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Desperately Keeping Someone: Relationships as Addiction

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> Looking back I see my love affair as a breakdown, as simply illness. It was a sickness, an emotional plague. It was equally as threatening as an alcohol or drug problem. I can honestly say it was the worst feeling I ever experienced. It's like being trapped in an elevator....all your self-respect, esteem, dignity, and integrity are washed away like a sand castle. You are helpless. You hear people chant, "What do you mean helpless? Out of Control? Can't help it? That's insane. Just stop what you are doing." Like they say, "Throw that candy away. Put out that cigarette? Flush those pills! Tote that barge!" Insane is an appropriate word. This is just how you feel, like you are under some spell and you find yourself doing amazing things. Suddenly you realize you excel in being a sneak, a detective of sorts. You creep about like a cat burglar, searching for clues of betrayal, hints of disloyalty, signs of confirmation for all the crimes you suspect he's committed. At the time you assume it is love from start to finish. But when the holocaust comes and you are lucky enough to survive, in retrospect, you will see there was no love, just a terrible need. (Person, 1988, p. 155)

To speak about relationships as addictions is to fly in the face of those who fear that the broad application of the term will render it diagnostically meaningless and confusing for treatment. As implied in the passage above, there is a striking correspondence with the DSM-IV description of substance dependence, a synonym for addiction, and the patterns of use, impairment, increased tolerance, and withdrawal found in addictive relating. As described, patterns of addictive relating involve more and more dependence with less and less fulfillment. One woman described it as being in a dark tunnel waiting longer and longer for the

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flicker of a light once seen. As with substance addiction, an inordinate amount of time is given to maintaining the connection, approval, or fantasized attachment to the fix, the other person, as well as time recovering from the depleting, often regressive, effects. Recurrent in the patterns of use are the unsuccessful attempts to stop and the fears and self-compromises that interfere. As with substance abuse, the impairment from addictive relating becomes obvious to the user and others. Activities are given up and responsibilities neglected because of intoxication or withdrawal reactions. Cycles of euphoria and depression are both replete with high anxiety. With the continued denial of self and intuition, there is impaired judgment and increased dependency. Tolerance follows. One man reveals, "I can't do anything without feeling the pain of not having her in my life. I don't know who I am." This psychological devastation is often accompanied by the symptomatology of physical withdrawal which can include sweating, cramps, anxiety, nausea, sleeplessness, eating difficulties, and disorientation.

In addition to its clinical correspondence to addictions, one only has to read the news or consider the themes in popular literature to recognize the prevalent need to understand the dynamics involved in "desperately keeping someone." We have all heard of self-help books such as Men Who Hate Women and the Women Who Love Them (Forward & Torres, 1986), Smart Women, Foolish Choices (Cowan & Kinder, 1985), The Hazards of Being Male: Surviving the Myth of Masculine Privilege (Goldberg, 1989), and Women Who Love Too Much (Norwood, 1985). Faced with patients who can quote chapter and verse from such self-help books but remain desperately involved, I have come to recognize the suitability of considering addictive relating from a psychoanalytic perspective. Because it is what is unknowable and as yet unspeakable that serves as the unbearable motivation of such relationships, psychoanalysis, which recognizes unconscious need, ego structure, and traces of early object relating, becomes relevant.

Psychoanalysis has had a long and curiously ambivalent relationship with addictions (Miller, 1990). Whereas analytic formulation appeared on the topic of addictions at the turn of the century, consistent follow-through has been absent until the last 15 years. Relatively little of the past literature has specifically examined relationships as addictions. Freud's earliest formulations emphasized the role of libidinal factors. Early writers, like Abraham (1908/1973), Glover (1932/1956), Rado (1933) and Fenichel (1945), pictured addiction as a way to relieve or avoid intolerable psychic pain, depression, amorphous tension, or overwhelming rage.

After 1970, with the emphasis of ego psychology and object relations theory, one finds formulations of personality dynamics with respect to alcohol and drug abuse. Summing the conclusions of many studies, Donovan (1986) describes the alcoholic personality in terms of generalized ego weakness, an inability to develop balanced conceptions of self and other, vulnerability to affect, impulsivity, and oscillations of self-esteem.

Considering the psychodynamics and personality profile in narcotic addiction, Khantzian (1974, 1978, 1982, 1985) emphasizes the difficulties with aggression, the disorganizing impact of such impulses, and the implied ego impairment. He describes the addict's disturbances in the ego and self in terms of problems of self-care, affect management, self-other relationships, and related coping.

