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THE PSYCHODYNAMICS OF FANTASY, ADDICTION, AND ADDICTIVE ATTACHMENTS

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> Our first way of experiencing the world is largely what psychoanalysts have called fantasy. This modality has its own validity, its own rationality. . . . For most of our social life, we largely gloss over this underlying fantasy level of our relationship. (pp. 30–31)
>
> R. D. Laing (1967)
> *The Politics of Experience*

Internal fantasy processes are inextricably involved in the etiology of addictive personality disorders, habit patterns, and attachments. Children deprived of emotional sustenance, threatened by separation anxiety, attempt to form a fusion through fantasy processes. The capacity for imagination is partially satisfying of primitive drives and emotional needs. Therefore, individuals deprived of "love-food,"[1] the necessary ingredient for satisfactory development, rely increasingly on fantasy gratification, which partly reduces tension and acts as a painkiller. They develop a self-parenting process in which they are both the parent and the object of parenting.

There are two basic aspects to the self-parenting process: self-nourishment and self-punishment. Self-nourishing propensities arise early in life, for example, in the form of thumb-sucking, masturbatory activity, and other self-gratifying behavior patterns. These habits become addictive for the rejected child or adolescent, and reliance on this self-support system is proportional to the degree of deprivation.

Later, adults feed themselves more directly with food, alcohol, and various chemicals as in eating disorders or substance abuse. Self-punishing tendencies are also manifested in the form of internal destructive "voices," self-critical attitudes, and behavior that is harmful to self.

Aspects of the self-parenting process can be externalized in the form of addictive interpersonal relationships. For example, a man or woman may act out either the grandiose, critical, punitive parent or the helpless, worthless child with their mate, leading to symbiosis, and a fantasy bond is

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formed. The dynamics of this form of attachment differ from a straightforward relationship characterized by genuine companionship, love, and sexuality. Thus, fantasy processes, acted inward or outward, in conjunction with primitive self-nurturing feeding patterns, can become a survival mechanism for those who suffer excessive deprivation in childhood.

The same defenses that protect children from experiencing overwhelming anxiety in their growing up lead to the development of an inward, addictive lifestyle. Reliance on fantasy processes tends to be progressively incapacitating, as dependence on fantasy interferes with goal-directed activity in the real world. A negative spiral of frustration, fantasy, and addiction, followed by increased frustration, is set into operation. When addictive patterns are acted out in personal relationships, they jeopardize couple and family relationships. For example, a masturbatory style of sexual relating characterized by a lack of real feeling can take on a mechanical quality that leaves each partner feeling empty and emotionally hungry.

The important issue here is that addictive patterns can come to be preferred over satisfactions in the interpersonal environment. People fearful of taking a chance again develop an inward lifestyle in which risks are limited and achievements are curtailed. *Thus, all human beings exist in conflict between an active pursuit of goals in the real world and a reliance on fantasy gratification*. Neurotic symptomatology, character disorders, and painful experiences in everyday life are closely related to a negative resolution of this core issue.

In the course of the developmental sequence, psychological equilibrium is achieved when a person arrives at a particular solution to the basic conflict. This equilibrium is often attained at the expense of satisfying object relations and is threatened by warm or constructive events that contradict earlier painful or traumatic experiences. Movement in either direction—a retreat further into fantasy and self-parenting or movement toward external goal-directed behavior—is accompanied either by negative or positive anxiety (Whitaker and Malone, 1953).

The defensive process eventually becomes addictive. It persists for long periods after deprivation has ceased and predisposes negative behavioral responses. For example, individuals who exist primarily in an inward state of fantasy drastically reduce their emotional transactions with others. A withholding style of relating is manifested and both giving and taking are restricted. Once the fantasy process and associated behaviors are established, they must be defended against intrusion at all costs.

