The Philosophies and Practices of Alcoholics Anonymous From a Psychodynamic Perspective

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Abstract
Although predominantly ignored in the existing literature, psychodynamic perspectives on addiction are relevant to understanding the twelve-step program known as Alcoholics Anonymous (AA). This dissertation analyzes specific psychodynamic perspectives on addiction including ego psychology, object relations theory, self-psychology, and attachment theory, as well as their derivations and the philosophies and practices of AA outlined in AA literature. These literatures are integrated to inform the findings and recommendations section, justifying certain AA practices while offering recommendations to improve the overall effectiveness of AA. Findings concentrate on AA helping members transition from utilizing primitive to mature defense mechanisms; manage volatile emotions in early recovery; increase humility in addressing alcoholism; establish consistency in the recovery program; participate in a nurturing holding environment; strengthen object permanence; establish transitional objects and address unmet selfobject needs, including helping members feel valued (mirroring); merge with an admirable object (idealizing); and experience alikeness with others.

Recommendations are made to AA leaders and include pronouncing the value of joining a home group in AA literature and having members state whether they attend a home group during meeting introductions, stressing respect for boundaries members should not cross, and maintaining consistency in where and when meetings take place and how they function. Newcomers are suggested to attend 90 meetings in their first 90 days of AA; have family and friends attend open anniversary meetings; choose sponsors whom they have the potential to emulate; receive treatment from mental health professionals when necessary; and discuss with their sponsors and peers regarding decreasing weekly meeting attendance. Members are encouraged to receive treatment from mental health professionals when warranted and promote collaboration between their sponsors and treatment providers. Mental health/addiction treatment professionals are advised to recommend AA meetings to their clients where they are most likely to form attachments with those in attendance.

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THE PHILOSOPHIES AND PRACTICES OF ALCOHOLICS ANONYMOUS

FROM A PSYCHODYNAMIC PERSPECTIVE

Noah Kass

A DISSERTATION

in

Social Work

Presented to the Faculties of the University of Pennsylvania

in

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Degree of Doctor of Social Work

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Dedication

This dissertation is dedicated to Jessie Kass and Ava Kass. I love you both so much.
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I would like to thank my dissertation chair, Ram Cnaan, Ph.D., for his unwavering support and guidance in the writing of this dissertation. In the dictionary, under the word *patience*, there should be a picture of Ram reading my frantic emails.

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To my dad and mom: Thank you for those big hearts. To my brother: Thank you for being such a great friend.
Abstract

Although predominantly ignored in the existing literature, psychodynamic perspectives on addiction are relevant to understanding the twelve-step program known as Alcoholics Anonymous (AA). This dissertation analyzes specific psychodynamic perspectives on addiction including ego psychology, object relations theory, self-psychology, and attachment theory, as well as their derivations and the philosophies and practices of AA outlined in AA literature. These literatures are integrated to inform the findings and recommendations section, justifying certain AA practices while offering recommendations to improve the overall effectiveness of AA. Findings concentrate on AA helping members transition from utilizing primitive to mature defense mechanisms; manage volatile emotions in early recovery; increase humility in addressing alcoholism; establish consistency in the recovery program; participate in a nurturing holding environment; strengthen object permanence; establish transitional objects and address unmet selfobject needs, including helping members feel valued (mirroring); merge with an admirable object (idealizing); and experience likeness with others.

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Introduction

This dissertation aims to understand how psychodynamic theories and their many derivations are relevant to the twelve-step program known as Alcoholics Anonymous (AA). Through this intellectual journey, I will identify and elicit the key classic and modern/contemporary psychodynamic writings on the etiology and treatment of addiction and substance abuse, and juxtapose them with the key essentials of the twelve-step program. I intend to review AA components in light of this psychodynamic literature. I will identify how psychodynamic literature justifies certain existing AA protocols while offering recommendations to improve the overall effectiveness of Alcoholics Anonymous.

The focus of this dissertation is alcoholism. Most early and modern psychodynamic theorists discuss addictions from a generalist perspective. These theorists focus on behavioral addictions as well as substances; within substances, they address alcohol, among other drugs. I will include these theorists’ observations on a range of addictions; however, I will narrow my focus on alcohol and alcoholism in the findings section.