The apparent difference between the person who relates to a person addictively and one who uses a substance can be misleading. Miller (1990) notes that an addiction implies a resistance to negotiate in the intersubjective arena to make a demand of someone. The addictive relationship looks interpersonal and becomes demanding, but like the use of substance, does not involve another person. The compulsive need to keep the other belies the desperation to hold on to a fragile sense of self.

The literature on trauma has relevance for addictions and addictive relating. Wurmser (1974) describes the depression of addicts as based on the traumatic loss of self-esteem due to very severe and repeated experiences of aggressive and sexual overstimulation throughout childhood. Meissner (1981) considers drug use as "the attempt to stabilize a relationship with a lost parental object..." (p. 278). In her work on Complex Post-Traumatic Stress Disorders, Herman (1992) describes evidence of suicidality, self-mutilations, eating disorders, compulsive sexuality, and impulsive risk-taking as distorted survival strategies consequent of inescapable stress. These are considered repetitions and reenactments of destructive internalizations in the absence of self-soothing strategies. Similarly, in their work on compulsive sexuality as a consequence of the post-traumatic stress of childhood sexual abuse, Schwartz, Galperin, and Masters (1993) consider destructive relational attachments as ritualized expressions of unresolved trauma.

We find in the personality profile and psychodynamics of drug and alcohol addiction descriptions of borderline states, or more broadly, borderline and narcissistic personality disorders (Hartocollis, 1977). Consistent with this, one finds attention to addictive relating in the literature on borderline pathology. Summers (1987) considers that

borderline pathology is best conceptualized as the blurring of self-object boundaries. A person relates addictively because without a fused attachment to another, there is the feeling the existence is slipping away. Kernberg (1975) recognizes the borderline's attachment to an idealized or devaluated object as protection against the rage of the unintegrated bad self and bad objects. McDougall (1985) considers addictive relating in terms of the failure to devise an acceptable way of transforming the infant-mother fusion into substitute satisfactions. According to McDougall, the addictive person disavows the essential otherness of people and attempts to use them as transitory symbols of this fusion.

This paper offers three formulations to our understanding and treatment of addictive relating. First, that a precondition for addictive relating is a personality organization with borderline features as reflected in ego weakness, pathology of internal objects relations, and use of specific defensive operations. Second, that central to the addictive attachment itself is an unconscious paranoid process in which the other person is modified by projective components to serve a self-sustaining function thereby becoming the fix. Third, that the relational psychoanalytic model has particular relevance in the treatment of addictive relating.

The clinical picture of addictive relating unfolds from different points. Despite the more popular attention to women who love too much, it would seem clinically that men suffer just as much and are just as prone to enslavement (Person, 1988). Some come to treatment in a state of overriding anxiety as they fear the dissolution of their addictive attachment. Some come with depression and somatic symptoms which they have not yet associated to the impairment from addiction. Some come to enlist help in changing the other, while some come to rage at a safe distance. Overall, most want to be soothed as they present the fix.

Evident in the picture is the lack of ego integration further impaired by defensive denial, splitting, and projective identifications. One sees in addictive relating a confused sense of self and an increased dependence on a misconstrued version of the other. People are experienced on the basis of single traits. Primitive idealizations of the other are often buoyed by denial of reality and self-devaluation. Split off from their otherwise high level functioning, there is a delusional perspective in relating. For example, a tenured professor believes that she is not bright enough to make a decision without the advice of the other; an attorney complains, "I think she is trying to trick me into getting strong and independent so she can leave."

Ego weakness is also reflected, as Wurmser (1994) describes, in the susceptibility to narcissistic crises and the ensuing affect regression and breakdown of affect defense that follows. Feelings are experienced as so overwhelming that they can neither be verbalized nor differentiated. To illustrate, a young woman betrayed by the idealized other feels she will burst. She develops somatic hives. Finding him in bed once again with another woman, she is confused as to whether this should make her want to leave. This example depicts the regressive generalization of cognition and perception (Wurmser, 1994).

The ability to trust is absent in addictive relating. As there is no secured sense of self, there is no sense of constancy in the experience of the other. Symptomatic of this are endless phone calls to lower anxiety and ensure that the other is still there, that he or she has not turned from loving to unloving. Despite endless external reassurance, functioning is jeopardized or impaired. A frightening internal world rules and cognition, logic, and memory have no emotional relevance. They cannot influence how he or she feels.

The obsessive preoccupation of addictive relating is often colored by jealousy and paranoid fears. Jones (1929/1961) tells us that jealousy is a sign of weakness, not strength, when in love. It is a source of fear, guilt, and hate. The jealous and paranoid fears reflect the threat of loss of self and the projection of early rage upon the merged other. The result is terrifying. As there is no clear differentiation between self and other, the rage is still felt but is compounded with fears of retaliation and abandonment. The addictive solution becomes more necessary. With more anger and fear, there is more possessiveness and control.

