drugs and alcohol is an attempt at managing or avoiding difficult feelings through artificial means. Instead of feelings, they argue, individuals with SUDs have drugs and alcohol.

Self-Medication. Recognition of the negative impact of stigma and guilt on individuals with SUDs has been discussed elsewhere in the literature. Khantzian (2003) has been critical of what he sees as the undue emphasis that was placed on the pleasurable and euphoric aspects of drug use stressed by many of the early psychoanalytic thinkers, including Freud (1897), Abraham (1908/1926), and Radó (1933). Khantzian has argued that this emphasis has resulted in the stigmatization of drug and alcohol addiction and the perception of SUDs as a moral problem rather than a health problem. Khantzian (1985/1997) has proposed his *self-medication hypothesis* (SMH) as a way of understanding and explaining how it is that some individuals become dependent on drugs and/or alcohol. According to the SMH, addicts use substances not simply because they are "seeking escape, euphoria, or self-destruction" (p. 438); rather they turn to drugs and alcohol in an attempt to self-medicate and find relief from their psychiatric problems and difficult emotions. In Khantzian's view, substance abuse is thus an attempt at self-repair and compensation that is ultimately unsuccessful and self-defeating.

Washton and Zweben (2006) have cited the SMH as providing a valuable perspective in clinical work with individuals with SUDs because it helps clinicians to understand and appreciate what the use and effects of substances mean to addicted individuals; it helps to shed light the role that drugs and alcohol play in these individuals' lives and what they are seeking through their substance use. Khantzian (2003), like Wurmser (1974) and others, argues that individuals are most likely to settle eventually on a particular substance or combination of substances, the effects of which seem to help them most with their particular type of distress. For example, individuals who struggle with feelings of anger and rage are often attracted to heroin and other opiates, while those who frequently feel depressed or lethargic often come to prefer the effects of stimulants such as cocaine or amphetamines (Khantzian, 2007). Khantzian (2007) has stressed the importance of understanding SUDs as a "self-regulation disorder," (p. 8) resulting from problems and failures during development that result in deficits and leave some individuals unable to care for themselves properly.

Self Psychology. Weegman (2002), in his examination of SUDs from a self psychology perspective, argues that "extensive damage to the self" (p. 49) is present in some individuals long before they become addicted to drugs. He does not, however, focus on SUDs as just an outcome of this earlier damage, arguing that clinicians don't have to feel forced into making this determination in order to effectively engage with and treat individuals with SUDs. Rather, he stresses the need to focus on the present and to appreciate the continuous "tragic interaction" (p. 49) between the damage and the addiction, the result of which is a destructive and self-perpetuating spiral.

Kohut (1977a) sees in the addicted individual "a central weakness … in the core of his personality [and] a defect in the self" (p. vii). In his view, substance abuse is an attempt—one that will ultimately be unsuccessful—to somehow alleviate the distress caused by this defect. In Kohut's self psychology, *selfobjects* are objects outside of the self "that give the self what it needs in order to become and remain energetic and cohesive" (Berzoff, Flanagan, & Hertz, 2002, p. 181). While it is true that selfobjects are most often other people, they can also be things, some common examples of which are music, literature, and art. Kohut (1977a) argued that, for an individual with an SUD, the substance becomes a substitute for a selfobject that failed the individual traumatically at some point earlier in his or her development. Kohut saw ingestion of a drug as an attempt to fulfill needs that were not previously met as they should have been by an individual's selfobjects. Goldstein (2001) describes the addicted individual as one who has an increased vulnerability to using substances because of a lack of proper internal self structures; substance use is an attempt to make up for this deficit.

Criticism of Psychodynamic Approaches. Zinberg (1975) has argued that most psychoanalytic thinkers have not paid enough attention to the importance of the social environment when examining the motivation for a particular individual to use illicit drugs. He asserts that "drug, set, and setting" (p. 567) all must be taken into account in order to reach such an understanding. He is also somewhat dismissive of the tendency, as he sees it, to attribute SUDs to individuals with particular personality types and unresolved conflicts from early in their development. Zinberg claims that such attribution "is based on retrospective falsification" (p. 568); he believes that one cannot assume that a drug-addicted individual's attitude and personality are necessarily the same as they

were before the addiction began. He argues that most psychoanalytic thinkers make just such an assumption—they observe the addicted individual in the present and then try to show that his or her drug addiction was the inevitable result of a long-term process involving developmental problems and disruptions in early relationships (Zinberg, 1975).

The Disease Concept of Addiction

Brickman (1988) has echoed some of the ideas presented by Zinberg (1975), specifically with regard to the idea of a psychoanalytic interpretation of drug abuse being essentially retrospective. Brickman has argued that it is often not possible for the psychoanalytic observer to determine with certainty any cause and effect relationship in cases of drug and alcohol addiction when considering the psychopathology of an individual with an SUD. Brickman discounts the idea that SUDs are necessarily secondary to underlying psychological disturbances and is dismissive of the belief that psychoanalytic insight offers any real hope of success in the treatment of SUDs. Brickman believes it is important to view substance abuse/dependence as a separate, primary illness, one that would require a "direct, nonpsychoanalytic intervention strategy leading to total chemical abstinence if analysis is to succeed" (p. 360). In order to add weight to his argument against the idea that SUDs are secondary to underlying psychopathology, he observed that one could see "the entire spectrum of psychopathology as a result of drug and alcohol intoxication" (p. 363) and he points to examples such as depression, anxiety, psychosis, and suicidal ideation. Similarly, Vaillant (1983), asserts that most of the psychopathological symptoms exhibited by

alcoholics, are actually the result, rather than the cause, of alcohol abuse—i.e., "alcoholism is the horse, not the cart, of mental illness" (p. 317).

Washton and Zweben (2006) observed that there is a growing body of evidence in the literature that points toward the conclusion that addiction is a chemically and biologically based brain disease. They discuss the existence of certain predisposing characteristics—e.g., an endorphin deficiency—that may make one individual more prone to developing an SUD than another individual who is not predisposed in such a way. Furthermore, they go on to describe the way that the continued use of drugs and/or alcohol by individuals who are biologically predisposed to developing an SUD can alter the chemistry of the brain in such a way that it is unable to return to its normal state, even after use has stopped. This, according to the authors, leaves such individuals forever at an increased risk for relapse and uncontrolled substance use. The authors assert that the disease concept, first proposed by Jellinek in a 1960 paper on alcoholism, has been well supported by recent research into the workings of the human brain. They also argue that the disease concept of addiction is especially useful in clinical work because it helps to reduce stigma and lessen a treatment-seeking individual's feelings of shame and guilt that might otherwise interfere with treatment (Washton & Zweben, 2006).

Flores (2004), writing from the disease perspective, states that addiction should not be viewed as "a symptom of a more serious core issue" (p. 15). Rather, it should be treated as a primary condition that must be dealt with directly and immediately. Flores asserts, as others writing from the disease perspective have done, that total abstinence from all substances should be seen as the most important and immediate goal of treatment. At the root of this emphasis lies the belief that individuals with SUDs will not

be able to benefit from psychotherapy as long as they are still actively using drugs or alcohol. Moreover, Flores (2004), like Washton and Zweben (2006), cites recent research involving brain imagery that shows evidence of chemical changes that can occur in the brain of an individual who uses drugs and/or alcohol in large enough quantities and over a long enough period of time. Such changes, Flores writes, involve permanent alterations to one's neurophysiology and brain functioning (Flores, 2004).

Cognitive Theory

Viewing SUDs from a cognitive perspective, Beck, Wright, Newman, and Liese (1993) have argued that one of the major reasons that certain individuals become dependent on drugs and/or alcohol is because of a set of dysfunctional beliefs they have about substance use and what it does for them. These *addictive beliefs,* as the authors refer to them, stem from "a cluster of ideas centering around pleasure seeking, problem solving, relief, and escape, [as well as] justification, risk taking, and entitlement" (p. 38). As with many other theoretical approaches, in the cognitive model of addiction, the role of an individual's emotional reactions to internal and external stimuli are acknowledged as being an important factor in his/her substance use. Beck et al. (1993) observe that addictive beliefs are exhibited by individuals only *after* they have become dependent on drugs or alcohol, and should not be seen as having caused or predisposed them to their addiction. However, once an individual has become addicted, these addictive beliefs do serve to perpetuate the addiction and place these individuals at increased and constant risk of relapse. With regard to the issue of what might predispose some individuals to develop SUDs, the authors assert that there are certain characteristics that may be evident

in certain individuals even before their drug use began. These could include, among others, a heightened sensitivity to unpleasant feelings, poor coping skills, a tendency to act on sudden impulses without considering consequences, and low tolerance for feelings of boredom and/or frustration (Beck et al., 1993).

Existential Psychotherapy

Frankl (1967, as cited in Nicholson et al., 1994) has argued that individuals could develop SUDs because they lack meaning in their lives. If one views the problem of SUDs through the lens of logotherapy, Frankl's particular model of existential psychotherapy, one might see drug addiction or alcoholism as being rooted in an individual's belief that his/her life is meaningless. Frankl believed that the search for meaning and purpose was the proper and ultimate drive of all human beings; he referred to this human characteristic as the "will to meaning" (Frankl, 1959, p. 121). He argued that if this quest was somehow blocked or disrupted the result will be a sort of *existential vacuum* in which the affected individual's life will become devoid of meaning. The use of drugs and alcohol can thus be viewed as an attempt to fill this existential vacuum (Frankl, 1967, as cited in Nicholson et al., 1994). Hull (1987) too acknowledges the importance of meaning and argues that if individuals are able to commit to some sort of positive purpose in their lives, they will be better able to manage stress and deal with difficult situations and feelings. Moreover, with regard to those individuals who have ceased their substance use and are now in recovery, he identifies the ability to establish a sense of meaning and purpose in life as a key component of relapse management (Hull, 1987).

