

ADDICTION AND PATHOLOGICAL ACCOMMODATION: AN INTERSUBJECTIVE LOOK AT IMPEDIMENTS TO THE UTILIZATION OF ALCOHOLICS ANONYMOUS

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This article explores the application of intersubjective systems theory to addiction and, more specifically, to the tenets of Alcoholics Anonymous (AA). Utilizing Bernard Brandchaft's ideas about derailed differentiation processes in early development, the author suggests that for addicts who have developed an adaptive style of pathological accommodation, the compulsive use of substances or sex can reflect a powerful life or death struggle to hold on to one's vital and authentic sense of self. The author shows that AA's implicit demand for compliance and conformity as a condition necessary to free the addict from his or compulsive behaviors reflects early classical psychoanalytic ideas. The implicit pull for conformity of this more traditional perspective may cause an aversive response in the addict/accommodator making it impossible for him or her to tolerate AA. Brief case examples are illustrated.

Keywords: intersubjectivity; addiction; Alcoholics Anonymous; differentiation; pathological accommodation; compliance; conformity

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Highly satisfactory as it is to live one's life for others, it cannot be anything but disastrous to live one's life for others as those others think it should be lived. One has, for better or worse, to choose his own life. [Bill W. Wilson, 1947, cited in Kurtz, 1979, p. 214].

INTRODUCTION

Heinz Kohut's (1971, 1977a, 1984) important theoretical concepts about addictive disorders as compensatory behavior for unsatisfied psychological needs in early development has been the catalyst for the recent advancement of self-psychologically informed addiction treatment (Levin, 1987; Dodes, 1990; Khantzian, 1999; Flores, 2004; Ulman & Paul, 2006). His conceptual framework consisted of the idea that by ingesting a substance, an addict is enacting a curative symbolic action for early selfobject failure (Kohut, 1977b). These ideas have been influential in moving addiction treatment beyond confrontative and moralistic clinical approaches that focus exclusively on the biological and behavioral aspects. Recently, the addiction field has been evolving more comfortably into empathic and explorative clinical modes. This shift has helped to facilitate a deeper understanding of the layered complexities of the addict's chronic use of alcohol, drugs, or sexuality by contextualizing it in early relational systems. It is my intent here to advance this trend in addiction treatment by utilizing the work of Bernard Brandchaft (1988, 1993, 1995, 2001) to explore the application of intersubjectivity systems theory to addiction, and more specifically, to the tenants of Alcoholics Anonymous (AA).

AA and other groups modeled after it, such as Narcotics Anonymous and Sexual Compulsives Anonymous, can provide tremendously needed structure and organization to some of our patients when active addiction has caused them devastating personal and financial chaos. For some people, these programs provide essential guidance and a supportive network of people to help abate addictive behaviors. Nevertheless, clinical research presented by McIntire (2000) shows that in actual ongoing recovery about one half of those who attend 12-step meetings do not remain for the introductory interval of 90 days. Fingerette (1988) reports even lower numbers. In an 18-month follow-up study, only 25% were consistent about attending meetings. The clinical thrust of this inquiry is to present some ideas about those patients who have continuing difficulty with AA, and those who find they cannot tolerate "the program."

My goals for this article are twofold. I first would like to make some contribution to the psychoanalytic understanding of addiction by highlighting the intersubjective developmental context in which it can be rooted. It is my belief that derailed or traumatic self-differentiation processes frequently characterize the histories of people who suffer from addiction. I further contend that these traumatic processes can result in pathological accommodation, a term I define shortly, which is an adaptive pattern that is often significantly present in the experiential world of the addict. The interplay between these patterns and the requirements implicitly found in AA can lead the addict to be overly compliant, ambivalent, or rebellious toward AA. For some, the superordinate struggle to overcome a life dominated by pathological accommodation may make participation in AA a painful or impossible endeavor. In arguing that some addicts find AA a psychologically bad fit, I do not refute the important contribution the anonymous programs make to some of our patient's lives. My focus is on the feasibility of AA for all alcoholics, and on the development of deeper understanding of the powerful negative therapeutic reaction some patients present about their involvement with AA.

My plan for this discussion is to present a sampling of the important theoretical advancements in our understanding of the etiology of addiction, and then to explicate the concept of pathological accommodation in relation to active addiction. I also present a brief overview of AA to show how early psychoanalytic ideas are reflected within its tenets. I then show how the classical psychoanalytic ideas that have influenced the program's philosophy may conceal implicit requirements that may cause the addict/accommodator to have an aversive response to AA. Finally, I illustrate how the implicit requirements in AA promote this response in patients because (a) the addict/accommodator may non-consciously associate them with the demands of their intrusive caregiver, and (b) they may reinforce compliant trends, causing the addict/accommodator to fall back on reflexive patterns of accommodation learned in early development. My hope is that clinicians can utilize this discussion to begin to think more critically about the viability of AA for patients who have undergone traumatic differentiation processes in early development.

HISTORIC PSYCHOANALYTIC THOUGHTS ABOUT THE ETIOLOGY OF ADDICTION

Freud (1905) placed addiction within his concept of drive derivatives, indicating that all addictions are displacements for masturbation—the first and

most primary addiction. He also believed that the use of narcotics was a substitute for a lack of sexual satisfaction. Otto Fenichel (1945) was the first to highlight narcissism as a factor in addiction and believed alcoholism to be a regression to the narcissistic stage of development. Leon Wurmser (1974) saw addiction as a way of contending with overwhelming affect states usually found in borderline states, *a la* Kernberg (1974, 1975), with chronic substance and alcohol use a primitive system of defense. Krystal and Raskin (1970) believed that addiction is the result of a deficient stimulus barrier that resulted in affect regression. These authors also postulated that the ingestion of alcohol was an attempt to realize certain ego functions that the alcoholic could not perform for himself due to a disturbance in the mother–infant relationship. This emphasis on impaired object relationships is unique in that it is the first theoretical perspective to move us closer in our understanding of addiction from the intrapsychic, or a one-person psychology to a relational or two-person purview.