Anything that threatens to disturb an individual's solution to the conflict between self-gratification and the active pursuit of real goals, i.e., any event that disturbs the psychological equilibrium, arouses considerable

fear. The rise in anxiety results in both aggressive and regressive reactions. This phenomenon can be observed in a wide range of settings and explains seemingly perverse reactions that are often difficult to understand or interpret; for example, an individual's retreat into addictive habit patterns and a self-destructive approach to life following an unusual achievement or success, or a patient's negative therapeutic reaction to progress in psychotherapy. It is important to note that the process of gratifying oneself in fantasy and that of seeking satisfaction in the external world are mutually exclusive. Thus, real satisfaction represents a threat to the fantasy process.

The author's objectives in this paper are (1) to elucidate the relationship between fantasy and addiction; (2) to understand addiction as a primary function of the self-parenting process; and (3) to discuss a therapy for addictive personalities. If we are to be effective in interrupting addictive habit patterns and attachments, we must come to understand the underlying dynamics at the core of these phenomena.

LITERATURE REVIEW

Addictive Properties of Fantasy

The capacity of human beings to imagine and symbolize is at once a strength and a weakness. The ability to create in fantasy an image of oneself and the fulfillment of one's goals can set the stage for psychological disturbances, especially those of an addictive nature. For example, research has shown that fantasy can be rewarding under conditions of physical deprivation. In one study (Keys et al. 1950), volunteer subjects were deprived of food and kept on a minimum sustenance diet. The subjects reported that they spent hours daydreaming about food, which partly alleviated their tension and hunger drive.

Fantasy plays a central role in the dynamics of schizophrenia. In explaining the survival function of the schizophrenic regression, John N. Rosen (1953) stated:

> When a wish for something is so important that it involves a matter of life and death, then, and only then, does the unconscious part of the psychic apparatus spring into action and provide the necessary gratification with an *imagination*. (pp. 107–108)

Rosen related the story of a soldier, lost in the desert, who imagined that the sand was water and scooped up handfuls of it, which he said were "wet and cool to his touch and refreshing to taste." Similarly, under conditions of emotional deprivation, fantasy functions to fill the void and

"nourish" the self by partially gratifying primitive needs and emotional hunger.

Psychoanalytic Conceptualizations of Addiction

Freud's (1930/1961) formulations concerning the fundamental relationship between addiction and fantasy are pertinent to the present discussion. In "Civilization and Its Discontents," Freud described chemical means of avoiding suffering: "For one knows that, with the help of this 'drowner of cares' [intoxication] one can at any time withdraw from the pressure of reality and find refuge in a world of one's own with better conditions of sensibility" (p. 78). In the same essay, he noted that fantasy processes served a similar function, that of diminishing the pain of everyday living:

> . . . [by] making oneself independent of the external world by seeking satisfaction in internal, psychical processes . . . one can try to re-create the world, to build up in its stead another world in which its most unbearable features are eliminated and replaced by others that are in conformity with one's own wishes. (pp. 80–81)

Kaufman (1974), in reviewing the work of early psychoanalytic theorists including Fenichel (1945), Rado (1933, 1958), and Glover (1932/1956), discussed their emphasis on the ability of drugs "to obliterate mental anguish and provide primitive need gratification" (p. 364).

A number of clinical studies since that time (Lidz, Lidz, and Rubenstein, 1976; Savitt, 1963; Wikler and Rasor, 1953) as well as several research findings (Gerard and Kornetsky, 1955; Gulas and King, 1976; Jessor and Jessor, 1978; Sadava, 1973) tend to confirm hypotheses relating addictions to deprivation. These theorists agree that the addict is strongly motivated by the longing for symbiotic merger with the mother and by a search for relief of pain, anxiety, and feelings of emptiness. Their studies, summarized in a review article by Blatt et al. (1984), showed that most addicts are:

> . . . reluctant or unable to seek satisfaction in normal interpersonal relationships and instead remain aloof and independent and use the drug to induce a blissful, symbiotic, narcissistic state. The drug replaces interpersonal relationships as a primary source of achieving satisfaction and pleasure. (p. 168)

Theoretically, the self-parenting process delineated in this paper can be understood as an addictive psychonutritional system wherein the person imagines that there are limited quantities of nourishment available in the

interpersonal environment and chooses to nourish his/herself. The child, and later the adult, unconsciously rejects real gratification and gives up goal-directed activities in order to hold on to the safety of a fantasy world over which he or she has complete control.