Binswanger (1944/1958a), one of the earliest and most influential thinkers in the field of existential psychotherapy, describes *toxicomania* (i.e., addiction) as a case in which one sees a "striking case of universal existential craving to which the 'decision-inhibited' man falls prey" (p. 347). In his discussion of the experience of an addicted individual attempting to fulfill this existential craving, Binswanger describes a sort of self-perpetuating cycle in which individuals attempt to fill the emptiness they feel and achieve enjoyment or pleasure by using drugs but then encounter shame and disappointment when they are struck by the unreality of their experience. Such negative feelings then compel these addicted individuals to repeat their substance use in yet another attempt to escape or feel something more positive (Binswanger, 1944/1958a).

CHAPTER III

SELF PSYCHOLOGY

Introduction

This chapter begins by providing some of the historical context and background on Heinz Kohut and the development of self psychology. This chapter also introduces a number of key terms and major concepts of self psychology, including *selfobjects* and *selfobject needs*; Kohut's concept of the *tripolar self*, consisting of the *grandiose self*, the *idealized parent imago*, and the *alter ego* or *twinship pole*; and the process of *transmuting internalization*. In addition, this chapter includes a brief discussion of the ways in which these key concepts and terms are relevant to an understanding of psychopathology from a self psychology perspective.

On a brief explanatory note, the term "selfobject"—which is used frequently in this chapter—has been written in different ways throughout the relevant literature, so in some quotations used here it is written as "selfobject," while in others it is written as "self-object." Indeed, Kohut himself, in his earlier writings, used the hyphenated form, but in later writings used the single, non-hyphenated form. I follow Kohut's later writings and the writings of several other authors and use "selfobject" in my own writing.

History

Heinz Kohut

Heinz Kohut (1913-1989)—doctor, psychoanalyst, and founder of self psychology—was born into a middle-class Jewish family in Vienna in 1913 and raised by his mother and father. In 1932, at the age of nineteen, Kohut entered the University of Vienna and enrolled in the medical faculty. He graduated with his medical degree and a specialization in neurology in 1938 at the age of twenty-five. Nearing the end of his time as a student, Kohut sought psychotherapeutic treatment with a handful of psychologists and psychoanalysts in order to deal with the emptiness and grief he experienced due to the loss of his father in 1937 (Strozier, 2001). These experiences with his own therapy—not all of which were pleasant or successful—and with the loss of his father seem to have contributed to Kohut's growing interest in the field of psychotherapy. One biographer observes that "Kohut's decisive move toward the world of psychotherapy was impelled by the death of his father" (Strozier, 2001, p. 49). In 1940 Kohut made his way to the United States and settled in Chicago, where he began working as a physician, specializing in neurology. Over the next several years, Kohut gradually moved away from medicine, toward psychiatry, and then into psychoanalysis, eventually becoming deeply involved with the Chicago Institute for Psychoanalysis, where he received his formal psychoanalytic training and went on to become a supervising and training analyst and a member of the teaching faculty (Strozier, 2001; Siegel, 1996).

Development of Self Psychology

During the 1950s and early 1960s, most of Kohut's energy and work was directed toward the theory and practice of classical psychoanalysis. He became increasingly interested in those patients who presented with what was generally understood to be an excessive an unhealthy amount of narcissism. From the point of view of classical psychoanalysis, such patients were considered to be unanalyzable due to their excessive self-absorption, a quality that would preclude the establishment of a transference within the therapeutic relationship (Mitchell & Black, 1995). Since Freud viewed the ability to develop a transference—i.e., the experience in which a patient brings into the therapeutic relationship feelings based on experiences in past relationships (Berzoff, Flanagan, & Hertz, 2002)—as a necessary requirement for the analytic process, patients with whom this was not possible were generally considered to be poor candidates for psychoanalysis (Mitchell & Black, 1995).

From the perspective of Freud's (1914) drive theory, every person has a finite amount of libidinal energy or *libido* and so whatever portion of it is directed outward, toward objects—usually people—then that much less is available for directing inward, toward one's self (Berzoff, Flanagan, & Hertz, 2002). Thus it follows from this model that self-love and object-love are mutually exclusive and, in a sense, in a zero-sum game with one other with regard to the available reservoir of libidinal energy; an increase in one requires a decrease in the other.

Freud believed that all infants are completely self-absorbed and that all of their libidinal energy is directed inward in the form of self-love. He considered this total self-absorption to be normal in the case of infants and viewed it as the natural starting point of

human development (Berzoff, Flanagan, & Hertz, 2002). This infantile form of self-love was labeled by Freud as *primary* narcissism and was meant to be distinguished from *secondary* narcissism, the latter being "a return of the original early infantile [narcissism]" (Freud, 1917, p. 424). According to Freud, in the course of normal development, individuals move away from the totally inwardly focused self-love of the infant and toward a stage where they begin to direct their libidinal energy outward and to focus it on external objects (i.e., other people). Secondary narcissism was understood by Freud to be a pathological state occurring later in life—often due to trauma, illness, or old age—in which an individual begins to withdraw libidinal energy from objects and direct it inward and back toward the self (Berzoff, Flanagan, & Hertz, 2002).

Largely as a result of his work with patients considered to have narcissistic character disorders, Kohut came to question the validity and the effectiveness of the classical psychoanalytic approach to working with such patients. In his 1914 essay, *On Narcissism: An Introduction*, Freud had written that the "libido that has been withdrawn from the external world has been directed to the ego and thus gives rise to an attitude which may be called narcissism" (p. 75). Kohut rejected this premise that there must be a negative correlation between self-love and love of others, and his own ideas on the topic of narcissism led him to a drastic reformulation of Freud's theory. In contrast to the traditionally pejorative connotation that went along with the term narcissism, Kohut came to the conclusion that a healthy amount of love for, and good feeling about oneself—i.e., an optimal degree of *healthy* narcissism—could actually be beneficial, and was even quite necessary in one's pursuit of healthy and fulfilling relationships with others. He

believed that it would lead to a sense of "internal solidarity and vitality [and] self-esteem that is reliable in the face of disappointments" (Mitchell & Black, 1995, p. 158).

In his work with narcissistic patients, Kohut had also come to believe that the classical approach—one in which interpretation, confrontation, and insight were seen as the key tools that would lead to a "cure"—was misguided and based on incorrect assumptions about the nature of these patients' problems. Rather than going along with the widely accepted view of narcissistic patients as being securely and confidently self-satisfied, Kohut came to see these individuals as "quite fragile, tending to plummet precipitously from a sense of soaring superiority to a clumsy crash landing on earth" (Mitchell & Black, 1995, p. 155). In his work with narcissistic patients, Kohut had often witnessed that beneath the outer surface layer of narcissism, these patients had deep feelings of inadequacy and personalities rooted in painful past experiences with humiliation. Furthermore, despite his background in classical psychoanalysis and his onetime label of "Mr. Psychoanalysis" (Strozier, 2001, p. xiii) during his early analytic career in Chicago, Kohut eventually came to reject Freud's model of psychological structure as being comprised of the id, ego, and superego. Nor did Kohut accept the classical view that working through problems caused by intrapsychic conflict was the way to psychological well-being and health. Instead, Kohut believed that a healthy self is "derived from experiences in which caregiving others, known as selfobjects, meet the specific needs of the emerging self" (Berzoff, Flanagan, & Hertz, 2002, p. 176). In contrast with the classical psychoanalytic view based in Freud's work, Kohut viewed aggression and rage not as innate but as reactions resulting from frustration at not having one's needs met by an empathically attuned caregiver.

Initially, Kohut believed the new insights he developed were applicable only to his understanding of, and his work with, individuals with narcissistic personality problems. However, Kohut (1984) eventually came to believe that flaws in the self—i.e., "defects in the structure of the self, … distortions of the self, … [or] weakness of the self" (p. 53)—were at the root of all psychopathology and that such flaws are the result of disruptions in the relationship between self and selfobjects during childhood. *Selfobjects*, according to Kohut, are objects (usually people) outside of the self "that give the self what it needs in order to become and remain energetic and cohesive" (Berzoff, Flanagan, & Hertz, 2002, p. 181). Kohut believed that the formation of a *cohesive self* was at the core of healthy psychological development for every individual. Some of self psychology's major concepts, including selfobjects and the notion of a cohesive self, will be discussed in greater detail in the next section of this chapter.

Key Concepts

The Self

Kohut (1977b) referred to the self as "the center of the individual's psychological universe" (p. 311) and he regarded it as "the center of initiative of the person that organizes experiences and regulates self-esteem" (Goldstein, 2001, p. 80). Kohut also asserted that it is not possible to know, with any certainty, anything about the precise nature of the self, beyond that which we can perceive by observing its psychological manifestations. His assertion was that "the self"—its true essence—is not perceivable through direct observation and therefore one cannot differentiate between 'self' and 'self representation,' since the representation is all that can be observed (Kohut, 1977b). Kohut

believed that the self is present at birth in a very basic form and that it evolves as a result of interactions with and empathic responses from selfobjects that it encounters during its development. Kohut stressed the importance of an "empathic matrix of relationships that offer a combination of optimal empathic responsiveness and manageable empathic failure" (Berzoff, Flanagan, & Hertz, 2002, p. 174) for the development of a healthy and cohesive self.

Kohut believed that the self was comprised of three distinct poles—the *grandiose self*, the *idealized parent imago*, and the *alter ego* or *twinship pole*—each with its own particular selfobject needs. In his earlier writings, Kohut identified only two poles of the self and thus referred to the self as "bipolar." In this original conception, he identified the pole of the grandiose self, the pole of the idealized parent imago, and "an intermediate area of basic talents and skills … activated by a *tension-arc* that establishes itself between ambitions [of the grandiose self] and ideals [of the idealized parent imago]" (Wolf, 1988, p. 31). However, in his later writings, Kohut (1984) spoke of the alter ego or twinship pole as being equal in importance to the other two poles, one with its own unique qualities and selfobject needs. Kohut believed that in order for healthy, normal development to occur, each of the three poles of this tripolar self requires selfobjects that empathically respond to its developmental needs (Kohut, 1977b; Berzoff, Flanagan, & Hertz, 2002).