Central to this dissertation’s mission is to understand why people use and become addicted to narcotics or alcohol, and what can be done to assist their recovery. While the addiction treatment community (largely consisting of AA supporters) has principally ignored psychoanalytic literature, I propose this rich body of work has more in common with AA’s philosophies and practices than previously conceived.

Charles Goldberg (2011), author of *Freud Meets Bill W.: A Model for the Dynamics of Alcoholism*, supported this position: “Historically there has been a lamentably wide gap between Alcoholics Anonymous (AA) and psychodynamic psychotherapy. Although each has a distinct language, they actually utilize parallel principles” (p. 141). In *Pragmatic Convergence in the*
Programs of Psychoanalysis and Alcoholics Anonymous, psychoanalyst David W. Mann (2002) contended that applications of AA and psychoanalysis are conducted in response to alike individual struggles:

Both AA and psychoanalysis came into being in response to forms of human suffering that appear, paradoxically, both self-induced and beyond the subjects personal control, both willed and caused, and that disrupt the physical, emotional, and spiritual well-being of their patients, and leave them both painful and pained, obnoxious and miserable. (p. 234)

The acknowledgement and exploration of these commonalities will help the academic community increase its understanding of Alcoholics Anonymous. Providing a psychoanalytic critique of AA that examines the program’s components can strengthen the fellowship’s intellectual significance, the underlining goal of this dissertation, making AA increasingly relevant to practitioners and scholars who have not personally experienced its benefits. As the treatment of addiction becomes more and more professionalized, it is vital that the tenets of AA be understood in as rich a context as possible.

The dissertation’s literature review will survey psychoanalytic views on substance abuse and addiction from the early 20th century to the modern era. Many psychodynamic theorists have described substance use and addiction in their writing. Unfortunately, the psychoanalytic community has neither fully embraced this literature nor utilized the findings therein. To my knowledge, no one has attempted a comprehensive review of these writings.

In Chapter 1, I will identify Sigmund Freud’s psychoanalytic concepts and constructs as central to any understanding on the subject. I will additionally review writings of those early-to-mid-20th-century psychoanalysts and psychologists whose work Freud heavily influenced.
Through these early writings, I am giving the reader a foundational knowledge of early psychodynamic addiction theory—necessary for understanding the more modern ego psychology, object relations, self-psychological, and attachment theory approaches to addiction to be examined in Chapter 2.

After providing the reader with a comprehensive review of the psychodynamic literature on addiction theory, I will describe the origins of Alcoholics Anonymous in Chapter 3, after which point I will discuss the major philosophies and practices of the Alcoholics Anonymous fellowship in Chapter 4. Finally, I will juxtapose psychodynamic writings with the essential elements of Alcoholics Anonymous to provide a fresh evaluation of the self-help program in Chapter 5.
Chapter 1:

Early Psychodynamic Perspectives on Addiction

The objective of this chapter is to identify the early psychodynamic theorists that have underscored substance use and addiction. These writings begin by studying this phenomenon in relation to Freud’s drive theory, which views psychopathology, including addiction, as the struggle between expression and repression of prohibited impulses (Levin & Weiss, 1994). They continue by examining substance use and addiction through early ego formulations and applications of object relations theory. Ego-psychological formulations focus on adaptive functions of addiction, while object relational formulations study the family dynamics and internal world of representations found in the addict (Levin & Weiss, 1994).

This chapter identifies substance use and addiction as caused by numerous factors, including defense mechanism against expression of forbidden impulses; unmet oral gratification from parents; narcissistic disturbances in the ego; attempt at chronic suicide; underlining personality disorder; disruptive family dynamics; effort to control anxiety; ego deficits; and pervasive narcissism. As this dissertation aims to critique AA from a psychodynamic perspective, I have provided, when available, these psychoanalysts’ public statements regarding the self-help program.

The first source I detail below is the writing of Freud. Freud’s drive theory is presented as the cornerstone of psychoanalytic addiction theory. Freud (1905/1975) described addiction as displacement and reenactment of infantile sexual behavior. He also saw addiction as self-punishment for early masturbation (Freud, 1928/1961). Freud (1930/1961) believed substance use could help reduce the pain that people experienced while living within social constraints. His
personal experimentation with cocaine and advocacy of its proposed healing properties are also discussed (Markel, 2011; Freud, 1884/1974).