The nature of addictive relating in and of itself escalates anxiety. According to Pinderhughes (1971), an addict needs the drug to be an available object that is predictable, always under control, and never lost. This is simply not possible when the addiction is to another. It cannot be used to soothe the rage toward the other or replace that loss of the other because the addiction is the other. As McDougall (1975) says, this truly is the theater of the impossible!

It seems to me that it is the failure of the addiction, not the wish to end the attachment, that most often brings people to treatment. To work with such patients is to know that these are attachments that defy reason and pain and override the ego's conscious protests. They fail to address the demands of the external world because they are internally motivated. These attachments are a function of an unconscious process between the person and the one being desperately kept.

Meissner's (1981) formulation of the paranoid process essential to drug addiction illuminates this attachment. In this formulation, the sense of self is considered to be organized around the core of introjects such as the internalizations of significant object relations in the person's life, the attribution to the child's sense of self, the qualities of others, and the qualities of self in interaction with others. If development has proceeded, these internalizations transform into stable structures of the sense of self. When development has been disrupted, the core of introjects is marked with conflict, primitive narcissism, aggression, and permeated with need. The resulting organization of self is pathological and unstable. This fragile self urgently needs stabilization from external sources.

The use of the external source is something much more than dependence. It involves projections derived from the core of introjects upon the other so that the other comes to possess the correlative or complimentary elements. For example, the sense of inferiority necessitates projections of superiority, that of aggressor coexists with victim. The projection is needed to maintain stability of self in terms of primitive configurations. This explains why the properties of the other in addictive relating acquire not only a compulsive but often a magical, even mystical, quality. "I can only be myself when I am with her." "I know you think he is abusive but only I understand how I cause his suffering."

The introjective experience around which one woman based her view of self included a depressed, unrelated mother, a father consumed with business and an affair of many years, and a younger handicapped sister. This woman's avoidance of seeing her mother as unattractive and unacceptable to her father left this woman anxious, self-demeaning, and without a positive self-reference. This was compounded by the humiliation and exclusion by her father, the confused daydreams of the other woman in his life, and the shame and guilt associated with her sister. A stable sense of self or clear perception of others was simply impossible for this woman.

In her early teens, addictive relating became a way of redressing these narcissistic vulnerabilities and deficits. At the time of her engagement, her marriage, and throughout her married life, the addiction to outside relationships persisted. Her husband represented the necessary but unacceptable caretaker to whom she had to stay attached but with whom she felt embarrassed, repulsed, even phobic to touch. Projecting a damaged and helpless sense of self, she consciously spoke of him as handicapped while loathing her dependence on him. The outside men,

on the other hand, became infused with the idealized phallic powers of her father. They knew all about the world, they were unavailable, and they were attached to other women.

Whereas sexual relating with her husband was characterized as obligation to which she submitted in a dissociated way to keep him attached, she was compulsive in her need to be sexual with the other men. Her sexual behavior reflected the chaotic mix of pre-genital and genital needs. In outside affairs, she was never orgasmic and reported no pleasure. Rather, there was a feeling of relief from being "non-existent." This was followed by a sense of power over the man for wanting her and supremacy over his wife from being excluded. The reported relief was brief. No sooner was it over than she was cascaded into feelings of depletion, fears of separation, and obsessive ruminations as to how she must have this fix again. In a sense, the connection never became an internalized sustained satisfaction. It remained transitory, simply escalating more need.

In his consideration of drug addiction, Meissner (1981) proposed that it is not simply a matter of transforming any drug substance by a projective distortion into the magical fix. The inherent pharmacological properties of the upper or sedative itself, in interaction with intrapsychic needs of the person, must be suitable and useful to sufficiently modify the inner state of turmoil. It must work, even at a great cost and for a short time.

Similarly, in addictive relationships, it is not just anyone, nor someone conventionally adored or respected, that becomes the addictive other. It must be someone who provides an answer to inner subjective needs. Someone whose qualities are an unconscious fit to the historical experience of self and the internal relationships that are revived and replaced in close relating. It must be someone also whose own failed development, sense of self, and symbiotic entanglements induce and sustain the projective identifications.