Selfobjects

When one looks at the world through a self psychological lens, the importance of the role played by selfobjects in an individual's development cannot be overstated.

Indeed, Kohut believed that the quality of the interactions between self and selfobjects during childhood is what determines whether the self that emerges will be healthy or damaged (Kohut & Wolf, 1978). Within the framework of self psychology, selfobjects are likened to oxygen with regard to their importance for a child's healthy development (Kohut, 1977b). Early selfobjects can be described as "empathic or attuned caretakers who perform vital functions [that the infant] cannot carry out for itself" (Goldstein, 2001, p. 80). One example that is often used to illustrate this point is that of a caregiver who acts to soothe the infant who has not yet reached the point where it has acquired the ability to soothe itself in times of distress. The crucial role of caregivers is emphasized often by Kohut and his ultimate message seems not so much to be about specific actions that must be taken, but rather about the caregivers own selves as it were. He asserts that "it is not so much what the parents *do* … but what the parents *are*" (Kohut & Wolf, 1978, p. 417) that is the real influence on the child's developing self and personality. If the parents are confident, flexible, and self-aware, and if their own selves are cohesive and healthy, then their child's development is likely to be healthy as well.

As important as selfobjects' empathically attuned responses to the needs of the self are, Kohut held that certain non-traumatic empathic failures were inevitable and just as important for healthy development, and part of a necessary two-step process in which "first, a basic intuneness must exist between self and its selfobjects [and] second, self-object failures (e.g., responses based on faulty empathy) of a non-traumatic degree must occur" (Kohut, 1984, p. 70). Such failures lead to what Kohut referred to as *optimal frustrations*—and which some others have preferred to re-label as optimal responsiveness—which are a necessary part of psychological growth and personality

development. These optimal frustrations lead in turn to the process Kohut labeled *transmuting internalization*, whereby the self takes over functions previously fulfilled by its selfobjects, thus reducing the importance of, or eliminating altogether the need for, the presence of the selfobject (Goldstein, 2001). Transmuting internalization can be defined as "the process through which a function formerly performed by another (selfobject) is taken into the self through optimal mirroring, interaction, and frustration" (Elson, 1986, p. 252).

It is important to note that while Kohut often emphasized the importance of early interactions between self and selfobjects for healthy development, he believed that an individual never outgrows the need for selfobjects. Indeed, he felt that "self-selfobject relationships form the essence of psychological life from birth to death" (Kohut, 1984, p. 47) and that "the need for others to provide support and sustenance continues all through life" (Goldstein, 2001, p. 81). Self psychology rejects the idea that complete autonomy and independence are good indicators of psychological and emotional health; rather it views an individual's capacity to seek out gratifying selfobject experiences and establish rewarding relationships with other people as the true sign of a healthy person (Goldstein, 2001).

Selfobject Needs

As mentioned earlier, Kohut believed that each of the three distinct poles of the self—the *grandiose self*, the *idealized parent imago*, and the *alter ego* or *twinship pole*—has its own particular selfobject needs. The pole of the grandiose self, for example, requires *mirroring* selfobjects, "people who will reflect and identify its unique capacities,

talents, and characteristics" (Berzoff, Flanagan, & Hertz, 2002, p. 181). Mirroring responds to the needs of the grandiose self and allows the developing child to feel admired, powerful, and special (Goldstein, 2001).

The pole of the idealized parent imago, which is the part of the self that holds an internalized representation of an idealized other, needs selfobjects that can be viewed by the self as special and competent so that the self can "have someone strong and calm to idealize and merge with in order to feel safe and complete within the self" (Berzoff, Flanagan, & Hertz, 2002, pp. 185-186). Such merger allows the establishment of the calmness and competence of the selfobject within the self. This in turn allows the individual to feel secure and soothed at times or at a stage of development when he or she is not capable of soothing him- or herself.

The alter ego or twinship pole needs selfobjects that allow the self to feel that there are others in the world to whom it is similar and with whom it shares characteristics. This allows the self not to feel too different or isolated from others and encourages a feeling within the self that it belongs in the world. It provides the self with a sense of connectedness and kinship with others in the world.

Kohut believed that these selfobject needs—mirroring, idealizing, and twinship—are present throughout one's lifespan. These needs, however, manifest themselves in different ways depending on the age and life-stage of the individual, and self psychologists describe *age-appropriate* selfobject needs as those which are normally required at certain ages in order to maintain an individual's self-cohesion and sense of well-being (Wolf, 1988). In the case of very young children—newborns, infants, and toddlers—mirroring and idealizing selfobject needs must be fulfilled in order to allow

them to build the internal self structure that allows them to develop a sense of their own individuality and selfhood.

During the Oedipal phase, selfobject needs center around the child's need to strengthen self structure and develop a gender identity, which is accomplished by the parents responding to the child's need for confirmation of his or her autonomy and maleness or femaleness. In later stages, from latency through adolescence and early adulthood, selfobject needs continue, but there is a gradual shifting away from the child's focus on his or her parents as the fulfillers of those needs; peers, teachers, and elements of age-group subcultures become sources of selfobject need fulfillment (Wolf, 1988). Selfobject needs continue through adulthood and throughout the various life stages and changing roles that come with the passage of time. Marriage, parenthood, middle-age, and old-age all bring with them their own types of age-appropriate selfobject needs, and the meeting of these needs continues to be important to the maintenance of a healthy, cohesive self for as long as one's life continues.

Psychopathology

As discussed previously, Kohut believed that psychopathology, in all its forms, had as its source flaws in the self, all of which are due to disruptions in the relationship between self and selfobjects during childhood (Kohut, 1984). Kohut felt that serious disorders of the self come about as a result of a "child's protracted exposure to a lack of parental empathy in at least two areas of selfobject need" (Elson, 1986, p. 50), e.g., a lack of sufficient mirroring and the absence of a suitable twin or alter ego. When selfobjects fail a child—and his or her developing self—to such a degree, the critical process of

transmuting internalization cannot occur, and thus the self is unable to properly develop its own internal structures (Goldstein, 2001). From the perspective of self psychology, what is most necessary for healthy development is the presence of empathically attuned caregivers, ones who can serve as "mature, cohesive, parental [selves who are] in tune with the changing needs of the child" (Kohut & Wolf, 1978, p. 417).

Kohut and Wolf (1978) classified self disorders into two different groups: primary and secondary disturbances of the self. *Secondary* disturbances of the self are understood to be normal reactions to a variety of circumstances that may be encountered during the life course, including loss, illness, injury, and failure. Such circumstances are seen as unavoidable and secondary disturbances of the self are described as non-pathological, temporary reactions of an undamaged self to the often unfortunate vicissitudes of life (Goldstein, 2001; Elson, 1986).

Kohut and Wolf (1978) divide the *primary* disturbances of the self into subgroups, based on the severity and nature of the disturbance. These subgroups include narcissistic personality and behavior disorders, borderline states, and psychoses. Kohut believed that all of these conditions were related, but he viewed borderline states and psychoses, which are characterized by serious damage to the self that is permanent or prolonged, as much more severe than the narcissistic disorders (Goldstein, 2001). The primary distinction between borderline states and psychoses is that in the case of borderline states one often sees an individual who is comparatively high functioning and whose defects are often covered by a series of complex and rigid defenses. Also, in the case of psychoses, there is often a biological predisposition present that contributed to the extent of the damage that was done to the self (Goldstein, 2001; Wolf, 1988).

Narcissistic personality disorders and narcissistic behavior disorders differ primarily, as their names suggest, in the way that their symptoms manifest—i.e., in psychological states in the case of the former; in actions and interactions in the case of the latter. With narcissistic personality disorders, one often sees individuals who are prone to hypochondria, depression, and hypersensitivity to slights and disappointments. Individuals with narcissistic behavior disorders often engage in behavior that is harmful to themselves or others, including substance abuse, compulsive sexual behavior, and criminal behavior (Kohut & Wolf, 1978; Wolf, 1988; Goldstein, 2001). Both types of narcissistic disorder involve "the break-up, enfeeblement or serious distortion of the self" (Kohut & Wolf, 1978, p. 416) and both are seen as being temporary and amenable to psychotherapeutic treatment.

CHAPTER IV

EXISTENTIAL PSYCHOTHERAPY

Introduction

This chapter begins by providing some of the historical context and background regarding the development of existential psychotherapy. This chapter also introduces a number of key terms and major concepts of existential psychotherapy, including existential psychodynamics; the four "ultimate concerns" (Yalom, 1980, p. 8) of human existence (i.e., death, freedom, isolation, and meaninglessness); boundary situations; and existential anxiety. In addition, this chapter includes a brief discussion regarding some of the ways in which these key concepts and terms are relevant to an understanding of psychopathology from an existential psychotherapy perspective.

Before proceeding, I would like to provide the reader with a minor point of clarification regarding my use of certain terms throughout this chapter. I have elected to use the term *existential psychotherapy* to refer to my topic of focus. This is the term used by Yalom (1980) and several other authors and is meant to serve, for my purposes, as an umbrella term encompassing a number of different but related approaches to psychiatry/analysis/psychotherapy. In referring to the works of some of these other authors, I may use different terms in order to refer to a specific analytic approach or school of thought, especially when quoting directly from authors' works or when discussing some of the historical background and context for the development of

existential psychotherapy. Other such terms that may be encountered throughout this chapter include *existential analysis*, *Daseinsanalysis*, *logotherapy*, and *existential therapy*. While there are some differences and distinct areas of emphasis among some of these approaches, they all share a number of elements in common and can, I believe, safely be included within the fold of *existential psychotherapy* for the purposes of this project.