Other Approaches to Addiction

A number of other theoretical models related to the etiology of addiction have been delineated.[2] One recurring theme they emphasize is that seemingly diverse forms of addictions are actually interrelated. Hall, Havassy, and Wasserman (1990), for example, based their studies of alcoholism on the premise that "commonalities exist across the addictions on important psychological dimensions" (p. 180). Similarly, Menninger (1938), Achte (1980), and Farberow (1980) contend that drug abuse and alcoholism are related to other types of "partial suicide." Firestone and Seiden (1987) described drug abuse, eating disorders, obesity, and drinking to excess as manifestations of "microsuicide" that exist on a continuum of self-destructive behaviors. Addictions represent "direct assaults against the individual's physical health and emotional well-being, leading to gradual deterioration" (p. 36).

The formulations of Khantzian, Mack, and Schatzberg (1974) are closely related to our view of the defensive function served by the self-parenting process. They conceptualized heroin addiction as a compensatory "self-caring" mechanism. They concluded that the drug becomes the only means for achieving the security and satisfaction that should have been experienced in the early relationship with the mother:

> We have been impressed with a rather specific ego impairment having to do with self-care and self-regulation that characterizes many addicted individuals. (p. 163)
>
> Their response has been to revert repeatedly to the use of opiates as an all-powerful device, thereby precluding other solutions that would normally develop and that might better sustain them. (p. 164)

Blatt et al. (1984) pointed out another motive underlying opiate addiction, that of the "need to find support and assistance in the modulation and regulation of intense and painful depressive affects such as feelings of inadequacy, guilt, worthlessness, and hopelessness" (p. 163). Other theorists have commented on the addict's internalization of harshly judgmental parental figures. Thomas Szasz (1975) suggested the importance of a superego in addiction whose function is to persecute the drug user. Wurmser and Zients (1982) observed that addicted adolescent patients often feel "'split' into the compliant, kind, yet false self, and the nasty, cruel, vengeful, spiteful self" (p. 547). These studies indicate that both aspects of self-parenting, i.e., those of self-nourishing and self-punishing, are closely associated with a wide range of addictive disorders in adult individuals.

ADDICTIVE LIFESTYLES VERSUS HEALTHY FUNCTIONING

One can develop a comparative model of mental health versus psychopathology in terms of the self-parenting process. The degree to which a person depends on self-nurturing mechanisms and internal fantasy processes can be conceptualized as a smooth progression ranging from external object gratification to complete autistic involvement in self-gratification. In general, the differences between healthy functioning and serious psychological disturbance are quantitative rather than qualitative. However, as one progresses through the continuum and there is extensive damage and more serious regression, there are qualitative changes, such as delusions, hallucinations, and thought disturbances.

Psychological functions and addictive propensities can be represented on parallel continuums, ranging from an outward lifestyle of pursuing goals in the real world to an inward lifestyle characterized by fantasy, passivity, and isolation as shown in the table:

goal-directed behavior	seeking gratification in fantasy
self-affirmation	self-destructiveness
self-fulfillment	self-denial
lack of self-consciousness	exaggerated self-consciousness
mild self-criticism	serious assault on the self
adaptability	nonadaptability
facing up to pain and anxiety with appropriate affect and response	utilizing substances as painkillers
relatedness to others	depersonalization
feeling state	cutting off or withdrawal of affect
involvement	isolation
genitality	masturbatory and addictive sexuality
maintaining a separate identity	merged identity and fusion
search for meaning and transcending goals	narrow focus

THREE STATES OF FANTASY INVOLVEMENT

The functions delineated above exist on a continuum from healthy functioning to serious pathology. However, for purposes of edification, they

may be arbitrarily divided into three categories that describe an individual's resolution of the central conflict: (1) the person with extreme propensities for fantasy and isolation, i.e., the psychotic individual; (2) the person who utilizes elements of reality primarily to reinforce and support an ongoing fantasy process rather than really investing in relationships and career; and (3) the person who lives a realistic committed life whose actions match aspirations and capabilities.