German psychoanalyst Karl Abraham’s (1908/1979) writings connected sexuality to alcoholic use. He described alcoholism as a sexual perversion and associated it with latent homosexual tendencies. He believed alcohol use was the result of oral conflict and alcoholism was a regressive oral tendency (Abraham, 1908/1979).

British psychoanalyst and physician Edward Glover (1932) saw substance use as an individual’s effort to release and control aggressive impulses, believing it was progressive in nature and a defense mechanism against sadistic tendencies and psychosis. He laid the groundwork for contemporary psychoanalytic thought on addiction as self-medication for aggression, anxiety, and other internal discomforts.

American psychiatrist Karl Menninger (1938) supported Freud’s death instinct theory, writing of alcoholism as a form of chronic suicide. Menninger (1938) described alcoholism as rooted in an oral gratification, identifying it as an individual’s attempt to punish his or her parent for observed neglect. He endorsed the effectiveness of the fellowship and practice of Alcoholics Anonymous (AA) in helping heal the addict (Menninger, 1960). Menninger also distinguished AA philosophies from the scientific method, focusing on its use of empathy, mutual stimulation, and group support.

Sandor Rado (1928), a Hungarian psychoanalyst, described addiction as rooted in narcissistic disturbances of the ego. He identified the impulse to use as a psychological disorder. (Rado, 1957). Rado (1933) labeled the “tense depression” from which addicts suffer and saw addiction as an effort to obtain mental health. He saw addiction as a substitute for sexual activity, believing substances produced an “alimentary orgasm” providing sexual satisfaction throughout
the body (Rado, 1928). He recognized a “narcotic super pleasure” obtained from substances that help reduce pain and induce pleasure (Rado, 1957). Rado (1928) also differentiated the effects of stimulants versus analgesics, leading contemporary psychoanalysts to speculate that an individual’s drug of choice may be rooted in individualized psychological needs.

Robert Knight (1937a), an American psychiatrist, described addiction as stemming from an underlining personality disorder, discussing family members’ impact on addiction development, and placing historical responsibility on the mother. Based on his work with institutionalized alcoholics at the Menninger Clinic, Knight (1937b; 1938) described two types of alcoholics: “essential” alcoholics and “reactive” alcoholics.

Austrian physician and psychoanalyst Otto Fenichel (1945) wrote of libidinal considerations found in the psychopathology of drug dependence and discussed alcohol as helping individuals negotiate id-superego conflicts. He addressed the narcissistic regression in addiction that focused on embracing the fantasy world; Fenichel also described similarities between addiction and manic-depressive cycles.

Paul Schilder (1941), an Austrian psychiatrist, discussed work with dual-diagnosed patients. He described relationships between addicts’ ego deficits and families of origin. Schilder also discussed the differing impacts that fathers and mothers have on addiction development as well as society’s role in fostering drug dependence.

American psychiatrist Harry Tiebout (1951) described addiction as a disease, writing about the coupling of addiction psychodynamic theory and Alcoholics Anonymous philosophies (Loose, 2002). Tiebout (1944) believed pathological narcissism was the central element in the development and sustainment of alcoholism. Additionally, Tiebout (1946) wrote how the alcoholic’s mind conceptualizes his or her outside environment.
Ernst Simmel (1949), a German neurologist and psychologist, described psychological factors that caused alcoholism. He believed that addicts were victims of morbid cravings (Simmel, 1929). Additionally, Simmel (1929) wrote about the role fantasy plays in the addictive psyche; he also connected aggressive wish fulfillment with the urge to use. He described the psychodynamics involved in the Alcoholics Anonymous healing process, including the power of mass psychology to counteract an alcoholic’s impulsive drives (Simmel, 1949; Loose, 2002).

**Sigmund Freud**

The father of psychoanalysis, Sigmund Freud, believed drug addicts were not suitable for psychoanalysis because difficulty in therapy eventually led to further drug use (Loose, 2002). In a 1908 letter to Carl Jung, Freud (1994) referenced friend Otto Gross’s increased morphine dependence: “Unfortunately there is nothing to be said of him. He is addicted and can only do great harm to our cause” (p. 80).