History and Context

Existential Philosophy

While a comprehensive discussion of the history, themes, major figures, and influence of existential philosophy is beyond the scope of this paper, a few brief statements regarding the term might be helpful. Ellenberger (1958) defines existential philosophy as "the philosophical trend of thought which takes as its focus of interest the consideration of man's most immediate experience, his own existence" (p. 117). Ellenberger acknowledges that existential themes have been taken up by philosophers and theologians "from time immemorial" (p. 117), but identifies the nineteenth century Danish philosopher, Soren Kierkegaard as the first person to state explicitly its basic assumptions. Kierkegaard's thoughts and writings can be seen as a reaction to, or a protest against the rationalism that permeated much of the scientific and philosophical thinking of his time. He felt that the assertion that there was some sort of knowable abstract, universal truth was a fallacy. Kierkegaard believed that one could know with certainty only that which was "true" or "real" for oneself. He asserted that truth exists for each individual only insofar as that individual produces it by means of his or her actions;

thus there are as many "truths" as there are individuals (May, 1958). Ellenberger notes that other thinkers since Kierkegaard have focused and elaborated on existential themes during the twentieth century, and he cites Karl Jaspers, Jean-Paul Sartre, Martin Heidegger, and Paul Tillich as among the most influential of these.

With regard to existentialist philosophy's relationship to psychiatry and psychology, Ellenberger identifies the work of Martin Heidegger, specifically citing Heidegger's book *Being and Time*, published in 1927, as having the most direct influence. This is especially true in the case of Binswanger's (1958b) development of his own form of existential analysis which he called *Daseinsanalysis*, which he based almost exclusively on the thought and writings of Heidegger. May (1958) writes that the "existentialists are centrally concerned with rediscovering the living person amid the compartmentalization and dehumanization of modern culture" (p. 14). In a similar vein, Cooper (2003) frames existential philosophy as a reaction to modes of scientific and philosophical thinking that take a reductionist and mechanistic view of human existence.

Development of Existential Psychotherapy

Origins. Existential psychotherapy has no single authoritative source or founder; nor can it be said to have arisen at one particular time and place. Rather, it emerged spontaneously and simultaneously in the works of several psychiatrists, psychologists, and psychotherapists throughout Western Europe—and subsequently in the United States—during the first half of the twentieth century (May & Yalom, 2000; Cooper, 2003). This emergence was due, in large part, to what was seen by many of the early existentialists as an overemphasis on rationalism and scientific modes of thinking,

especially as they had been applied to the understanding of human thought, emotion, and behavior. Many of these early existential therapists felt that other psychotherapeutic approaches of the day—e.g., Freudian psychoanalysis, behaviorism, Jungian psychology—had made "man" into something of an abstraction and had, in a sense, lost sight of the actual person to whom these theories and therapies were being applied; they seemed to ignore subjective human experience (Bauman & Waldo, 1998; May & Yalom, 2000).

The work of a number of early existential therapists and theorists, including Heidegger, Binswanger, Boss, May, Frankl, and others, is often framed primarily as a reaction to, and a rejection of, many of the tenets of Freud's (1923) approach to psychoanalysis, in particular Freud's concept of the human individual as one governed by instincts and drives. The existentialists saw the Freudian conception of the human condition as one in which the actual living, vital, immediate, and *existing* person had been lost sight of (May & Yalom, 2000).

Daseinsanalysis. Ludwig Binswanger, a Swiss psychiatrist and a close friend and associate of Freud, developed his own existential approach to psychoanalysis that he termed Daseinsanalyse (or Daseinsanalysis or existential analysis). The name comes from Heidegger's term, *dasein*, translated as "being there," which Heidegger used to refer to the human individual, since human beings are defined primarily by the fact that they exist, that they inhabit the world (Binswanger, 1958b). It is also important to note that, similar to Kierkegaard, Binswanger used the term "dasein" in order to emphasize the fact that each human being, though he or she exists and is "there" ("da") in the world, at the same time *creates* the world that he or she inhabits (Yalom, 1980). Binswanger described

Daseinsanalysis, which was one of the earliest attempts to develop an existential approach to therapy (Cooper, 2003), as "an anthropological type of scientific investigation—that is, one which is aimed at the essence of being human" (Binswanger, 1958b, p. 191).

Binswanger found fault with Freud's approach to psychoanalysis and what Binswanger saw as Freud's conceptualization of human beings as "an inhuman collection of causal mechanisms, instincts and formulae" (Cooper, 2003 citing Binswanger, 1963). He felt that this view of human beings was unnecessarily and inaccurately reductionist, in that it seemed to ignore their actual lived reality in favor of seeking out their inner causal mechanisms and component parts. Binswanger was also critical of what he saw as an attempt by Freud to separate humans from the world in which they lived, citing this as an example of the "subject-object divide" (Cooper, 2003, p. 35) that Binswanger and other existentialists found troubling and which, in their view, permeated much of Western psychological and psychoanalytical thinking of the time.

Medard Boss, a Swiss psychiatrist who was Binswanger's friend and colleague, worked with Binswanger on the development of Daseinsanalysis and eventually became the most prominent advocate for the application of Heidegger's thought to psychotherapeutic practice. According to Boss—who, like Binswanger, was critical of many of Freud's ideas—one aim of Daseinsanalysis was to engage in psychotherapeutic practice that paid attention to the genuine lived experience and the real, everyday lives of individuals, rather than trying to understand these individuals in terms of drives or instincts as in Freudian psychoanalysis (Cooper, 2003).

Logotherapy. Victor Frankl (1959) developed his own form of existential psychotherapy that he called *logotherapy*, from the Greek, *logos*, which translates as "meaning." In his development of logotherapy, he focused on the idea of there being a human impetus to find or create meaning, even in the face of meaninglessness (one of the four ultimate concerns of human existence mentioned earlier in this chapter). Frankl asserted that "man's search for meaning is the primary motivation in his life and not a 'secondary rationalization' of instinctual drives" (p. 121). This was, in part, Frankl's way of stating his rejection of the idea that human beings' desire for meaning in their lives is merely the product of the workings of drives and defense mechanisms taking place at a level beneath their conscious awareness (Frankl, 1959).

Frankl (1959) often spoke of a "will to meaning" (p. 121) that he believed to be present in all human beings. When Frankl speaks of meaning, he is not referring to it in the sense of a grand, ultimate "meaning of life" that exists as a fixed, universal truth for all. What Frankl is talking about is meaning on an individual, personal level, "the specific meaning of a person's life at a given moment" (p. 131). He believed that every individual had a unique task or vocation that only he or she could fulfill and thus he saw an individual's attempt to find meaning in his or her life as something of a responsibility as well as a source of motivation (Frankl, 1959; 1967). Frankl (1967) has written that "one could define logotherapy by the literal translation as healing through meaning" (p. 140).

As a therapeutic approach, the goal of logotherapy is not to *give* clients meaning in their lives, nor to tell them what it is that they should find meaningful. Instead, logotherapy aims to help clients discover for themselves meaning and purpose in their own lives and, by means of this discovery, overcome feelings of emptiness and despair

(Cooper, 2003). According to Frankl (1959), logotherapy focuses on the future rather than the past, being "less *retrospective* and less *introspective*" (p. 120) than Freudian psychoanalysis.

Existential Psychotherapy in the United States. Rollo May (1958), an American existential psychotherapist, is identified as the person primarily responsible for introducing existential psychotherapy to the United States with the publication in 1958 of *Existence: A New Dimension in Psychiatry and Psychology*. It was by means of the publication of this book that the writings of Binswanger and other European proponents of existential psychotherapy were brought to the United States and gained a wider audience (Cooper, 2003). The American tradition of existential therapy has tended to focus more on the individualistic aspect of existentialist philosophy than its recent European progenitors. In particular, it has emphasized the idea that human beings are capable of standing alone and directly confronting "the anxiety of existence" (Cooper, 2003, p. 64).

Irvin Yalom, an American existential psychotherapist and by some referred to—along with most other American existential psychotherapists—as an "existential-humanist psychotherapist" (Bugental & Bracke, 1992; Cooper, 2003), has contributed much to the field of existential psychotherapy in the United States, in particular by his many writings on the subject, including the 1980 publication of *Existential Psychotherapy*, which has since been frequently cited and is widely considered to be one of the most comprehensive and accessible books on the topic of existential psychotherapy. One aspect that Yalom has focused on in his writing and in his work as a therapist is the importance of paying attention to how clients are feeling in the present

moment—i.e., "in the 'living moment' of the therapeutic encounter" (Cooper, 2003, p. 70)—and this is in keeping with the existentialist mode of thinking wherein the immediate, lived moment of the individual's existence is the focus of attention.

Key Concepts

Existential Psychodynamics

Yalom (1980) offers a concise definition of existential psychotherapy, describing it as "a dynamic approach to therapy which focuses on concerns that are rooted in the individual's existence" (p. 5). Existential psychotherapy is considered to be a dynamic approach in that it holds that there are conscious and unconscious forces within each individual. These forces often conflict with one another, and "thought, emotion, and behavior, both adaptive and psychopathological, are the resultant of these conflicting forces" (Yalom, 1980, p. 6). What makes existential psychotherapy's approach different from other dynamic approaches—Freud's (1905) drive theory, to take one example—is its understanding of the nature of these internal forces and the conflicts that occur. From the existential psychotherapy perspective, internal conflicts arise not, as in Freudian psychodynamics, as the result of a struggle between id and superego, nor due to sexual or aggressive instincts. Instead, conflict arises as a result of an individual's encounter with "the givens of existence. … [i.e.,] certain ultimate concerns" (Yalom, 1980, p. 8) of human life: death, freedom, isolation, and meaninglessness. In this framework the individual is viewed primarily as fearful and suffering rather than instinctually driven; the existential psychodynamic model begins with awareness and fear rather than instincts and drives (Yalom, 1980; May & Yalom, 2000).

Within the context of existential psychodynamics, there are also situations which individuals encounter that are referred to as *boundary situations*. These are unavoidable situations, inherent to human existence, "which cannot be dealt with by using the type of rational knowledge used to solve problems in everyday life" (Gordon, 1999, p. 227). According to Yalom (1980) a boundary situation is "a type of urgent experience that propels the individual into a confrontation with an existential situation" (p. 159). A boundary situation is seen as both a challenge and an opportunity. When faced with such a situation, one can respond with fear, anxiety, or despair, but one can also respond by gaining a greater sense of awareness and responsibility, and may choose to take an action that will lead to a sense of well-being and achievement.