Kohut (1971) emphasized that the craving of substances is an attempt at curing the central defect in the self. Substances become a substitute for a selfobject that traumatically failed the addict in terms of his need for praise and support or his need to merge with an idealized source of strength. Drawing heavily on Kohut's formulations, Levin (1987) looks at alcoholism as a regressive fixation at the level of "pathological narcissism" (p. 232). He extends our understanding of substance abuse treatment by emphasizing the importance of the therapist's selfobject function in the addict's successful recovery.

Khantzian (1985, 1997) discusses the *self medication* function of drug use. He asserts that different drugs moderate opposing affect states. For example, someone prone to depressive states may choose cocaine or crystal methamphetamine for its up-regulating and expansive effects. Khantzian and Mack (1983) also offer a developmental model, regarding alcoholic suffering as a behavioral response to vulnerabilities and deficits in affect management and self care. Khantzian (1987) later surmises that most alcoholics suffer from aspects of narcissistic vulnerability, a phrase I soon explore, and that severe disorganization and primitive narcissistic pathology may be later associated with advanced alcoholism.

More recently, Dodes (1990) recasts addiction as a compulsive response to intense feelings of helplessness, and the use of drugs as fueled by the rage an addict experiences in the face of that helplessness. Dodes (1990) believes that by utilizing drugs, the addict is attempting to "restore a sense of control" (p. 402) when he experiences his control as being diminished. Flores (2004) utilizes Bowlby's early formulation on attachment and

also writes about addiction as a result of unmet emotional needs in early development. For Flores, addictive behavior is designed to help the addict avoid interpersonal attachments. Ulman and Paul (2006) provide a fantasy-based model of addiction. For these authors, substances provide an addict with an “ersatz self-object” (pp. 50, 311) experience. Chronic use of alcohol, drugs, gambling, or sex becomes a symbolic act reflecting what they refer to as the “megalomaniacal” (Ulman and Paul, 2006, p. 28) self, through which the addict can wield magical control over his environment.

ADDICTION AND PATHOLOGICAL ACCOMMODATION

In this section, I explore a deeper understanding of the tenacious fight many addicts and alcoholics are engaged in when they are contemplating the cessation of their drug and alcohol use. It is my belief that for many the use of substances reflects a powerful life and death struggle to hold on to one’s vital and authentic sense of self. I ground my understanding of these processes in the work of Bernard Brandchaft (1988, 1993, 1995, 2001, 2007), who has been working to help clinicians understand and explore the complicated ramifications of derailed differentiation processes from an intersubjective systems perspective.

In his chapter, “Bonds That Shackle; Ties That Free” (Stolorow, Atwood, and Brandchaft, 1987), Brandchaft argues that a normative separation-individuation phase (Mahler, Pine, and Bergman, 1975) does not require a child to *inevitably* negotiate experiences of self-deflation and helplessness in facing a new and challenging world. Using Kohut’s understanding of the need for requisite selfobject experiences in early development, Brandchaft believes that the notable presence of feelings of depletion and helplessness in the child reflects a failure within the selfobject milieu. Brandchaft writes that the caregiver system must help the child to negotiate and metabolize the affect states that ordinarily come with forging ahead developmentally. If caregivers are misattuned to alternations between elation and discouragement, the child may later vacillate between poles of “grandiosity” and painful self-disappointment.

Brandchaft also believes that as a result of these misattunements, conflict emerges between the child’s authentic perspective of himself and the perspective of a parent, a point of view the child may embrace to maintain the tie to the much needed caregiver. In his published case illustrations, Brandchaft has described three different adaptive measures a

child may come to rely on in negotiating these emergent conflicts.¹ The case of Martin (Stolorow et al., 1987, chap. 4), presents an instance of staunch rebellion against the pressures to comply, which resulted in his living a life of loneliness and estrangement from others. In "A Case of Intractable Depression" (Brandchaft, 1988), a man subjugates experiences of excitement and pleasure, conforming his view of himself and his potential to his parents' view that fulfillment and success were neither their destiny nor his. The case of Patrick (Brandchaft, 1993) presents an adaptive style of marked ambivalence, involving vacillations between poles of enthusiasm and self-deflation. The vital thread in all of these cases can be found when the developing child attempts to use his own feelings as central organizer's of his experience, and the structural remains of the archaic tie to caregivers intrudes to suppress or foreclose these authentic aspects of self experience. Brandchaft (1993) states, "... the individual is compelled to submit to a definition of himself determined by forces external to his control or volition, a definition determined by the needs, wishes, and fears of caregivers or those who represent them psychically" (p. 216). Brandchaft (1988, 1993, 2001) believes that obsessive rumination, compulsive ritual, and addictive processes reflect the relentless self-doubt these people experience in their fight for their realization of a more authentic self-experience.

Of the various adaptive strategies Brandchaft delineates (those of marked rebellion, submission, or ambivalence), my clinical interests have focused on the experience of men in the throes of active addiction who have fallen under the strain of over compliance and a pre-reflective driven quality to be "too good" in an effort to fit in with the rigid affective proclivities of their caregivers. It is here that addictive processes (including any genetic susceptibility) become an important source of information about the developmental pasts of these individuals and their desperate need to break free from these debilitating overly compliant patterns.