The world’s most famous analyst never offered a unifying psychodynamic theory on drug use or addiction. This contributed to future psychodynamic theorists not fully investigating the phenomenon of addiction and the minimal psychodynamic theory found in substance abuse research today.

Despite this shortsightedness, Freud’s overall psychoanalytic concepts and constructs represent the starting point in formulating a psychodynamic approach to addiction, attempting to understand how psychological factors influence the addict’s behavior. Theories on the phenomenon of the unconscious; the relationship between id, ego, and superego; and trauma-related developmental issues focused on infantile fixations established the psychoanalytic underpinnings for future analysts’ attempt to understand the reason individuals use, abuse, and become addicted to drugs.
In examining Freud’s drive theory, addiction could be seen as part of the eternal human struggle between the expression and repression of sexual and aggressive impulses. Alcohol allowed the individual to express forbidden impulses and then punish himself. Freud believed addiction was a displacement and reenactment of infantile sexual behavior. Writing to his friend Wilhelm Fliess in 1897, Freud stated,

It has dawned on me that masturbation is the one major habit, the primal addiction, and it is only as a substitute and replacement for it that the other addictions to alcohol, morphine, tobacco and the like come—into existence. (as cited in Levin, 1990, p. 154)

Freud believed the cycle of reduction and increased anxiety found in masturbation paralleled addictive behaviors (Volkan, 1994). He considered that the act of masturbation resulted in the doer’s instinctual gratification. Simultaneously, the doer felt forbidden to act on this impulse because he had assimilated parental authorities and societal restraints into the psyche, creating guilt and anxiety in the doer that was only relieved through continued masturbation.

In *Dostoyevsky and Parricide*, Freud (1928/1961) analyzed the Russian novelist’s gambling problem:

He never rested until he had lost everything. For him gambling was a method of self-punishment…Time after time he gave his young wife his promise or his word of honor not to play anymore or not to play anymore on that particular day; and, as she says, he almost always broke it. When his losses had reduced himself and her to the direst need, he derived a second pathological satisfaction from that. He could then scold and humiliate himself. (pp. 456–457)
Freud described Dostoyevsky as an “instinctual character” with an unconscious desire to lose at the roulette table. He concluded the essay by discussing the utility of Dostoyevsky’s gambling problem:

If the addiction to gambling, with the unsuccessful struggles to quit the habit and opportunities it offers, is a repetition of the compulsion to masturbate, we shall not be surprised to find that it occupied such a large space in Dostoyevsky’s life. (p. 460)

Freud’s (1905/1975) *Three Essays on the Theory of Sexuality* hypothesized clinical similarity between neurotic psychosexual life and the “phenomena of intoxication that arises from the habitual, toxic use of pleasure inducing substances” (p. 82). He saw that sustained childhood oral fixations could lead to addicted adults: “If that significance persists, these same children when they are grown up…will be inclined to perverse kissing, or, if male, will have a powerful motive for drinking and smoking” (as cited in Loose, 2002, p. 36).

Freud’s (1930/1961) *Civilizations and Its Discontents* examined the pain individuals experience while living within a community and conforming to societal constraints. Freud saw alcohol and drugs as options for reducing this suffering:

The crudest, but also the most effective among these methods of influence is the chemical one—intoxication. I do not think that anyone completely understands its mechanism, but it is a fact that there are foreign substances which, when present in the blood or tissues, directly cause us pleasurable sensations. (p. 27)

Casual observers of psychoanalysis may associate Freud with one word: cocaine. In the early 1880s, pharmaceutical companies praised cocaine as a panacea for many psychological and physical issues. Freud was cocaine’s leading advocate; he wrote about its healing properties, prescribed it to patients, and experimented personally with the drug (Markel, 2011). Freud
assumed his study of cocaine’s medicinal uses would be his greatest professional achievement. He believed cocaine’s anesthetic properties would be effective for eye surgery, an idea that his friend Dr. Carl Koller would later patent and achieve great financial success with (Volkan, 1994).