The "Ultimate Concerns" of Human Existence

Death. Within the theoretical framework of existential psychotherapy, human beings' confrontation with the idea of death, their understanding that they will one day cease to exist, plays a significant role in their lives. Death is seen as a "core existential conflict" (Yalom, 1980) that inevitably results in a certain amount of anxiety for every individual. The conflict arises as a result of one's awareness of the inevitability of death juxtaposed with what most existential psychotherapists identify as human beings' inherent wish to continue living indefinitely. "Man" is thus identified as a being who is constantly aware "that at some future moment he will not be; he is the being who is always in dialectical relation with non-being, death" (May, 1958, p. 42). This awareness of and confrontation with death is inevitably a source of anxiety (Tillich, 1952; Yalom, 1980; May & Yalom, 2000) and, in the case of children, who normally become aware of

and concerned with the idea of death at a very early age, coming to terms with and accepting the idea of one's eventual death—the knowledge that one will someday cease to exist—is considered to be one of the primary developmental tasks of childhood (Yalom, 1980, p. 76). Tillich (1952) saw the individual's anxiety about death as something inherent in the human condition, as an unavoidable component of one's existence and something that could not possibly be eliminated or avoided.

Death is often referred to by existentialist thinkers as a primary example of a boundary situation. When an individual considers his or her own mortality and faces the reality that he or she will one day cease to exist, one possible reaction to this is a sense of dread or despair. However, it might just as well be the case that confronting the idea of one's own finiteness and eventual death could serve to "awaken the urgency of living authentically without self-deception" (Gordon, 1999. p. 228) or shift "one away from trivial preoccupations and [provide] life with depth and poignancy and an entirely different perspective" (Yalom, 1980, p. 160).

Freedom. From the perspective of existential psychotherapy, the concept of freedom has potentially frightening and disturbing implications. Whereas in most discussions, the word "freedom" or the idea of being "free" has only positive connotations, freedom carries additional weight and a deeper, more nuanced meaning as seen through the lens of existential psychotherapy. According to the existentialists, if humans are truly *free*, this implies that they are also utterly *responsible* and without any sort of guidance or assistance as they make their way in life. Existential psychotherapists hold that this freedom, and the responsibility that it implies, is often a source of great anxiety for many individuals. Further, they posit that human beings desire to have some

sort of guidance and structure in their lives. As Yalom (1980) has written, freedom, from an existential therapy perspective, "has a terrifying implication: it means that beneath us there is no ground—nothing, a void, an abyss (p. 8). In the context of existential psychodynamics, this concept of freedom, or groundlessness, can be a source of uncertainty and anxiety when juxtaposed with the innate human desire for ground, for some kind of structure or guidance.

Isolation. Within the context of existential psychotherapy, the concept of isolation refers primarily to a particular type of isolation, namely *existential isolation.* Yalom (1980) describes three distinct types of isolation—all of which are likely to be encountered by psychotherapists during their work with clients—that every human being faces during the normal course of life. One of these is *interpersonal* isolation, which refers to an individual's isolation and separation from other individuals. This type of isolation is generally experienced as loneliness. Another type of isolation, *intrapersonal* isolation refers to an individual's isolation from him- or herself. This would include instances where an individual somehow stifles his or her own feelings, thoughts, or desires. It would also include situations in which part of an individual's self has been partitioned off in some way, as in the case of a defense mechanism such as dissociation or repression. The third type, and the one most germane to existential psychotherapy, is *existential* isolation, which refers to "an unbridgeable gulf between oneself and any other being. It refers … to an isolation even more fundamental—a separation between the individual and the world" (p. 355). This third type, existential isolation, is an intrinsic factor of human existence and persists regardless of how satisfied people are in their relationships with others or how self-aware and well-integrated they are with themselves.

Meaninglessness. From an existential perspective, an individual's confrontation with meaninglessness arises due to the fact that human beings seek meaning and yet are adrift in a world without any set plan or direction for them to follow; their demand for some sort of meaning or larger purpose in the universe goes unheard and unanswered (Bauman & Waldo, 1998). The idea of a "will to meaning" (Frankl, 1959, p. 121) and the utter importance of meaning for human life is a key aspect of existential psychodynamics. Yalom (1980) makes this point when he addresses the difficulty of confronting meaninglessness, writing that an "existential dynamic conflict stems from the dilemma of a meaning-seeking creature who is thrown into a universe that has no meaning" (p. 8). This is what Albert Camus, a French-Algerian writer and philosopher whose works often addressed existential themes, would have recognized as being reminiscent of his idea of the absurd—i.e., the situation that humans are faced with due to the fact that they seek and need meaning, all the while being confronted by a world that is meaningless and indifferent to this need (Camus, 1991). Existential philosophy acknowledges meaninglessness in the larger world and asserts that human beings can transcend it by creating meaning for themselves in their own immediate reality (Bauman & Waldo, 1998). Existential psychotherapists accept this concept of meaninglessness and attempt to put it into practice in their work with their patients, one goal of which is to help each patient to discover what it is that might lend a sense of meaning or purpose to his or her life.

It may be worth pointing out that the type of meaning being referred to here—the meaning which Yalom, Camus, Frankl, and others speak of, and view as both valid and necessary—is the type of meaning that an individual may find within his or her own life.

Frankl (1959) writes that "this striving to find a meaning in one's life is the primary motivational force in man" (p. 121) and yet "what matters is not the meaning of life in general, but rather the specific meaning of a person's life at a given moment …. One should not search for an abstract meaning of life" (p. 131). The point here is that, from an existential psychotherapy perspective, while an individual may not be able to find meaning in "the world" or "the universe," this does not mean that he or she must not attempt to live his or her life in a way that is meaningful on an individual, personal level.

Psychopathology

From the point of view of existential psychotherapy, many forms of psychopathology are understood largely in terms of individuals' confrontation with the "givens of existence" (Yalom, 1980, p. 8)—i.e., the four ultimate concerns discussed above (death, freedom, isolation, and meaninglessness)—and are all seen as beginning with anxiety. Existential psychotherapists believe that a certain amount of *existential anxiety* is inevitable and must be faced by all human beings due to the fact that everyone confronts these ultimate concerns. Existential anxiety is further divided into two types—*normal* anxiety and *neurotic* anxiety. When one's anxiety seems reasonably proportional to the situation being faced—admittedly a subjective judgment in many cases—and does not require repression or the activation of defense mechanisms, it is referred to as *normal anxiety*. Anxiety at the normal level is also seen as a potentially constructive or creative force, in that it often leads individuals to seek and find a solution to the problem or situation being faced. When an individual fails to maintain their inevitable existential anxiety at a manageable level, it is then referred to as *neurotic anxiety*; this is the level

and type of anxiety at which psychopathology occurs. This type of anxiety differs from normal anxiety in that it is out of proportion with the situation being faced, often leads a person to resort to repression, and is destructive rather than constructive (May & Yalom, 2000).

Yalom (1980) and May and Yalom (2000) have written that psychopathology, to a significant extent, arises due to an individual's inability to come to terms with the inevitability of his or her eventual and inevitable death. These authors assert that psychopathological symptoms as well as "maladaptive character structure have their origin in the individual terror of death" (May and Yalom, 2000, p. 284). Yalom (1980) asserts that those individuals who present as patients in clinical settings arrive there after having "been driven to extreme modes of defense" (p. 111) after failing to find other ways of coming to terms with their fear of death. It may be worth mentioning that, from an existential perspective, psychopathology is a matter of degree rather than kind; "the difference between normality and pathology is quantitative, not qualitative" (Yalom, 1980, p. 13). This statement is made in recognition of the fact that each and every individual must at some point confront the inevitability of his or her eventual death, just as we all must face the other "ultimate concerns" of human existence.

Frankl (1967), whose logotherapy holds *meaning* as its primary focus and concern, believed that all human beings have, as their primary need in life, a need for meaning and purpose. He saw psychopathology as the result of this "will to meaning" (Frankl, 1959, p. 121) being somehow frustrated or blocked. He described a type of problematic situation he referred to as an *existential vacuum* in which individuals experience *existential frustration*. Frankl referred to this existential vacuum as "the mass

neurosis of our age" (p. 140) and he believed that in "cases in which existential frustration produces neurotic symptoms, one is dealing with a new type of neurosis [which he called] 'noogenic neurosis'" (p. 140). Frankl believed anxiety that rose to the level of neurosis could be avoided, but he, like other existential psychotherapists, acknowledged that a certain amount of existential anxiety was unavoidable. He believed that this was an inevitable fact of life and unique to human beings and, in particular, those living in the present age. Frankl believed that human beings, unlike animals, lacked instincts and drives that guided them in their lives, and he also felt that human beings in current times lacked belief in strict traditions and values that could govern them and tell them what to do in their lives.

CHAPTER V

DISCUSSION

Introduction

In this chapter, the reader is presented with an analysis of SUDs using the two theoretical lenses that are the focus of this study—self psychology and existential therapy. The chapter begins by examining SUDs using two different models—deficit and conflict—to explain the etiology and nature of these disorders. The chapter then reintroduces a number of key concepts from both theories that were previously introduced in Chapters III and IV, and discusses them here in the context of their relevance to understanding the nature of SUDs. There is also a discussion regarding the application of these key concepts from both theories in therapeutic treatment. The reader is then presented with each of the two theories' views regarding individuals' early development and its relevance to treatment. The chapter will also consider implications of this study and these two theoretical perspectives for clinical practice involving work with clients with SUDs.

Deficit vs. Conflict

Self Psychology: A Deficit Model

From the point of view of self psychology, SUDs are the result of deficits—i.e., defects or weakness in the self. Kohut (1978) considered "addictive behavior" to be a

major symptom of narcissistic behavior disorders, which he believed were due to an underlying disorder involving "the break-up, enfeeblement or serious distortion of the self" (Kohut & Wolf, 1978, p. 416). Kohut (1977) sees in the addicted individual "a central weakness … in the core of his personality [and] a defect in the self" (p. vii). In his view, substance abuse is an ill-fated attempt to alleviate the distress caused by this defect. Kohut saw ingestion of a drug as an attempt to fulfill needs that were not previously met as they should have been by an individual's selfobjects. Goldstein (2001) describes the addicted individual as one who has an increased vulnerability to using substances because of a lack of proper internal self structures; substance use is an attempt to make up for this deficit.