Self-actualizing individuals (Category Three) have a good deal of personal integrity, i.e., their words are consistent with their actions. In contrast, people who are self-denying lack integrity in relation to their desires or motives. In failing to act on their wants and priorities, they find it difficult or even impossible to communicate honestly. If they deny their needs or desires, they deceive themselves and others; on the other hand, if they have wants that they withhold or fail to pursue, their manifest behavior contradicts their expressed motives. In other words, most people do not really want what they say they want and are duplicitous in their communications. Their mixed signals are damaging to personal relationships and particularly harmful to children. Discrepancies between words and actions are "crazymaking"[3] because they fracture an individual's sense of reality.

Individuals in Categories One and Two often react with anger or rage to real love, recognition, and success. These emotions are generally suppressed or repressed because they are irrational or inappropriate. They are redirected and internalized in the form of self-criticism and self-attack or elaborated into paranoid attitudes toward the source of approbation or gratification, i.e., the person or persons responsible for the positive experience. Acting out may take various forms such as unresponsiveness, bitterness or coldness, misinterpretation of kindness or approval, suspicion as to other people's motives, withholding of positive traits, poor performance, manifesting signs of inadequacy, and other inappropriate responses. These acting-out behaviors are the most important factor influencing the deterioration and breakdown in close personal relationships over the course of time.

Individuals in Category Two merely give the impression or illusion of seeking satisfaction in reality. They utilize real events as a means of reinforcing or "feeding" their most prized fantasies, and value form over substance in interpersonal relationships. For example, in a destructive, addictive attachment, fantasy-bonded individuals place a strong emphasis on ritual or role-determined responses, such as the Saturday-night date, sleeping together, routine sex, and formalities such as remembering birthdays and anniversaries, etc. At the same time, they may treat each other indifferently or disrespectfully. Indeed, a fantasy bond is a destructive type of relationship in which elements of self-parenting are projected and reciprocated to the detriment of both participants. There is a desperate holding on to the other person, with a corresponding lack of genuine relatedness.

In considering the dynamics of couple relationships from this perspective, one can determine where each partner is on the continuum by observing his/her reactions to genuine affection or a satisfying sexual encounter. For example, following a close sexual experience, an inward[4] person may withdraw almost immediately; whereas in subsequent days, an individual pursuing *real* gratification would more than likely remain close and seek a repetition of the experience. In the first case, the sexual experience is very often utilized as a means for maintaining an illusion of closeness and relatedness, while the subsequent withdrawal represents the person's discomfort or anger at the disturbance to his/her psychological equilibrium, i.e., defensive process.

Paradoxically, a satisfying sexual experience (a real, but temporary physical union) interferes with the fantasy of fusion or connection that is a basic component of the self-parenting process. Inward, self-protective individuals often resort to masturbation, rejection, or isolation after a satisfying sexual experience. Argumentativeness and reactions of resentment and hostility following sexual intimacy and/or emotional closeness are common in longstanding couple relationships.

Unusual support, personal accomplishment, or recognition upset the defensive balance. People shy away from gratification of their most precious fantasies because real successes challenge fantasy processes and there is a heightened sense of loss of control and strong feelings of increased personal vulnerability. Many people mistake an internal image or feeling of love for the behavior or outward expressions of affection, respect, and concern for another person. For example, a man, recently married, complained to his wife that she had been distant from him for several days and he had begun to feel rejected, fearing a loss of her interest in him. Her response was: "How can you say that? I haven't been distant; I've been thinking about you a lot. In fact, all week I have been having sexual fantasies about you and feeling very excited." In professing her love and sexual interest, this woman described her *internal state* accurately; nonetheless, for nearly a week, her behavior toward her husband had been neither affectionate nor friendly.

It is difficult to try to convince people who are trying desperately to preserve a fantasy of love that they are not in a loving relationship. They know that they *feel* love and attraction, they spend considerable time *thinking about* it, yet their outward expressions of affection may be very limited or even contradicted by hostile or rejecting behavior toward their mates or families.