Brandchaft (1995, 2007) has written two manuscripts that describe in detail the experience of a child who has succumbed to an adaptive strategy of "pathological accommodation." This is a phrase Brandchaft uses to convey what can occur when a child's sense of individuality and unique self are consistently ignored, and he begins to relinquish his own affective experience to the emotional stance of those around him. The child's early devel-

¹Dr. Shelley Doctors has contributed to the understanding and formulation of Dr. Brandchaft's ideas in the following section.

opment, and the crucial tie he will develop with his parents will become a catalyst for what Brandchaft refers to as a “compromise solution” where he will become enmeshed in processes that will inhibit his knowing more authentic aspects of himself. The child learns to rely on “borrowed cohesion” (Kohut, 1984, p. 167) where he utilizes the prevailing attitudes of the parental system as aspects of his own sense of self. Because the child develops no sense of inner referents, there is an increased dependency on the faulty caregiver. This creates an inner life of conflicted rumination around what the child might recognize as important for himself versus what the parent requires of him. These processes generally work outside conscious awareness, where the child implicitly feels that something is wrong but does not have the ability to know what the problem is or how to set it right.

To compensate for chronic self-doubt, the child develops rigid criteria for his own thoughts, feelings, and behavior. The child learns to compulsively apologize for any problems that may arise in the family system, and he will reflexively repair any interpersonal disjunctions by holding himself exclusively responsible. He relinquishes his own inner resources as the genuine source of his experience of the world. Self-regulatory functions are surrendered to the intruding authority figure, and the child may grow up without the ability to adequately soothe or care for himself.

Brandchaft believes the daily accumulation of personal injury has a subtle and shattering effect of chipping away at the child’s core sense of self. Out of necessity, the child must navigate an extreme and harsh environment and in this process may develop an acute sensitivity to people and places where he may experience a re-enactment of the original selfobject deprivations. His experience may be marked by the unconscious expectation that with any new relational involvement, it will be demanded of him that he *surrender* himself to the agendas of others. Brandchaft also sees this as a point where masochistic organization can begin by his assertion that the search for pain becomes functional in that it helps the child to maintain the tie to the intruding caregiver. The adult trapped in chronic patterns of accommodation will unconsciously reenact compliance in new relationships because accommodative trends often bring approval from others and are easily mistaken for psychological growth.²

²Brandchaft’s ideas about structures of accommodation resonate closely with Helen Deutsch’s (1942) “as-if personality” and with Winnicott’s (1965) idea of the “the false self.” These widely known psychoanalytic ideas are similar versions of the processes of compliant patterns that often occur when the “not good enough mother” consistently ignores an infant’s “spontaneous gestures” and “sensory hallucinations” by intruding with her own agenda (Winnicott, 1965).

The endeavor of attempting to pull apart these processes in psychoanalytic treatment is complicated because any movement in the direction of a new experience of self-delineation for the patient brings with it an unrelenting terror Brandchaft (1995) refers to as “death anxiety” (p. 49). As the patient begins to feel himself move in the direction of his own sense of authenticity or authority, he will undoubtedly retreat into self-debasing attitudes as a symbolic act reflecting his desire to seek the safety of the enmeshed tie to the offending parent. Brandchaft (1995, 2007) writes that psychoanalysts underestimate the power and frequency of patterns of accommodation in their patients’ experience. He also believes it to be the core of what other schools of psychoanalytic thought might envision as unconscious processes that establish character formation, fantasy, symptomology, and basic conflict.

Brandchaft (1995; see also Stolorow, Brandchaft, and Atwood, 1994) sees accommodative patterns as often disguised or displaced by addictive process, where the tie to the demanding parent and fear of self-assertion converge. He asserts that sexual reenactments and addiction to substances are a way to counteract feelings of inner deadness and depletion that are the result of these accommodative patterns. It is my belief that in this assertion, Brandchaft oversimplifies the addictive processes by inadvertently joining Khantzian (1985) with his own version of the self-medication hypothesis.

Following Kaufmann (2008), I add another complexity involved in the addictive process. Integrating Brandchaft (1995) and Goldberg (1999), Kaufmann posits that some addicts, his men who please too much, pursue addiction as a part of their “secret lives” through which they rebel against their reflexive compliance, and assert aspects of themselves that they have disavowed. I have also found that, in pursuing addictive behavior, an individual is in part trying to ensure the essential survival of his authentic self. Through the ingestion of drugs and alcohol, or by engaging in compulsive sexual behavior, the addict is deeply protesting against the pressure to comply and accommodate to the demands of others. Simultaneously, he is making a valiant, albeit unconscious, attempt to assert and validate his own opposing perspectives and individual preferences. These opposing preferences represent aspects of the dynamic unconscious, or what Goldberg believes to be vertically split from the person’s more socially acceptable experience. This aspect of the person has not been formulated or articulated because it is unacceptable, and thus they cannot let themselves be aware of it and cannot share it with others. For the accommodator, the cycle of addiction can be understood as being deeply rooted in an unconscious desire to transcend reflexive compliance, and it represents an attempt to bring the addict back to a part of himself he has yet to know.

For addicts/accommodators, the use of alcohol or drugs demonstrates a juncture where massive self-doubt, rigid internal requirements, and restorative fantasy converge to create the cycle of addictive action. The taking of substances becomes an amalgamation of both the desperate need for assertion and a shameful behavior that continues to promote a sense of self-loathing. As the addict may feel a kernel of momentary freedom and relief from his use of substances, the self-debasement he will experience will ultimately become the predominant experience. This will cause the addict/accommodator to fear the very nature of his personal self-assertion. This fear of asserting his personal needs and wishes will create collateral anxiety and depressive affect that will reinforce his tie to the faulty caregiver. It will also act as an emotional antecedent for more compulsive addictive behavior. The addict ultimately becomes enslaved by his unconscious attempt to free himself and *de novo* finds himself recapitulating compliance due to his deep desire to assert himself.