Khantzian's (1985/1997) self-medication hypothesis (SMH)—which posits that addicts use substances in an attempt to self-medicate and find relief from their psychiatric problems and difficult emotions—strikes a similar tone to that of Kohut's conception of the function of selfobjects. Khantzian, like Kohut, argues that the addicted individual turns to substances seeking a method of fulfilling certain functions—e.g., affect regulation, self-soothing, self-esteem—that the individual is unable to do for him- or herself. Khantzian believes that SUDs are the result of deficits—i.e., defects or weakness in the self—rather than intrapsychic conflict, and this too is in keeping with Kohut's perspective. Weegman (2002) examines SUDs from a self psychology perspective and he, like Kohut and Khantzian, sees SUDs in terms of deficit rather than conflict. He argues that "extensive damage to the self" (p. 49) is present in some individuals long before they become addicted to drugs. He stresses the need for clinicians to appreciate the

continuous “tragic interaction” (p. 49) between the damage and the addiction, the result of which is a destructive and self-perpetuating spiral.

Wurmser (1974) sees the use of drugs as an effort at self-treatment and he argues that drugs are employed as a means of defense against overwhelming affects and difficult emotions. Wurmser (1974) and Khantzian (1997) both believe that there is a significance to the particular substance that is selected by an individual—the “drug of choice”—since different substances have different effects, and addicts tend to settle on the particular substance(s) that help them cope with the specific affects and emotions that cause them the most difficulty. Again, this echoes Kohut’s view of substance use as an attempt to use drugs and alcohol as substitute selfobjects that can perform certain functions that these individuals are unable to perform for themselves.

Existential Psychotherapy: A Conflict Model

Existential psychotherapy, like self psychology, rejects Freud’s concept of human beings as creatures governed by instincts and drives. Both theories also share the view that SUDs are an outward, behavioral manifestation of an underlying problem. A key difference, however, is that while self psychology sees this problem in terms of *deficit,* existential psychotherapy sees it in terms of *conflict*. The nature of the conflict that existential writers describe involves the interaction between human beings’ needs/desires and the realities of existence—e.g., the wish to go on living and the knowledge that death is inevitable; the need for meaning in the face of meaninglessness; and the desire for guidance and structure in the face of freedom and groundlessness.

Theoretical Concepts

Selfobjects

While Kohut did not work primarily with addicted clients or deal with the issue of SUDs explicitly in much of his work, the ideas he developed regarding the nature of psychopathology in all its forms—one of which is addiction to drugs and/or alcohol—can be helpful when thinking about and working with clients with SUDs. Kohut's conception of *selfobjects* and their functions is a good example of one such helpful idea. In self psychology, selfobjects are objects outside of the self "that give the self what it needs in order to become and remain energetic and cohesive" (Berzoff, Flanagan, & Hertz, 2002, p. 181). As mentioned earlier, while selfobjects are usually people, they can also be "things," common examples of which include various enriching and creative pursuits such as art, music, and literature. However, drugs and alcohol are also "things" that, for some, may serve selfobject functions.

Kohut addressed the issue of addiction directly in one of his writings (1977), arguing that individuals who are addicted to drugs use drugs as substitutes for selfobjects that failed them traumatically at some point during their earlier psychological development. That is to say, something vital to the healthy development of a cohesive self was missing. According to Kohut, the drug-addicted individual, through use of the drug, is attempting to satisfy his or her unfulfilled selfobject needs. Thus the drug may serve as a mirroring selfobject that soothes and accepts, or as an idealized selfobject that allows merger and provides the self with a sense of power (Kohut, 1977).

Existential Psychodynamics

From the point of view of existential psychotherapy, individuals who become addicted to drugs and alcohol often do so because of feelings of emptiness—a sort of existential vacuum—which causes a great deal of distress and unhappiness. These feelings of emptiness, when understood in the context of existential psychodynamics, are seen as resulting from an individual's confrontation with the existential realities of life—i.e., the "ultimate concerns" of human existence: death, freedom, meaninglessness, and isolation (Yalom, 1980). For individuals with SUDs, substance use is a means of seeking relief from difficult emotions and experiencing pleasure. However, due to the temporary nature of the effects of drugs and alcohol, the addicted individual becomes stuck in a self-perpetuating cycle in which only temporary relief can be achieved. The real root of the individual's problems—namely feelings of emptiness and a lack of meaning in his or her life—is thus never addressed, and so the cycle continues, without any lasting improvement or growth (Nicholson et al., 1994).

Binswanger (1944/1958) describes addiction, which he referred to as *toxicomania*, as a case in which one sees a "striking case of universal existential craving to which the 'decision-inhibited' man falls prey" (p. 347). In his discussion of the experience of an addicted individual attempting to fulfill this existential craving, Binswanger describes a self-perpetuating cycle in which individuals attempt to fill the emptiness they feel and achieve enjoyment or pleasure by using drugs but then encounter shame and disappointment when they are struck by the unreality of their experience. Such negative feelings then compel these addicted individuals to repeat their substance use in yet another attempt to escape or feel something more positive (Binswanger, 1944/1958).

The Understimulated Self

In his discussions of various psychopathological conditions, Kohut (1978) describes the *understimulated self* as a condition that comes about due to a lack of stimulating responsiveness from the child's selfobjects. The result is an individual who lacks vitality and who is unable to feel a sense of excitement from within their own selves. Thus, they must turn to external and artificial sources of stimulation in order to stave off a sense of inner lethargy and deadness. In children this can involve a variety of acting out behaviors, and in the case of adolescents and adults, drugs and alcohol provide them with an external means of altering their inner state and producing feelings of excitement. However, given the artificial and temporary nature of such methods, the individual who relies on substances to induce excitement is caught up in an up-and-down cycle of compulsive substance use during which no lasting change or strengthening of self-structure can occur.

Transmuting Internalization

Khantzian echoes in his writing much that can be found in the ideas of Kohut's self psychology. Khantzian (2007) argues that individuals with SUDs suffer from certain developmental deficits resulting from their failure to internalize soothing, comforting, and validating aspects of attuned and empathic caregivers. This essentially parallels Kohut's description of the process of transmuting internalization, whereby the self takes over functions previously performed by its selfobjects (e.g., soothing, affect regulation), thus reducing or eliminating the need for the selfobject (Goldstein, 2001). Transmuting internalization occurs through a process involving optimal mirroring, interaction, and

frustration between the self and its selfobjects. When successful, this process allows the developing self to reach a point where he or she is able to perform functions for which selfobjects had to be relied on previously (Elson, 1986). Referring back to Khantzian's point, one result of the deficits that he notes regarding SUDs is that addicted individuals rely on drugs and alcohol to help them perform functions like self-soothing and affect regulation, since they were unable to internalize these functions through self-selfobject interactions during their earlier development.

Narcissistic Crises

Wurmser (1974) attributes the initiation of compulsive drug use in most cases to an acute narcissistic crisis, often occurring during adolescence and caused by events in which an individual experiences intense feelings of disappointment, either toward others or toward him- or herself. In such a crisis, the individual is overwhelmed with difficult feelings and is unable to cope without some kind of artificial defense. Such disappointments in the self and others seem reminiscent of Kohut's ideas regarding the tripolar self and the selfobject needs of each the three poles.

Looking at Wurmser's statement regarding the occurrence of a narcissistic crisis from a self psychology perspective, one can view the "intense disappointments" about oneself as having a negative impact on the pole of the grandiose self—the pole that needs to feel admired, powerful, and special. Similarly, the intense disappointments felt toward others that Wurmser cites as a causal factor in narcissistic crises can be seen as having a negative impact on the tripolar self in more than one way. It may be that the disappointment is caused by a lack of proper mirroring, which is required by the

grandiose self. It may also be the case that the disappointment is more of an issue related to the pole of the idealized parent imago, which requires others whom the self can idealize and look up to and whom the self can rely on and merge with in order to feel safe.

Boundary Situations

The concept of boundary situations was discussed earlier in this paper, and I mention it again here because it seems to be a useful concept to consider when examining the issue of SUDs. In the context of existential psychodynamics, a boundary situation is "a type of urgent experience that propels the individual into a confrontation with an existential situation" (Yalom, 1980, p. 159). Such situations are seen as both a challenge and an opportunity; one can respond with fear, anxiety, or despair, but one can also respond by gaining a greater sense of awareness and responsibility, and may choose to take an action that will lead to a sense of well-being and achievement.

This concept seems especially relevant to the experience of individuals with SUDs, since many of them have, throughout the history of their substance use, been brought closer to certain existential realities—e.g., death, isolation—than many other people. Looking at substance use and addiction as a type of boundary situation can be useful during treatment as a therapist attempts to understand the world and subjective experience of a client struggling with addiction. While individuals may begin using drugs and alcohol as a way of trying to manage difficulties involving a particular sort of boundary situation, it may also be just such an encounter with an "existential reality"—e.g. health problems, an overdose, damaged relationships—that led to the client's

decision to seek treatment in the first place. Thus it may be useful in helping the therapist to keep such a client engaged in treatment and hopeful about the potential for positive change in the future.

Treatment

Self Psychology

As discussed earlier, Kohut stressed the importance of selfobject experiences and fulfilling relationships not only during early development but throughout one's entire life. This lifelong need for selfobject experiences is an important and useful consideration for clinicians to be mindful of in their work with clients, since, from a self psychology perspective, treatment is an opportunity for repair and the provision of new selfobject experiences that may have been lacking earlier in clients' lives. Therapy is seen as another chance for individuals to repair existing self-deficits—otherwise referred to by self psychologists as narcissistic vulnerability—and move forward in their development. It is an opportunity for clients to grow and strengthen their personality in ways that they were not able to do in the past.