Again, for purposes of delineation, there is a good deal of difference in

the feelings, responses to favorable events, and behaviors of individuals in Categories Two and Three. In the former, people's emotional responses or variations in mood are related to experiences that impact on fantasy images rather than reacting appropriately to real events in their everyday lives. They tend to have strong emotional reactions to the loss of the fantasy of closeness while they ignore real losses in their lives.

SELF-NOURISHING HABITS AND ADDICTIVE PAINKILLERS

Self-nourishing habits can be categorized as "ego-syntonic" in that they originally are perceived as positive and arouse minimal conflict with normal ego functioning. Until their use becomes clearly self-destructive or potentially dangerous, they are in consonance with the person's ego (Freud, 1916/1963). However, well-established self-nurturing habits become progressively self-limiting and self-destructive because they interfere with a person's capacity to cope with everyday experiences. When these behaviors are associated with a more generalized retreat from the world, they no longer feel acceptable to the self and arouse considerable guilt (Firestone, 1985). People are very defensive about their addictive patterns, fantasy involvement, inwardness, and depersonalization.

The majority of individuals in our society are faced with a basic dilemma. They are conditioned to respond with "neurotic" guilt (remorse, shame, or self-attack) to the direct pursuit of their goals and wants (Firestone, 1987). Although they are encouraged to compete, their strivings are also labeled as selfish or too competitive. Very often, destructive voices are aroused as a person moves forward, and these voices can only be relieved or quieted by backing off or reverting to addictive habits. On the other hand, when people do retreat from their goals or seek gratification in fantasy and addiction, existential or ontological guilt is aroused. People exist within these boundaries, and self-punishing thought processes mediate both kinds of guilt.

ADDICTIONS

As children grow older, they develop increasingly sophisticated habits and techniques with which to parent or symbolically feed themselves. Nail biting, smoking, excessive drinking, masturbation, addictive sex, and drug abuse are some of the activities that are relied on for self-gratification, relief of tension, and partial fulfillment of needs. Addictive reactions associated with a self-nourishing lifestyle can be divided into three groups: (1) addiction to physical substances; (2) addiction to ritualistic behavior and routines; and (3) addictive attachments.

Addiction to Physical Substances

Food often becomes a primary focus for children who are starved for emotional sustenance in the family situation. In these cases, food takes on a special meaning other than simple enjoyment and gratification of a physical need. When food is consistently used as a drug or painkiller to minimize or defend against painful emotions and experiences, it becomes part of an addictive pattern. The addiction to food is manifested in repetitive cycles of overeating and dieting, as well as in binges and subsequent purges. These self-feeding patterns are very inward, self-centered, and functionally maladaptive. They interfere with other areas of a person's existence.

Anorexia nervosa, a condition that can reach life-threatening proportions, is also associated with self-parenting in that the patient is exercising total control over food intake. These patients, the large majority of whom are young women, are generally cut off from affect and lack a clear awareness of the sensation of hunger. The anorexic patient's symptomatology of refusing food reflects a desperate attempt to ward off the extreme anxiety or panic associated with maternal feeding experiences. Noting the prevalence of inadequate or inconsistent maternal care in the childhoods of women with eating disorders, Kim Chernin (1985) points out that:

> This sense of the mother's actual or impending breakdown has burdened the childhood and adolescence of women with eating disorders. Again and again we find a vision, carefully hidden, of the mother's inner collapse and emotional crisis. (p. 77)
>
> Virtually every woman who has come to talk to me about a serious problem with eating believes that her mother experienced stress so severe in mothering her that . . . we are forced to wonder whether it was a breakdown. (p. 72)

The use of substances to satisfy oneself is closely correlated with oral deprivation and maladaptive parenting. When children suffer unusual frustration, they resort to compensatory self-nourishing habit patterns. Later, there is an attempt on the part of these individuals to comfort themselves and relieve their own tension. In every case, the addiction supports a pseudo-independent posture and an illusion of self-sufficiency.