This subjective meaning of the other is striking in the case of one man whose object of addiction changed as he integrated formerly denied aspects of self. His answer to a childhood of physical and sexual abuse had been a presentation of self as macho, ruthless, and in control. His denied dependency upon a passive, clinging partner was belied by endless phone calls to her, an inability to travel without her, and compulsive sexual demands coupled with an inability to be himself sexually. Slave to traumatic re-enactment and sadistic introject, this attachment reflected the attempt to merge with the traits of a less

terrifying, much wished for mother without having to relinquish his characterological armor.

Years later, this man, less terrified, more introspective, beginning to risk caring, and more identified with his sexual self, found himself in a relationship with a critical, aggressive, controlling woman, or as he termed it, a version of himself from the past. Recognizing this, he felt awe and disdain. As he idealized her power and became her victim, he was claustrophobic but frightened to leave. He moved his clothes in and out of her closets, he called and hung up. He was filled with shame and self-reproach for staying and tremendous fear of loss for leaving. Unconsciously, he could not move because he was unable to leave behind aspects of self projected onto this all too suitable recipient.

To consider that addictive relating is underscored by a paranoid process is to propose that treatment must include a dynamic understanding of the meaning of the relationship, a systematic uncovering of its projective elements, and a linking of these elements with the introjects (Meissner, 1981). The addictive relationship is secondary to the real addiction to the introjects and their correlative projections. In the case above, the man was still addicted to the aggressive self easily projected onto his new attachment. He had started owning the nurturing, even more dependent qualities of self but was unable to modify and integrate the contradictory introjects within his sense of self. As he still experiences a vulnerable myopic version of self, the addictive relationship to a sadistic and powerful another remains compelling and necessary.

From what we have come to know in psychoanalysis, this necessary integration, this owning of aspects of self, must unfold in the fabric of human connectedness. As misconstrued attachment has become the addiction, so therapeutic attachment must be utilized for finding an alternative. Informed by an understanding of the ego status and borderline qualities of the person who relates addictively, treatment must offer an attachment of containment and attunement as well as a mutual exploration of associations, dreams, body memories, feelings, historical events, needs and demands, self-other configurations, and their reenactment in the relationship with the analyst. I am proposing that the analyst moves through modes of participation in the treatment of the addictively related patient. For example, whether conceptualized as a container or a holding environment, the analyst must first serve to contain feelings. The patient has come because of intolerable affect associated with the loss of self in terms of the actual or threatened departure of the addictive other. In the initial phase, the holding, the

empathetic attunement, affords some stabilization. It does not end the addiction. The demand and need is for a self-object who will contain and remain in face of retaliatory rage, fantasized reconciliation, self-blame, and shame. With the analyst's support and the patient's increased awareness of his or her addiction comes the critique of the harsh super-ego and the shame. The wish is for the therapist to serve the protective self-soothing role that neither the patient's internal structures nor the addictive choice can provide.

Countertransferentially the analyst may feel empathic pain, bewilderment, and often the rage of exploitation as the patient goes back to the addicted other again and again. The projected introjects of victim as well as aggressor are often felt by the analyst and the urge to act on them by interpreting, withdrawing, or forbidding the relationship is there. To remain attuned, to contain and tolerate these feelings as well as one's subjective response is to participate therapeutically. It allows eventual use of such feelings to understand the unconscious configurations, to begin to invite the patient's fantasies with respect to the analyst's feelings, and to begin to grasp a glimpse of the transference counterpart of the countertransference.

Essentially, in approximations of empathy, inquiry, and engagement, the analyst participates, moving as it were from containment to involvement. To fail to engage, to simply support is to protect the addiction. Rather, the analyst must, as Meltzer (1979) describes, risk everything in the voyage to the underworld. The analyst must receive and experience the projections and inevitably know the engulfment and demands of being the object of addiction.

It is the co-participant process that brings patient and analyst out of this addiction, beyond the projections, and from subjective to objective experiencing. It is the process in which patient and analyst translate their transactions to understand what was unknowable, to experience what was intolerable, to own what was denied, and to relate in a way that celebrates individuation and self-value.

The therapeutic goal in the treatment of addictive relationships is captured in the following poem written by Derek Walcot (1986), the West Indian Poet, who received the Nobel Prize in literature October 9, 1992.

Love After Love

The time will come when, with elation, you will greet yourself
Arriving at your own door, in your own mirror.
And each will smile at the other's welcome and say,
Sit here. Eat. You will love again the stranger who was your self.

Give wine. Give bread. Give back your heart.
To itself, to the stranger who has loved you
All your life, whom you ignored
For another, who knows you by heart.
Take down the love letters from the bookshelf,
The photographs, the desperate notes.
Peel your own image from the mirror.
Sit. Feast on your life. (p. 328)

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