Self psychology is an approach to psychotherapy in which a great deal of emphasis is placed on the therapist's use of empathy as the primary means of collecting data and engaging with the patient. Kohut often emphasized the critical role of empathy, which he referred to as vicarious introspection and defined as "the capacity to think and feel oneself into the inner life of another person" (Kohut, 1984, p. 82). Indeed, he believed that it was empathy—and empathy alone—that would make it possible for the therapist to engage with the patient. Kohut went so far as to label empathy as "the

operation that defines psychoanalysis" (Kohut, 1984, p. 175) and to assert that it would be impossible for a clinician to gain any real understanding of clients' complex mental states and processes without the use of empathy.

As mentioned previously, Kohut believed that all psychopathology—including SUDs—has as its source flaws in the self, all of which are due to disruptions in the relationship between self and selfobjects during childhood (Kohut, 1984). Given this understanding, self psychology approaches the treatment of SUDs as it would many other forms of psychopathology. However, Kohut (1959) has made some specific comments regarding the treatment of addicted clients, stating that during the process of therapy, the addicted client, in a way, becomes addicted to the therapist. Kohut believes that this is a normal part of the treatment process for individuals with SUDs; however, he points out that this is new addiction should not be confused with transference. In such cases, "the therapist is not a screen for the projection of existing psychological structure but a substitute for it" (p. 476). As a substitute for weak or missing aspects of the client's psychological structure, the therapist is serving a similar purpose to that which the drug had been serving before the client entered treatment. What clients need in such cases are the continued empathy, soothing, and support of the therapist; given time and the ongoing engagement within the therapeutic relationship, the client will eventually be able to strengthen his or her own psychological structure and become less dependent on the therapist as a substitute.

Existential Psychotherapy

With regard to treatment, existential therapists place emphasis on the importance of the therapist's effort and ability to *understand* the client; all other concerns are considered to be less important. May (1983) believes that *technique follows understanding* and that being able to understand a client is in fact the "central task and responsibility" (p. 151) of the therapist. He argues that all other considerations, including one's theoretical orientation or particular therapeutic method, are secondary to achieving this understanding. May acknowledges the wide range of therapeutic techniques that have been employed by various existential therapists. From an existential therapy perspective, the most important consideration regarding the use of one technique or another is the reason that it is being used and the purpose that it will serve in the work with a particular client at a particular time. As a theoretical framework, existential therapy is intended to provide therapists with a perspective that will help them to understand their clients' world and subjective experience. As such, therapists are free to employ any technique in pursuit of such understanding and in order to encourage their clients' growth and psychological well-being (Bauman & Waldo, 1998).

In their work with addicted clients, it is important for clinicians to try to understand the role that drugs or alcohol played in these clients' lives so as to appreciate the nature of the void that is inevitably created by the removal of these substances once the clients have stopped using drugs or alcohol. Once individuals with SUDs enter treatment and stop using drugs or alcohol, attention must be paid to the void that has been left, the needs that are no longer being fulfilled by means of the use and effects of substances. Meaning—on an individual, personal level—is an important, if not essential,

focus of consideration for individuals in treatment for and seeking recovery from SUDs. Hull (1987) acknowledges this, arguing that individuals in recovery will be better able to manage stress and avoid relapse if they can develop a sense of meaning or purpose in their lives. This is in keeping with many of the ideas put forth by Frankl in his logotherapy-based approach to understanding psychopathology, wherein he argues that the problem of an "existential void"—a feeling of emptiness resulting form a lack of meaning or purpose in one's life—is often the cause of emotional distress and psychopathology (Frankl, 1959).

The importance of addressing clients' need for some sort of meaning in their lives may be especially significant in the case of individuals with SUDs. Frankl (1967, as cited in Nicholson et al., 1994) has argued that individuals may develop SUDs because they lack meaning in their lives. If one views the problem of SUDs through the lens of Frankl's logotherapy, one might view an individual's addiction to drugs or alcohol as the result of a belief that his or her life is meaningless. Frankl believed that the search for a meaning or purpose in life—a "will to meaning" (Frankl, 1959, p. 121)—was an intrinsic part of being human. He argued that if this pursuit was somehow blocked, the result would be an existential vacuum in which an individual's life would lose all meaning. In such cases the use of substances can be seen as an attempt to fill this existential vacuum (1967, as cited in Nicholson et al., 1994).

It is not the intention of existential psychotherapists to eliminate all existential anxiety from their clients' lives—even if such a feat were possible, they would not see it as desirable. Existential therapists believe that a *normal* amount of anxiety can actually be a constructive or creative force, in that it often leads individuals to seek and find a

solution to the problem or situation being faced. However, when an individual fails to maintain their inevitable existential anxiety at a manageable level, it is then referred to as *neurotic anxiety*; this is the level and type of anxiety at which psychopathology occurs. This type of anxiety differs from normal anxiety in that it is out of proportion with the situation being faced, often leads a person to resort to repression, and is destructive rather than constructive (May & Yalom, 2000).

In the end, existential psychotherapy takes a very respectful view of clients and their struggles, as clients' difficulties are seen as the result of universal concerns and things which all individuals must deal with during the life course. As mentioned earlier, existential psychotherapists view psychopathology as a "matter of degree rather than kind" and as quantitative rather than qualitative—we all face these issues, but in the cases of certain individuals, coping skills fail and psychopathology results (Yalom, 1980).

Development

Self Psychology

Because self psychologists view SUDs and other forms of psychopathology as the result of problems during early development, they focus a great deal of attention on learning about a client's childhood and his or her self-selfobject relationships. The point of this is that self psychologists view therapy as an opportunity for repair and further development, so the present relationship in the therapeutic dyad is seen in part as a way of gaining insight into the nature of the disruptions and developmental failures that occurred earlier in the client's life. This knowledge can then allow for greater understanding of a particular client's needs and the nature of his or her deficits. During

therapy, self psychologists expect that *selfobject transferences* will occur in which the client reenacts frustrating early selfobject experiences "in the new, more empathic and non-judgmental context of treatment" (Goldstein, 2001, p. 111). Thus the therapist's experiences with the client in the present therapeutic relationship help to provide a window into the client's experiences and difficulties in the past.

Existential Psychotherapy

Existential psychotherapists place much less emphasis than do self psychologists on early development and its impact on the client in the present moment. It would not be true to say that early development is seen as unimportant; Yalom (1980) writes about the importance of the child's developmental task of coming to terms with and accepting the idea of his or her eventual death, as well as the inevitable death of loved ones. However, developmental issues are considered to be much less relevant than what the client is feeling and experiencing in the here-and-now. The question of what, at the present moment, is the source of the client's deepest fears and most intense anxiety, is not seen as one that can be answered by looking into the client's earliest experiences. This is also an example of the different view that existential therapists have of words like "deep" and "fundamental" as compared with most other psychodynamic theories. Existential therapists do not see a justification for equating words like "deep" and "fundamental" with the idea of "earliest"—for them, "to explore deeply from an existential perspective does not mean that one explores the past; rather, it means that one brushes away everyday concerns and thinks deeply about one's existential situation" (Yalom, 1980, p. 11).

Implications for Clinical Social Work Practice

Despite the many differences that become apparent when looking at these two theories alongside one another, self psychology and existential psychotherapy share some important qualities that make them useful for clinical social workers and which are in keeping with the ethics and mission of the profession. Both of the theories that are examined in this study take a very optimistic view of the potential for clients to heal and improve their lives through treatment. While self psychology sees psychopathology in terms of deficit and past damage, it also places a great deal of emphasis on the potential for repair and future development through the new and supportive selfobject experiences that can occur during therapy. So, while self psychologists look to the past for sources of current defects and difficulties, they see selfobject needs and continued development as a lifelong process, so the opportunity for healing and growth is always present.

Existential psychotherapists are also optimistic about the potential for healing and positive change, though they focus more on addressing a client's immediate lived existence and place much less emphasis on working through problems originating in the past. From an existential psychotherapy perspective, therapists believe that they can work with clients to help them achieve new perspectives regarding their existential situation. Therapy is also seen as an opportunity to help clients understand that that all human beings face challenges and fears similar to theirs, whether it is the inevitability of death or the search for some kind of meaning in life.

Both theories also focus on the importance of imperfect attunement and empathic failures between therapist and client during the course of therapy. For self psychologists, such occurrences are seen as being necessary to further development, since they provide

new opportunities for clients to work through past disruptions in their selfobject relationships and experience the process of transmuting internalization. Similarly, existential psychotherapists believe that it is important for clients to learn what they can and cannot get from relationships with others, so the client-therapist relationship is seen as an opportunity to model a deep but realistically imperfect relationship between two real people in the world. Existential therapists believe that clients' experiences in their relationships with their therapists will help them in their other present and future relationships.

Another area of overlap between the two theories that is relevant to clinical practice is their concern with the subjective experience of the client. In self psychology, this can be seen in Kohut's and others' focus on the importance of empathy as a therapeutic tool. Indeed, as mentioned previously, Kohut cited empathy as the therapist's primary method of collecting data and engaging with the patient. Kohut referred to empathy as "vicarious introspection" and defined it as "the capacity to think and feel oneself into the inner life of another person" (Kohut, 1984, p. 82). Furthermore, Kohut asserted that it would be impossible for a clinician to gain any real understanding of clients' complex mental states and processes without the use of empathy. While existential therapists do not write often about "empathy" as such, they do discuss, in a similar vein, the importance of understanding the client's world and subjective experience. It would seem that whether or not one chooses to describe it in the same terms, self psychologists and existential psychotherapists would affirm May's (1983) assertion that being able to understand a client is in fact the "central task and responsibility" (p. 151) of the therapist.