As noted earlier, the dynamics in eating disorders revolve around the central issue of control and self-parenting. The same issues are central in drug abuse and alcoholism.

The negative thought process or "voice" plays an important role in addictive self-feeding patterns. First, it induces the person to indulge the habit, and later punishes the person for acting out. The alcoholic tells himself, for example: "Take one more drink, you need to relax," then accuses

him/herself of having no willpower and calls him/her a "drunken bum." In attempting to alleviate the pain of these self-recriminations, an individual invariably resorts to more painkillers, and the cycle continues.

It is very difficult to break these patterns, because the anxiety allayed by the use of substances comes to the surface during withdrawal, leaving the patient in a state of disorientation and helplessness. There are painful emotions of sadness or rage that are complicated by childlike or regressive behavior when patients attempt to abstain from the use of these substances.

Addiction to Routines and Habitual Responses

Repetitive behaviors and rituals come to have addictive properties; they tend to dull one's sensitivity to painful feelings and lend an air of certainty and seeming permanence to a real life of uncertainty and impermanence. Obsessive or compulsive patterns that temporarily reduce anxiety become habitual and later foster anxiety. When these habits intensify, they can become seriously maladaptive. In the "normal" range of functioning, many people become addicted to routines and personal habits such as TV watching, the necessary morning cup of coffee, video games and computer games, compulsive reading, shopping, and many others.

Very often, routines and compulsive behaviors are perceived as acceptable, or even desirable. Despite the fact that physical-fitness programs are beneficial to one's health, jogging, running, and compulsive exercising are potentially addictive because they are primarily inward, self-involved, and narcissistic activities. The dynamics of the "workaholic" reflect similar needs. So-called "normal" individuals use what might otherwise be considered constructive work activities to isolate themselves, cut off feelings, and soothe their pain. Basically, "workaholics" effectively retreat from relationships and essentially ruin their lives while utilizing defensive rationalizations that justify hard work. Individuals working at repetitive, mechanical job functions (bookkeepers, accountants, computer programmers) have unique opportunities to cut off feelings and depersonalize, whether they intend to or not. When these activities take on an addictive element characterized by long hours and great difficulty pulling oneself away from the task, they have a very destructive effect.

Routine or excessive masturbation to reduce tension is generally a symptom of emotional deprivation. The child discovers early on that touching his/her genitals not only leads to pleasant sensations but tends to neutralize emotional distress. This activity can develop into a self-soothing, isolated method of taking care of oneself for those who are rejected or deprived. When habitual masturbation persists and is preferable to sexual activity with another, it is representative of a self-feeding process and inward lifestyle.

Disturbed children often masturbate compulsively. In a residential treatment facility, one youngster with a pervasive developmental disorder masturbated excessively before falling asleep each night. As part of an experimental treatment plan, the nurses offered him a glass of milk each night. They also left a glass of milk on the night table next to his bed. Within a few days, there was a dramatic reduction in masturbatory activity. Evidently, the boy's willingness to accept *real* nourishment from the nurses freed him from the compulsive need to satisfy himself.

Sexual relationships can also be utilized as painkillers. They can function as a means of partially gratifying primitive longings and deeply repressed oral needs. Couples very often develop a routinized, mechanical style of lovemaking, concomitantly holding back affection and a full sexual response. There is an emphasis on control and fantasy (to increase excitement) when self-gratifying, withholding modes of sexual relating come into play. Whenever sex is being used primarily for control, power plays, manipulation, security, self-soothing, i.e., for purposes other than its natural functions of pleasure and procreation, there is generally a deterioration in the sexual relationship. An underlying understanding of how fantasy and the self-parenting process operate in disorders of inadequate sexual desire and other sexual malfunctions is important in planning intervention in these cases.

Addictive Attachments

The gradual decline in personal relating, sexual attraction, and desire that occurs in many relationships and marriages has its basis in the self-parenting process. Very early in a relationship, the new love object begins to threaten the defensive psychological equilibrium firmly established in each individual. Insecurity and lack of tolerance of intimacy are the principle causes of marital failures. People try to preserve their original feelings of attraction and love while they hold on to habitual methods of self-gratification and a pseudo-independent posture. As noted earlier, the two conditions are mutually exclusive. The dilemma is obscured by a fantasy of love and closeness, while real love, friendship, and concern are gradually replaced by an intrusive, possessive style of relating.