In the preceding pages I have delineated Brandchaft's ideas of how traumatic differentiation processes in early development can produce patterns of pathological accommodation in some children. These patterns represent an adaptive strategy of psychic survival in which the child must deny and disavow aspects of himself to comply with demanding and intrusive caregivers. In my view, addiction can be seen, in part, as a way to transcend compliance and to validate opposing tendencies and authentic aspects of self yet unknown to the addict.

I now further my thesis by considering how the tenets of AA are rooted in early, more traditional psychoanalytic ideas. Implicit in these ideas is a marked requirement for compliance as the addict is asked to *surrender* certain aspect of his personal experience. In the following section, I have italicized some of the aspects in AA that may attempt to influence the participants into this conformity. It is my belief that these tenets evoke a deep conflict at an unconscious level that may cause the addict/accommodator tremendous conflict about attending AA.

ALCOHOLICS ANONYMOUS

AA is the creation of Vermont-born Bill Wilson, and was developed in his desperate attempt to find a cure for his own baffling and seemingly hopeless condition. The philosophy of AA is based on insight, medical information, and spiritual principles Wilson garnered from various sources, including psychoanalyst Dr. Carl Jung, the nondenominational Oxford Group, the

American psychologist William James, and Wilson's own experience of learning to talk with other alcoholics (Kurtz, 1979; AA, 1986). Wilson was also greatly influenced by a Freudian psychiatrist, Dr. Harry M. Tiebout, who spent much of his career publishing clinical articles about the therapeutic effectiveness of AA. Tiebout introduced Wilson to the concept of the demanding "His majesty the baby," found in Freud's (1914) article, *On Narcissism*, which ultimately found its way into the AA literature. He was also fervent in his belief that the alcoholic must conform to the idea of *surrendering his inflated ego* as a requirement for getting sober.

The AA way of life involves the alcoholic's acceptance of his problem, a *surrender of control*, the development of a personal relationship with a secular "higher power," the admission and acknowledgment of personal *character defects*, and the personal restitution of harm the alcoholic may have caused others during the period of his active addiction. An AA way of life is consolidated by the communal sharing of the alcoholic's "experience, strength, and hope" during daily meetings, and by "sponsorship," where an alcoholic with stable sobriety mentors a newcomer through the often dynamic process of "working" the 12 steps. Although it is stated in the AA preamble, "the only requirement for membership is a desire to stop drinking," immersion into the fellowship of AA can be rigorous, especially during the first 90 days when the alcoholic is most vulnerable to relapse. The alcoholic newcomer is urged to take program "suggestions" that include attending 90 meetings in 90 days, making daily phone calls to his sponsor, taking on commitments, the "working" of the 12 steps, and exploring the AA literature. AA is considered a maintenance program where a new and sober lifestyle mandates that the alcoholic learn to live more responsibly and maturely. This process involves a continual process of *divesting oneself of ego* and *character defects*, daily practice of prayer or meditation, helping others, and learning and sharing about the disease of alcoholism (AA, 1986).

It is apparent that the dimensions of AA that I have italicized are, in part, a remnant of classical psychoanalytic ideas about narcissism that may have been born out of conversations between Tiebout and Wilson during the 1930s when the Freudian approach was the most prominent psychoanalytic theory.³ From the Freudian perspective, narcissism (and the attend-

³Bach (1994) reminds us that the early psychoanalytic literature tended to overemphasize the grandiose or over-inflated narcissist, reserving other diagnosis for those narcissistic types who present with a sense of depletion and inferiority.

ing inflated ego) was understood as an immature self-love that was to be analyzed and ultimately renounced by the patient. It would then eventually give way to higher forms of love for others (object love). According to this perspective, the *sick* and *selfish* patient was to conform to the authority by renouncing pleasure seeking and aggressive impulses to make room for more libidinal energy for relationships with others.

With the advent of the newer paradigm of psychoanalysis in the 1970s, we have a new understanding of narcissistic organization. Kohut (1971) separated narcissism and object love into two distinct lines of development. He believed that each set of phenomena proceeded from less mature to more mature forms if responded to adequately by caregivers. Thus, behavior that a Freudian might have judged as “immature” would have been understood by Kohut as the residue of early emotional deprivations. Narcissism, inflated ego, and the attendant low sense of self therefore could not be renounced. According to Kohut, it was to be thoroughly understood, painstakingly worked through, and eventually transformed into more mature forms of self-love. In its essence, a self-psychological analysis does involve a maturational process, but the focus of treatment is to identify and emotionally nourish aspects of the patient’s nuclear self that had been disavowed due to emotional misattunements from caregivers (Kohut, 1977a). Kohut, and other relationally oriented therapists of the time (Fairbairn, 1952; Winnicott, 1965; Guntrip, 1974) built the platform from which psychoanalytic theorists could begin to understand a patient’s psychology as contextually driven and formed within the matrix of its early relational environment (Flores, 2004).

Bill Wilson was also greatly influenced by Dr. William Silkworth, the alcoholism expert at Towns Hospital in New York City where Wilson was institutionalized during his many relapses (Kurtz, 1979; Alcoholics Anonymous, 1986). During his stays at Towns, Silkworth impressed on Wilson the utter hopelessness of the alcoholics he had encountered. Silkworth’s theory of alcoholism was that it was an allergy that was combined with mental obsession. According to Silkworth, when the alcoholic drank alcohol, the allergy would take over and the alcoholic would become obsessed with more drinking. As Wilson’s relationship was developing with Silkworth, Wilson also reestablished his friendship with an old drinking buddy named Ebby Thatcher. Thatcher had become sober and told Wilson he had stopped drinking because he found God. This is where Dr. Silkworth and Ebby Thatcher’s influence on Bill Wilson converged to make the obsessive experience both a psychological and spiritual concern.