Conclusion

The central guiding question of this theoretical thesis has been, "How can the theoretical lenses of self psychology and existential therapy help clinical social workers and other mental health professionals better understand substance use disorders (SUDs) and inform their work with addicted clients?" The two chosen theories were used together in order to better understand the nature of SUDs as well as the underlying psychological and existential factors that may contribute to the development and persistence of such disorders in certain individuals. It is hoped that further exploration of the compatibility of these two theoretical perspectives in the treatment of clients with SUDs can occur in the future. One area of potential focus in pursuit of this would be to collect data in the form of personal accounts from any clinicians who have relied on both of these theoretical lenses to inform their clinical work with their addicted clients.

It is believed by this writer that both of these two theoretical lenses—separately and even more so together—can be useful to clinicians when thinking about treatment options in their work with clients with SUDs. As mentioned earlier, both of these theories, despite their many differences, share a number of important similarities that make them useful for clinical social work. These include an optimistic view of the potential for growth and healing through treatment; an emphasis on trying to understand the client's subjective experience; and a genuinely humane and respectful view of all clients, including those struggling with SUDs.

References

Abraham, K. (1926). The psychological relations between sexuality and alcoholism. *International Journal of Psycho-Analysis, 7*, 2-10. (Original work published 1908)

American Psychiatric Association (1952). *Diagnostic and statistical manual of mental disorders* (1st ed.). Washington, DC: Author.

American Psychiatric Association (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). Washington, DC: Author.

American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

Bauman, S., & Waldo, M. (1998). Existential theory and mental health counseling: If it were a snake, it would have bitten. *Journal of Mental Health Counseling, 20*(1), 13-27.

Beck, A. T., Wright, F. D., Newman, C. F., & Liese, B. S. (1993). *Cognitive therapy of substance abuse.* New York: Guilford.

Berzoff, J., Flanagan, L.M., Hertz, P. (2002). *Inside out and outside in: Psychodynamic clinical theory and practice in contemporary multicultural contexts*. Lanham, MD: Rowman & Littlefield.

Binswanger, L. (1958a). The case of Ellen West: An anthropological-clinical study. In R. May, E. Angel, & H. F. Ellenberger (Eds.), *Existence: A new dimension in psychiatry and psychology.* (pp. 237-364). New York: Basic Books. (Original work published 1944)

Binswanger, L. (1958b). The existential analysis school of thought. In R. May, E. Angel, & H. F. Ellenberger (Eds.), *Existence: A new dimension in psychiatry and psychology.* (pp. 191-213). New York: Basic Books. (Original work published 1946)

Brickman, B. (1988). Psychoanalysis and substance abuse: Toward a more effective approach. *Journal of the American Academy of Psychoanalysis, 16*, 359-379.

Bugental, J. F. T. & Bracke, P. E. (1992). The future of existential-humanistic psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 29*(1), 28-33.

Camus, A. (1991). *The myth of Sisyphus and other essays*. New York: Vintage International.

Cooper, M. (2003). *Existential therapies*. London: Sage Publications Ltd.

Ellenberger, H. F. (1958). A clinical introduction to psychiatric phenomenology and existential analysis. In R. May, E. Angel, & H. F. Ellenberger (Eds.), *Existence: A new dimension in psychiatry and psychology.* (pp. 92-124). New York: Basic Books.

Elson, M. (1986). *Self psychology in clinical social work*. New York: Norton.

Flores, P. J. (2004). *Addiction as an attachment disorder*. Lanham, MD: Jason Aronson.

Frankl, V. (1959). *Man's search for meaning*. New York: Washington Square Press.

Frankl, V. (1967). Logotherapy and existentialism. *Psychotherapy: Theory, research and practice, 4*(3), 138-142.

Freud, S. (1897). Letter 79 extracts from the Fliess papers. *The standard edition of the complete psychological works of Sigmund Freud, volume i (1886-1899): Pre-psycho-analytic publications and unpublished drafts*, 272-273. Retrieved January 2, 2009, from PEP Web database.

Freud, S. (1905). Three essays on the theory of sexuality. *The standard edition of the complete psychological works of Sigmund Freud, volume vii (1901-1905): A case of hysteria, three essays on sexuality and other works*, 123-246. Retrieved April 26, 2009, from PEP Web database.

Freud, S. (1914). On narcissism. *The standard edition of the complete psychological works of Sigmund Freud, volume xiv (1914-1916): On the history of the psycho-analytic movement, papers on metapsychology and other works*, 67-102. Retrieved March 15, 2009, from PEP Web database.

Freud, S. (1917). Introductory lectures on psycho-analysis. *The standard edition of the complete psychological works of Sigmund Freud, volume xvi (1916-1917): Introductory lectures on psycho-analysis (part iii)*, 241-463. Retrieved March 1, 2009 from PEP Web database.

Freud, S. (1923). The ego and the id. *The standard edition of the complete psychological works of Sigmund Freud, volume xix (1923-1925): The ego and the id and other works*, 1-66. Retrieved April 26, 2009 from PEP Web database.

Goldstein, E. G. (2001). *Object relations theory and self psychology in social work practice.* New York: The Free Press.

Glover, E. (1932). On the aetiology of drug-addiction. *International Journal of Psycho-Analysis, 13*, 298-328. Retrieved January 4, 2009 from PEP Web database.

Gordon, H. (1999). *Dictionary of existentialism*. Westport, CT: Greenwood.

Khantzian, E. J. (1997). The self-medication hypothesis of addictive disorders: Focus on heroin and cocaine dependence. In D. L. Yalisove (Ed.), *Essential papers on addiction* (pp. 429-440). New York: New York University Press. (Original work published 1985)

Khantzian, E. J. (2003). Understanding addictive vulnerability: An evolving psychodynamic perspective. *Neuro-Psychoanalysis, 5*, 5-21.

Khantzian, E. J. (2007). *Treating addiction as a human process* (Reprint ed.). Lanham, MD: Jason Aaronson.

Knight, R. P. (1997). The psychodynamics of chronic alcoholism. In D. L. Yalisove (Ed.), *Essential papers on addiction* (pp. 72-86). New York: New York University Press. (Original work published 1937)

Kohut, H. (1959). Introspection, empathy, and psychoanalysis—An examination of the relationship between mode of observation and theory. *Journal of the American Psychoanalytic Association, 7*, 459-483.

Kohut, H. (1977a). *Preface to psychodynamics of drug dependence* (NIDA Treatment Research Monograph # 12). Rockville, MD: National Institute on Drug Abuse.

Kohut, H. (1977b). *The restoration of the self*. New York: International Universities Press.

Kohut, H. (1984). *How does analysis cure?* Chicago: University of Chicago Press.

Kohut, H., Wolf, E. S. (1978). The disorders of the self and their treatment: An outline. *International Journal of Psycho-Analysis, 59*, 413-425.

Krystal, H. (1978). Self representation and the capacity for self care. *Annual of Psychoanalysis, 6*, 209-246. Retrieved December 12, 2009, from PEP Web database.

May, R. (1958). Contributions of existential psychotherapy. In R. May, E. Angel, & H. F. Ellenberger (Eds.), *Existence: A new dimension in psychiatry and psychology.* (pp. 237-364). New York: Basic Books.

May, R. (1983). *The discovery of being*. New York: Norton.

May, R., & Yalom, I. (2000). Existential psychotherapy. In R. J. Corsini & D. Wedding (Eds.). *Current psychotherapies* (6th ed.) (pp. 273-302). Itasca, IL: Peacock Publishers.

Mitchell, S. A., & Black, M. J. (1995). *Freud and beyond*. New York: Basic Books.

Morgenstern, J., & Leeds, J. (1993). Contemporary psychoanalytic theories of substance abuse: A disorder in search of a paradigm. *Psychotherapy, 30*(2), 194-206.

Nicholson, T., Higgins, W., Turner, P., James, S., Stickle, F., & Pruitt, T. (1994). The relation between meaning in life and the occurrence of drug abuse: A retrospective study. *Psychology of Addiction Behaviors, 8*(1), 24-28.

Radó, S. (1928). The psychical effects of intoxication: Attempt at a psycho-analytical theory of drug-addiction. *International Journal of Psychoanalysis, 9*, 301-317. Retrieved January 4, 2009, from PEP Web database.

Radó, S. (1933). The psychoanalysis of pharmacothymia (drug addiction). *Psychoanalytic Quarterly, 2*, 1-23. Retrieved January 4, 2009, from PEP Web database.

Saunders, J. B., Schuckit, M. A., Sirovatka, P. J., & Regier, D. A. (2007). *Diagnostic issues in substance use disorders: Refining the research agenda for DSM-V*. Arlington, VA: American Psychiatric Publishing

Siegel, A. M. (1996). *Heinz Kohut and the psychology of the self*. New York: Routledge.

Strozier, C. B. (2001). *Heinz Kohut: The making of a psychoanalyst*. New York: Farrar, Straus and Giroux.

Substance Abuse and Mental Health Services Administration. (2008). *Results from the 2007 national survey on drug use and health: National findings*. (Office of Applied Studies, NSDUH Series H-34, DHHS Publication No. SMA 08-4343). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Tillich, P. (1952). *The courage to be.* New Haven: Yale University Press.

Vaillant, G. E. (1983). Natural history of male alcoholism v: Is alcoholism the cart or the horse to sociopathy? *British Journal of Addiction, 78*, 317-326.

Washton, A. M., & Zweben, J. E. (2006). *Treating alcohol and drug problems in psychotherapy practice: Doing what works*. New York: Guilford.

Weegmann, M. (2002). The vulnerable self: Heinz Kohut and the addictions. In M. Weegmann & R. Cohen (Eds.), *The psychodynamics of addiction*. (pp. 31-49). Philadelphia, PA: Whurr.

Wolf, E. S. (1988). *Treating the self*. New York: Guilford.

Wurmser, L. (1974). Psychoanalytic considerations of the etiology of compulsive drug use. *Journal of the American Psychoanalytic Association, 22*, 820-843. Retrieved January 4, 2009, from PEP Web database.

Yalisove, D. L. (1997). *Essential papers on addiction*. New York: New York University Press.

Yalom, I. D. (1980). *Existential psychotherapy*. New York: Basic Books.

Zinberg, N.E. (1975). Addiction and ego function. *Psychoanalytic Study of the Child, 30,* 567-588.