Later, when either partner moves away from the addictive attachment toward independence or autonomy, symptoms similar to those manifested in withdrawal from chemical dependency are aroused in the other. These symptoms include feelings of desperation, emotional hunger, disorientation, and debilitating anxiety states. The intensity of these emotional reactions indicates the powerful nature of the imagined connection or fantasy bond existing between the partners.

One woman, in describing her reasons for marrying, inadvertently defined the essence of addictive attachment:

> I knew I was afraid of being in a *real* feeling relationship with any person, man or woman, and I knew, too, that I was terrified of being alone. Forming a bond with my husband was a solution. I could stay somewhat distant from him yet I would always have somebody *there for me*.

Incidentally, this couple slept wrapped in each other's arms while acting out hostility and abuse toward each other during waking hours. The relationship ended in a bitter divorce.

The child born to a couple involved in a fantasy of love while acting out behavior that is emotionally distant, rejecting, or outright hostile to one another will be provided with very little emotional sustenance. Children growing up in this parental atmosphere learn to "take care" of themselves through fantasy and self-nourishing behaviors, thereby completing the intergenerational cycle.

THERAPEUTIC INTERVENTIONS

A necessary objective in treating addicted patients is to provide them with an authentic relationship during the transition from relying on addictive substances to seeking and finding satisfaction in genuine relationships outside the office setting (Firestone, 1990). Therapists actively confront the patient's self-nourishing habit patterns without being judgmental or parental while the transitional relationship with the therapist makes reality more rewarding. The approach is twofold in its focus: (1) it challenges and disrupts the addictive patterns and (2) it encourages movement toward real gratification and autonomy in the external environment.

Therapy with Schizophrenic Patients

In my early work with schizophrenic patients, I came to understand the important role that fantasy played in the psychotic regression. Deprivation of love and care in interpersonal relations results in anxiety states that disturb the psychological equilibrium, and this tension is relieved by fantasies of fusion. The primary fantasy, therefore, is the "self-mothering" process or the incorporation of the maternal image within the self as a nourishing and controlling agent (Firestone, 1957).[5]

Two kinds of activities are required in the treatment of schizophrenic patients: the therapist must counteract the psychotic dream solution, thereby disturbing the psychological equilibrium and creating anxiety. Concomitantly, he/she needs to encourage the patient to "take a chance" again and

learn to reinvest in personal relationships. This is accomplished by the consistent provision of love and sensitive care by the therapist over an extensive time period.

An important aspect of the therapy involves restriction or control over the patient's life, actively limiting the acting out of psychotic propensities.[6] Both control and affection (love-food) are necessary to counteract the effects of an inadequate emotional environment. Our methodology challenged patients' idealization of the mother and provided the emotional support that enabled them to progress through the early stages of development where they had previously been fixated (Firestone, 1957).

Therapy with Addicted Patients

The ultimate goal of therapy is to help patients move away from compulsive, addictive lifestyles so that they can expand their lives and tolerate more gratification in reality. Methods that challenge addictive patterns have been described comprehensively in another paper (Firestone, 1990). Manifestations of the self-parenting process are challenged at every level, affectively, cognitively, and behaviorally, through (1) intense feeling release, (2) verbalization and identification of negative thought patterns (voice therapy), and (3) corrective suggestions for behavioral change.

Patients' lack of self-control and compulsive involvement in self-nourishing behavior patterns point up an important prerequisite for therapy: it is necessary for the patient to give up addictions before any real therapy takes place. This creates an incredible paradox. The alcoholic or drug addict must give up these substances in order to get well, yet this is the presenting problem. Nevertheless, no real therapy will take place as long as these patterns are acted out. In spite of this dilemma, a therapist of strong character, concerned and sensitive, can establish a preliminary contract with the patient on this issue.