According to AA, obsession is a phenomenon involving the alcoholic's deep craving for "more," a metaphor for his unconscious desire for spiritual transcendence through the means of ingesting ethyl alcohol (Kurtz, 1979). Thus obsession for alcohol reflected an attempt to transcend painful moods and feelings because the alcoholic denies his human limitations, is overly dependent on others, and tries to find *absolute control* in relationships and in everything he attempts (Kurtz, 1979). To curtail his obsessive tendencies, it is recommended that a newly sober alcoholic seek refuge with other alcoholics who are also recovering from their own obsessive need for alcohol. The alcoholic then learns to *accept* how his obsession reflects his *self-centered* desire for more and his *inability to admit his human limitations*. For those in AA, the alleviation of the obsessive experience is again dependent on conforming to the group's requirement for renunciation of narcissistic *self-centeredness*, the alcoholic's *inflated ego*, and the attending pathological desire for *absolute control*.

In the 70 years since Wilson crafted his understanding of the alcoholic tendency for obsessive thinking, contemporary psychoanalytic thought has helped us to grasp many alternative understandings of the obsessive experience. Brandchaft's (2001) article, *Obsessional Disorders*, provides us with a more experience-near way of understanding the obsessive experience as it is related to the pathological accommodator. Brandchaft asserts that obsessional tendencies begin to form when a child is required to disconnect from his own experience to keep the equilibrium of the parent intact. With the accumulated experience of surrendering himself and his own point of view to the intrusive parent's perspective, the child learns to disavow aspects of his individual experience. According to Brandchaft, obsessive tendencies thus begin to emerge, reflecting chronic self-doubt and a compulsive organization of "shoulds" and "shouldn'ts" that unconsciously dominate his experience. In my observation, obsessive rumination in its various forms can also reflect (a) an unbidden and active experience of longing for the requisite selfobject experience that would help to counter an individual's chronic self doubt, and (b) an experience of reclaiming and asserting the intense feeling states (often anger) that understandably emerge in reaction to early emotional deprivations.

Brandchaft and contemporary psychoanalytic thought has expanded our understanding of the obsessive experience (including the marked obsession for alcohol) by shifting it away from the blame implicit in the idea that the alcoholic is attempting to assert *absolute control*. Our new understanding casts it in the light of the more experience-near phenomenon re-

flecting both the remnant of personal experience that has been subjugated and split off to comply with a caregiver's reality, and the contaminating doubt that has developed that the alcoholic has any right to his own emotional life or personal point of view. From this perspective, the alleviation of obsessive symptoms is not dependent on renunciation of *inflated ego* or *absolute control*, but on the growing experience of self-cohesion that stems from a responsive selfobject milieu. This raises the vital question: Can AA with its many implicit requirements and "shoulds" and "shouldnts" provide the addict/accommodator with a nurturing and reparative therapeutic experience?

A more thorough deconstruction of the meaning and significance of AA in relation to both the traditional and more contemporary psychoanalytic perspectives would be an important thesis, but it is beyond the aspirations of this article. However, with the newer paradigm of psychoanalytic thought as part of our expanded understanding of addiction, it is interesting to wonder what AA might be like if, on his journey to understanding alcoholism, Bill Wilson had encountered Heinz Kohut's self psychology rather than that of Dr. Tiebout's Freudian perspective? Would AA be more accessible to people if the emphasis was less on ego deflation and more on encouraging alcoholics to strengthen their core sense of themselves? By insisting on the surrender of narcissistic self-interest and the taking of personal responsibility, does the program deny or dilute the devastation some of its members experienced during their traumatic development? Does AA posit an unreachable ideal that ultimately alienates people from more authentic emotional experience? There is some evidence that Bill Wilson himself was unable to break away from his own early patterns of accommodation within his maternal relationship (Cheever, 2004). Is Wilson's own compulsive compliance reflected implicitly within the tenets of AA? Imagining a re-visioning of AA through the lens of more contemporary psychoanalytic theoretical perspectives raises these and many other interesting questions with regard to the understanding of the addict who has undergone a traumatic and overly accommodating developmental history.

Earlier in this article I have suggested that the addict/accommodator use of substances is, in part, an attempt to pursue his freedom. By choosing to use drugs or alcohol, the addict/accommodator is refusing to subjugate his own authentic desires and opposing preferences. I have also suggested that, by utilizing older psychoanalytic ideas, AA implicitly demands conformity as a condition to meet the goal of freeing the addict from his compulsive use of substances. It is my belief that the convergence of the

addict/accommodator's unconscious pursuit of freedom and AA's implicit demand for conformity create a co-construction that may, in some cases, cause the addict to have an aversive response to AA.

DISCUSSION AND CASE EXAMPLES

In this section, I illustrate how AA's implicit demand for conformity, which is implemented by the program's philosophical conventions, slogans, and many suggestions, may cause the addict/accommodator to have an aversive response to AA in two important ways. I believe that the addict/accommodator may unconsciously associate AA's implicit requirements with the demands of an intrusive caregiver. I also believe that put into practice, many of the implicit requirements found in AA reinforce compliant trends the addict/accommodator learned in early development in their effort to maintain the tie with their demanding caregiver. It is my hope to show how the interplay between the implicit requirements in AA and patterns of accommodation converge to create a problematic fit, causing a negative therapeutic reaction in the addict that may impede his utilization of AA.

In Bill Wilson's *Alcoholics Anonymous* (Alcoholics Anonymous, 1986), which is often referred to as the "The Big Book," the author makes an ardent attempt to assure the safety and freedom of the alcoholic, a group of people he knew did not like to be told what to do (Kurtz, 1979). To protect the autonomy of those who were to embark on his *prescribed* journey to sober living he created this phrase: "The only requirement for AA membership is a desire to stop drinking." This important AA declaration can be found as a part of the AA preamble, the preliminary statement of AA's purpose that is read at every meeting. It can also be found as a part of the 12 traditions, the program's guiding principles of self-governance. Other phrases or slogans that promise autonomy are "Take what you want and leave the rest" or "Wear it (AA principles) like a loose garment." All of these phrases encourage the alcoholic to perceive AA as a "take it or leave it" program, and new members do have a choice in how they decide to participate in it. In stark contrast, found within The Big Book (Alcoholics Anonymous, 1986) are phrases that take a considerably more authoritarian stance. These phrases include the following: "Those who do not recover from alcoholism are people who cannot or will not *completely* give themselves to this simple program . . ." (p. 58), "Some of us have tried to hold on to our own ideas and the result was nil until we let go *absolutely*" (p. 58), or

“Half measures availed us nothing” (p. 59). To my mind, the slogans and some sections found in *The Big Book* reflect a contradiction where the promise of autonomy conceals an implicit pressure to conform. If one takes on the purported suggestions of the program, everything will be fine. If one does not subscribe to the suggestions, one will get drunk again and possibly die. While writing *The Big Book*, Bill Wilson was apparently walking a difficult tightrope. Whereas he wanted to make AA available to the sensitive alcoholic, the ferocious nature of alcoholism also mandated a marked authoritarian perspective.

The implicit contradictions that can be found in *The Big Book* may cause the addict/accommodator to experience the AA suggestions as heavy-handed demands. These demands, in turn, may resonate deeply with the dogmatic, authoritative, and guilt laden requirements of unyielding caregivers. The AA suggestions may thus become imperatives, gaining power both from the implicit authority written into the text (as cited earlier) and from the addict/accommodator’s unconscious expectation that he may have once again have to surrender himself to the agendas of others (Brandchaft, 1995). This convergence reflects a co-construction that may cause the addict/accommodator to mistrust AA, and fuel his skepticism about attending meetings.

Similar to classical psychoanalysis, the AA lexicon is infused with evocative and “assumption-loaded” (Orange, 2003, p. 79) words and phrases that are designed specifically to influence the addict into a compliant position. An example of these terms is AA’s insistence on the addict’s complete *surrender*. As noted earlier, AA’s directive around surrender is an attempt to influence the addict to divest himself of his so-called inflated ego and desire to control. Certainly, there is no doubt that the addict must come to understand how his addiction has ravaged his life. He may also need to recognize that his return to compulsive substance use could cause him more devastation and possibly death. However, from the perspective of the addict/accommodator, who has never learned to negotiate or fight for his needs in a tempered and useful way, what purpose does it serve to call for his complete surrender? In our sustained effort to help him to find more adaptive ways to meet his needs, would it not be more beneficial to help him to strengthen his sense of himself by utilizing more affirming and empowering language? To my mind, AA’s notion of surrender embraces both a discouraging and righteous tone that implicitly connects to the addict/accommodator’s already established subjective experience of submission and sense of defeat.

AA's notion of surrender can cause the addict/accommodator further conflict. As he emerges from his reflexive patterns of accommodation, he will begin to develop some strength in his own personal perspective, and he will develop some capacity to defend himself and "push back" when needed. He may also begin to appreciate and enjoy, without apology, the growing expansive aspect of his personality. Yet, as he allows himself this new freedom, AA's notion of *surrender* may cause him to shake a self-doubting finger at himself. He will begin to worry that by actively engaging in a process of strengthening his core sense of self, he is falling into what the program refers to as *self will*, *grandiosity*, and the *slippery slope* toward relapse. The implicit message that comes with the program's requirement for total *surrender* may reinforce the self-doubt ("death anxiety") that Brandchaft (1995) believes automatically emerges and attacks the accommodator when he makes any movement in the direction of his own needs and authentic desires.

Another problematic term found in AA is *defects of character* (AA, 1986, p. 59). This is a phrase used by AA to describe the unwanted aspects of personality the program advises members to relinquish to their *higher power*. As the addict/accommodator cultivates a more contextual picture of his life, and as he attempts to more deeply understand and transform his sense of personal value, the idea that he may be *defective* may haunt him. Thinking of himself as *defective* may reinforce the addict/accommodator's already negatively saturated view of himself, a composite of organizing principles that stem from the close attunement he developed to his demanding parent's implicit disapproval. When the patient begins to understand that his personality adaptations are not loathsome reified *things* inside him but a crucial means of psychic survival, the term *defects of character* may seem unnecessarily blaming, and may weaken rather than strengthen his tie to AA.

As my patients have helped me to look at AA through the eyes of the addict/accommodator, I have come to believe that the program may be problematic in other ways as well. In the following examples, I view aspects of AA through the lens of Brandchaft's (1995, 2007) description of the experience of the pathological accommodator. For the sake of brevity, the case vignettes I provide omit extensive case histories.

Both Mr. J and Mr. B grew up in the shadows of unrelentingly demanding mothers. These mothers found their son's negative affect states intolerable and had difficulty acknowledging and empathically responding to their discouragement, anger, and frustration. As a result, both men disowned their more aversive feelings and grew up to be good boys. In early ad-

olescence they both discovered substances to escape the demands of entrenched and pre-reflective accommodation. In the time that I have been working with them, they have maintained continuous sobriety, but have always remained conflicted about their attendance at AA.