Very early on, the therapist points out, in nonevaluative terms, the serious consequences of the patient's addiction. It is important that patients *not* relate to their behavior as a moral issue, rather that they become aware, on a feeling level, of the harm they are inflicting on themselves through the continued use of substances. The therapist's warmth, independence, and maturity are essential in gaining and holding patients' respect and trust so that they will continue to be motivated to give up the addiction. If the patient refuses to enter into such an agreement at this time, prognosis is poor.

This approach is not limited to working with patients where addiction and drug abuse are primary. Contracts with respect to abstinence as a prerequisite for therapy have been shown to be effective in all types of therapeutic endeavors. The prohibition against commonly used self-nourishing

habits such as smoking, drinking of alcoholic beverages, acting out, or taking medication as a precondition for therapy is a powerful treatment method in and of itself. Interference with these addictive patterns fosters a state of deprivation, which, in turn, arouses anxiety and renders repressed feelings more accessible. In our work with an intense feeling release therapy, we found that, as a result of these preconditions, patients felt close to their underlying pain, leading to deep catharsis and the development of their own crucial intellectual insights. Patients who continued to control the acting out of habitual addictive patterns progressed rapidly and made important behavioral changes, whereas those who reverted to addictions and acting out were limited in their therapeutic gains.

Based on our clinical experience and therapeutic position, we have come to the conclusion that all patients, indeed all people, suffer from some degree of addiction that interferes with their living fully. Our primary goal is to help people come to terms with the painful feelings and frustration that caused them to retreat into fantasy and self-nurturance. Most patients believe on a deep level that they cannot survive if they have to face the primitive wants and the rejection they experienced early in life. Indeed, they are terrified of being in a wanting state and experiencing frustration. People will accept self-denial, restrict their personal goals, and otherwise limit themselves, as this is under their control. Similarly, they are comfortable to express a need when they feel that they are guaranteed it will be met. However, they are terrified of indicating their wants honestly and having them refused or rejected. They react to this situation as though it were life-threatening. They respond as though they were still as vulnerable as they once were when they were young children, utterly dependent on their parents to keep them alive.

Regardless of the specific techniques, interventions, or therapeutic approach, patients must become aware of their ongoing needs and desires and use the therapeutic situation to ask directly for what they want. The inevitable limits to personal gratification inherent in the structure and discipline of the therapeutic encounter lead to frustration of the patient's infantile needs. Patients learn that they can survive without the therapist's "parental support" and come to terms with their anger at being frustrated (Firestone, 1985).

This is the crux of a positive or lasting therapeutic process with addicted individuals, for in the course of facing their anger at the inevitable frustration, they strengthen their independence and relinquish the fantasy bond with their parents, as well as dependency on internal sources of fantasy gratification. Insight and growing awareness of the fact that they can never obtain the gratification they needed so desperately as children, that, in fact, these needs are no longer vital to adult survival or happiness, can

help addicted individuals expand their boundaries, get more enjoyment out of life, and remain free of self-parenting addiction.

NOTES

1. "Love-food" is a concept that refers to a product-relationship variable existing in the psychonutritional exchange between the mother and her child. The good mother must be able to offer affection and warmth as well as the strength and maturity to provide physical nourishment and socialize the child (Firestone, 1957).
2. Regarding research into biological factors involved in the etiology of addiction, in a "Summary Report of the Standing Committee on Alcoholism and Substance Abuse" (Division 42) for the 1990 American Psychological Association, Freudenberger (1991) states, "Review of the literature does not support genetic basis of alcoholism to date" (p. 40).
3. "Crazymaking" experiences were described by George Bach and Ronald Deutsch (1979) in their book *Stop! You're Driving Me Crazy*.
4. Not to be confused with an introverted or introspective character type.
5. The "self-mothering" process is described in a theoretical doctoral dissertation, *A Concept of the Schizophrenic Process* (Firestone, 1957).
6. Therapeutic methods for treating schizophrenic patients through the direct interpretation of their symptoms and productions at an oral level has been described in *Direct Analysis* by John N. Rosen (1953).

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