For Mr. J, during the creation of his “moral inventory” (a device that is utilized in Step 4 where the addict must confront his *character flaws*), he balked at the idea of making a list of his *defects*. He told me that because of his experience of attending a devastatingly confrontational rehab, he was fully aware of what was *wrong* with him. Mr. J further explained that what he really needed to do was to make a list of his positive qualities and have them validated by others so that he might have the chance to believe that he did genuinely possess these personal attributes. He also told me he found the step that required making a list of persons he had *harmed* during his active addiction (Step 8) and his having to make amends to them even more troubling (Step 9). Mr. J and I came to an understanding that the making of these personal restitutions implicitly reinforced his already established procedural patterns of feeling responsible for other people’s feelings. This was an adaptive strategy he co-constructed with his mother in early development when he learned to apologize reflexively to her for any interpersonal conflict between them. Furthermore, the listing of his *defects*, the making of amends, and the pursuit of a *self ideal* that are AA’s recommendations for a sober life create a culture of people who are involved in a process of “drastic self-appraisal” (AA, 1986, p. 76). The rule in this environment of unyielding self-evaluation is “to be hard on ourselves, but always considerate of others” (AA, 1986, p. 74). For Mr. J, a path of chronic self-evaluation repeats his preoccupation with his mother’s demands, needs, and affective states during childhood. It reflects and reenacts the rigid criteria to which Brandchaft’s (1995, 2007) accommodator holds himself hostage in early development.

The Big Book (Alcoholics Anonymous, 1986) states, “If we were to live, we had to be free of anger.” It also refers to anger as “a luxury of normal men, but for alcoholics these things are poison.” (p. 66).⁴ Implicit within these statements is the Cartesian notion that emotion, especially anger, is an isolated mind product that needs to be discarded, rather than an emergent emotional experience that results from early relational systems (Stolorow et al., 2002; Orange et al., 1997). AA’s call for emotional sup-

⁴Mr. B’s complaint resonates with Levin’s (1984) assertion that AA can promote emotional suppression.

pression causes great conflict for Mr. B, because anger is a disavowed aspect of his personal experience that he has only recently begun to reclaim. In his treatment with me, he is beginning to understand his anger in the vast context of his abusive early environment. He is also learning to rely on his anger as a signal for perceived danger and for the developing awareness of his personal boundaries. Concurrently, he does not believe he can honestly share his angry feelings in his AA group because he fears the judgment of other members who do not question the authoritarian sanctions (as cited earlier) that are written into the pages of *The Big Book*. I believe the emotionally suppressive aspects of AA match Mr. B's developmental status quo. The further reinforcement of it would support a position of more accommodation. It would also be congruent with his early disavowal of difficult affect states and therefore would obstruct the development of a richer, more fluid, emotional life.

According to some of my patients, the failure to develop a complete commitment to AA runs the risk of being labeled by other program members as "denial," an inability to "surrender," or even as "resistance."⁵ I believe this amounts to what Levin (1987) refers to as a collective idealizing transference that recovering addicts can form with AA. This is an idealization that can sometimes develop into a dogmatic perspective that engenders a tacit authoritarianism within the ranks of program membership.⁶ This is exemplified in Mr. B's experience with one AA sponsor who was absorbed in a fantasy of being a mental health professional. According to Mr. B, this sponsor had some experience in his own psychotherapy and had developed a familiarity with traditional one-person psychoanalytic terminology. When Mr. B would disagree with an AA concept or suggestion his sponsor advocated, his sponsor would use clinical words such as "acting out" and "resistance" in an attempt to influence my patient into AA conformity.⁷ Mr. B experienced his sponsor as a person who believed that by looking through the lens of AA he possessed a complete understanding of psychology and had found an objective reality to which all people, not only Mr. B, *should* adhere. He tended to make assumptions about Mr. B's alcoholic personality and also believed that he knew what my patient's mental

⁵Dodes (2003) has uncovered the tendency of AA members to proselytize and to suppress opinions that diverge from AA philosophy.

⁶Kasl (1992) refers to this as "recovery narcissism."

⁷It is recommended that a sponsor stay with his own personal experience when helping a newcomer (AA, 1986, pp. 89–103).

health *should* look like. From my patient's perspective, his sponsor did not listen well and was intrusive with advice giving. He was also prone to make evaluative interpretations about Mr. B that were not always relevant to my patient's own personal experience. Even more troubling was the "cordon sanitaire"⁸ Mr. B believed his sponsor had built around himself and his own behavior. Mr. B perceived that his sponsor thought he had a right to engage in a bullying and dogmatic manner because he had the *authority* of AA behind him. With the often impinging advice and rigid adherence to program principles his sponsor appeared to advocate, and his sponsor's inability to own his contribution to the rupture that was occurring between him and my patient, this relationship felt too close to the absolute loyalty Mr. B's mother demanded of him in childhood.

After many months of bringing to light and supporting Mr. B's anger, my patient, in a huge developmental leap, ultimately confronted and fired his sponsor. If he had taken for himself his sponsor's perceived idealization of AA or rigid view of a sober life,⁹ it may have continued to reinforce Mr. B's inability to question authority. This would have kept him in the same submissive role he found himself in his childhood. Choosing this position of compliance would have maintained Mr. B's prototypical behavior by symbolically reinforcing his emotional tie to his unrelenting and domineering mother—the *sine qua non* of Brandchaft's (1995, 2007) pathological accommodator.

During the years I have been working with addict/accommodators, I have grappled with their conflicted feelings about their attendance at AA. Working from an intersubjective theoretical position, I have come to accept and appreciate the fact that there is more than a grain of truth in their protests about the program. My acceptance of this has helped me to align myself with their complaints, and I have come to recognize that the prob-

⁸Therapists establish a "cordon sanitaire" around them by rendering a patient's complaints about them as a "distortion" (Brandchaft and Stolorow, 1990). This forecloses an investigation of the analyst's contribution to the interaction, and views pathology as exclusively within the patient. According to the authors, requiring the patient to identify with the analyst's perspective is an invitation "to cure by compliance."

⁹Assisting the overly compliant addict to avoid the development of a "complementarity" (Racker, 1968; Benjamin, 1988) with AA is essential. This is when AA inadvertently becomes a dominant and unrelenting force. A complete submission to program principles may reenact a dangerous procedural cycle of reflexive accommodation that will reinforce a patient's unconscious tie to a sadistic parent. This could result in depression, relapse, and possibly suicide.

lems they encounter in the rooms of AA need not stem from a “projection” or “distortion” in perception, but is actually occurring to a lesser or greater degree. I have also come to believe that many of the implicit requirements in the tenets of AA’s philosophy cause some addict/accommodators to fall back on the adaptive strategies they may have utilized in their negotiation of a derailed differentiation process during early development. As these men begin to change their reflexive patterns of accommodation, it becomes easier to observe the conflict that arises between their growing ability to sense and feel their way into their own thoughts, wishes, and personal values and the authoritarian directives imposed by AA. It is my hope to help them to utilize their own perspective as the basis for a new and vital sober life.

CONCLUSION

Earlier in this article I offered my hypothesis that the addict/accommodator’s use of alcohol, drugs, or sex is an attempt to set him free from the tyranny of others’ demands. I have also argued that implicit within the AA program are requirements for conformity and compliance that are sanctioned by the group’s collective conscience. For addicts whose self-differentiation process has been marked by pathological accommodation, this demand for conformity can be felt implicitly. It may also be what causes deep conflict in addicts about their attendance at AA due to terror of repeating similar traumatic experiences found in early development. The hypothesis I present in this article has important and further reaching implications for current trends in addiction treatment. It is my hope that we might use the ideas I have offered here to help therapists identify how addiction and processes of pathological accommodation may converge. In this endeavor, we can help our patients discover how their addiction may reflect an unconscious attempt at unhinging from pre-reflective compliance. Perhaps we can also encourage our patients to utilize what makes sense for them in AA and also help them to reflect more critically on the personal viability of the aspects of the program about which they have personal doubts. Finally, it is also my hope to continue to question more thoroughly the imposed so-called objective constructs within addiction treatment that are often sanctioned as “the rules” of recovery. With this new and thoughtful inquiry, perhaps we can continue to respectfully expand our conversations about alternative treatment options

for those who cannot utilize 12-step facilitation as a viable tool for recovery from this baffling and dangerous syndrome.

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TRANSLATIONS OF ABSTRACT

Este artículo explora la aplicación de la teoría de los sistemas intersubjetivos a la adicción, y más específicamente, a los principios de los grupos de *Alcohólicos anónimos*. Utilizando las ideas de Bernard Brandchaft sobre los trastornos de los procesos de diferenciación en el desarrollo precoz, se sugiere que para los adictos que han desarrollado un estilo adaptativo del tipo 'acomodación patológica', el uso compulsivo de sustancias o del sexo puede constituir una lucha a vida o muerte para mantener un sentido de sí mismo vital y auténtico. Se señala que la demanda implícita de sumisión y conformidad por parte de los AA como una precondition necesaria para liberar al adicto de sus comportamientos compulsivos, es un reflejo de las primeras ideas del psicoanálisis clásico. La demanda implícita de conformidad en esta perspectiva más tradicional puede causar una respuesta aversiva en el adicto/sobreadaptado haciéndole imposible tolerar los AA. Se ilustra con ejemplos clínicos breves.

Cet article explore l'application de la théorie des systèmes intersubjectifs aux dépendances, et plus spécifiquement, aux principes des Alcooliques Anonymes. En utilisant les idées de Bernard Brandchaft au sujet des processus avortés de différenciation dans le développement précoce, l'auteur suggère que, dans le cas des dépendants ayant développé un style adaptatif d'accommodation pathologique, l'utilisation compulsive des substances ou de la sexualité peut manifester une intense lutte à mort pour tenter de maintenir un sens de soi authentique et vigoureux. L'auteur démontre que les exigences implicites de soumission et de conformité chez les AA comme condition nécessaire à la libération du dépendant de ses comportements compulsifs reflètent les idées de la psychanalyse classique antérieure. La poussée implicite vers la conformité dans cette perspective plus traditionnelle peut occasionner une réponse aversive chez le dépendant/accommodateur lui rendant impossible de tolérer les AA. De brefs exemples de cas sont offerts en illustration.

Diese Arbeit untersucht die Anwendung der intersubjektiven Systemtheorie auf dem Gebiet der Sucht, spezifischer auf die Grundsätze der „Anonymen Alkoholiker“. Indem der Autor auf Bernard Brandchaft's Überlegungen zum entgleisten Differenzierungsprozess in der frühen Entwicklung zurückgreift, nimmt er an, dass für Süchtige, die einen pathologischen Anpassungsstil entwickelt haben, die zwanghaft Verwendung von Substanzen oder von Sexualität ein machtvolles Ringen um Leben oder auch Tod widerspiegelt, zum Zweck, ein vitales und authentisches Gefühl des Selbst zu erhalten. Der Autor zeigt, dass die „Anonymen Alkoholiker“ implizit Unterwürfigkeit und Konformität verlangen, als notwendige Bedingung dafür, den Süchtigen von seinem zwanghaften Verhalten zu befreien, was eine frühe Idee der klassischen Psychoanalyse widerspiegelt. Die implizite Forderung nach Konformität, die in dieser mehr traditionellen Perspektive enthalten ist, kann eine aversive Reaktion im Süchtigen auslösen, die es ihm unmöglich macht, die „AA“ zu akzeptieren. Kurze Fallbeispiele werden dargestellt.