On April 22, 1884, Freud bought what appears to be his first gram of cocaine (Breger, 2000). Shortly after, he wrote to his fiancée, Martha Bernays,

I will kiss you quite red and feed you till you are plump. And if you are forward you shall see who is the stronger, a little girl who doesn’t eat enough or a big strong man with cocaine in his body. In my last serious depression I took cocaine again and a small dose lifted me to the heights in a wonderful fashion. I am just now collecting the literature for a song of praise to this magical substance. (as cited in Breger, 2000, p. 67)

And in his paper “Über Coca,” Freud (1884/1974) endorsed using the drug as a recreational activity:

You perceive an increase of self-control and possess more vitality and capacity for work…. In other words, you are simply normal, and it is soon hard to believe you are under the influence of any drug…. Long intensive physical work is performed without any fatigue…. This result is enjoyed without any of the unpleasant after-effects that follow exhilaration brought about by alcohol…. Absolutely no craving for the further use of cocaine appears after the first, or even after repeated taking of the drug. (p. 205)

He also stated that cocaine had numerous benefits in relieving medical problems, including digestive weakness, stomach disorders, and febrile diseases.

According to Markel (2011), Freud proposed cocaine as a treatment method for morphine addicts as well. He attempted to wean the physician Ernst Von Fleischl-Marxow off of morphine
with cocaine. Marxow had been abusing morphine since contracting a hand infection during a laboratory experiment. Initially, the cocaine helped relieve Marxow’s pain, and he stopped using morphine. However, Marxow would soon require higher and higher dosages to receive the desired effect. Marxow became a cocaine addict, endured a period of “cocaine psychosis,” returned to morphine use, and died several years later of complications related to cocaine addiction. Freud rethought his position in 1900: “I had been the first to recommend the use of cocaine in 1884, and this recommendation has brought serious reproaches down on me. The misuse of that drug has hastened the death of a dear friend of mine” (as cited in Byck, 1974, p. 211).

Freud made no more public comments endorsing cocaine. According to Markel (2011), Freud continued personal cocaine usage in treating depression and migraines (as cited in Vetter, 1985). He did not think he was addicted to cocaine, but his experience with Marxow taught him that others might be. In Dancing Among the Maenads: The Psychology of Compulsive Drug Use, Kevin Volkan (1994) wrote: “Freud puzzled over why cocaine, which was seemingly harmless to him, was destructively addicting to others. He concluded that there must be present in the personality of the addict, some pathological element, of which he is free” (p. 4).

Freud’s earliest followers would use his theories to formulate psychoanalytic explanations for substance use and misuse, expanding on the notion that addiction was the result of intrapsychic conflict. Their writings on psychoanalytic addiction theory are informed by Freud’s drive theory; they also constitute the beginnings of looking at addiction through ego formulations and applications of object relations theory.

**Karl Abraham**
Karl Abraham was a German psychoanalyst and reportedly one of Sigmund Freud’s favorite students (Ulman & Paul, 2006). His research focused on infantile sexuality in character development and psychopathology (Wurmser, 1978). In 1908, Abraham wrote “The Psychological Relations Between Sexuality and Alcoholism,” the first psychoanalytic paper on substance abuse, based primarily on Freud’s drive theory of psychoanalysis (Yalisove, 1997).

Abraham wrote, “Alcoholism is a nervous and sexual perversion” (as cited in Levin, 1977, p. 154) and also that the alcoholic through drinking releases perversions related to homoerotic tendencies, an observation based on his analysis of male alcoholics being openly affectionate with each other in a beer hall:

In normal individuals the homosexual component of the sexual instinct undergoes sublimation. Between men, feelings of unity and friendship becomes divested of all conscious sexuality. The man of normal feelings is repelled by any physical contact implying tenderness with another of his own sex…. Alcohol suspends these feelings. When they are drinking, men will fall upon one another’s necks and kiss one another…. The homosexual components that have been repressed and sublimated by the influence of education becomes unmistakably evident under the influence of alcohol. (as cited in Levin & Weiss, 1994, pp. 54–55)

Building on Freud’s theories, Abraham’s ideas on psychosexual phases and character formation informed the conceptualization of alcoholism (Wurmser, 1978). According to Abraham, alcohol use was the result of oral conflict (Loose, 2002), and alcoholism was an oral regressive tendency (Volkan, 1994). Attention to the oral character, where infants’ sources of pleasure and aggression were located in the “oral zone,” made Abraham believe that alcoholism was caused by blocking oral expressions during infancy.
Abraham’s focus on analyzing male drinking in Berlin taverns led future psychoanalysts and addiction specialists to examine how cultural settings impact individuals’ relationship with addictive substances. Abraham also spoke about how gender and society impact an individual’s propensity to engage in chronic drinking:

There are wide circles in which to be a hard drinker is looked upon as a sign of manliness, even as a matter of honor. Society never demands in this way that woman should take alcohol. It is the custom with us rather to condemn drinking as unwomanly; nor is drinking ever a matter of boasting among normal woman as it is among men. (as cited in Levin & Weiss, 1994, p. 53)

Abraham’s 1908 paper was the first scientific literature to reference “alcoholism” as the habitual act of drinking rather than the physical symptom of drinking (Rotskoff, 2002). This publication marked a shift in psychoanalytic literature from alcoholism as a medical condition to an underlying psychiatric disorder. It led to numerous early psychoanalytic writings regarding alcoholism as a manifestation of latent homosexuality; however, except for orthodox Freudian theorists, psychoanalytic theorists have widely dismissed the link between homosexuality and addiction.

**Edward Glover**

The British psychoanalyst and physician Edward Glover believed individuals used substances progressively, attempting to simultaneously control and release aggressive impulses. He saw drugs as a successful defense against paranoid-sadistic tendencies:

In the choice of a noxious habit, the element of sadism is decisive. The drug would then be a substance with sadistic properties which can exist both in the outer world and within the body, but which exercises its sadistic powers only when inside…the addiction would
represent a peculiar compound of psychic danger and reassurance. \(\text{(Glover, 1932, p. 318)}\)

Glover (1932) believed addicts were filled with such internal rage, teetering on the edge of psychosis, that drugs/alcohol could act as successful self-medication for this internal discomfort. They were a defense against aggressive impulses, helping create temporary equilibrium and acting as protection against psychotic reactions. He also classified substance addictions, as compared to behavioral addictions, as falling within the spectrum of mental health disorders. They were neither neurosis nor psychosis but rather transitional states (Loose, 2002).

In *On the Etiology of Addiction*, Glover expanded this theory, writing

\[\text{I would place the average drug addiction as transitional between paranoias and obsessional character formations, the reason being that in drug addictions the projection mechanisms are more localized and disguised than in the paranoias, yet stronger than in obsessional disorders. (as cited in Wurmser, 1978, p. 50)}\]

Glover believed alcohol released oral aggression. He saw the act of drinking as human beings’ expression of that aggression (Levin, 1977).

**Karl Menninger**

The American psychiatrist Karl Menninger, founder of the famous Menninger Clinic in Kansas, viewed alcoholism as a form of chronic suicide. In his book *Man Against Himself*, Menninger (1938) wrote,

\[\text{…the victim of alcoholic addiction knows what most of his critics do not know, namely that alcoholism is not a disease, or at least the principle disease from which he suffers, furthermore, he knows that he does not know the origin or nature of the dreadful pain, and fear within him which impel him blindly to alcoholic self-destruction…we frequently see patients who start out with conscious suicidal ideations and end up by getting drunk (or}\]
who get drunk first in order to make a suicide attempt), as if this was (as it is!) a less certain death than shooting. (p. 155)

Menninger (1938) supported Freud’s theory of the death instinct: “In the end each man kills himself in his own selected way, fast or slow, soon or late. We all feel this, vaguely; there are so many occasions to witness it before our eyes” (p. 5). He saw alcoholism as a punishment against the self for aggressive impulses that the individual found unacceptable (McCord & McCord, 1960). The individuals’ aggression was unconscious, stemming from beliefs that their parents betrayed them in their childhood. This betrayal was connected to frustration over oral desires not being met in infancy, leading to intense anger toward one’s parents (McCord & McCord, 1960).

Menninger was an early proponent of Alcoholics Anonymous (AA), and in the afterword for “Three Talks to Medical Societies” by Bill Wilson (1958), cofounder of AA, he stated, “I have the utmost respect for the work AA is doing, for its spirit, for its essential philosophy of mutual helpfulness. I lose no opportunity to express my endorsement publicly and privately where it is of any concern” (p. 37). In “An AA Appraisal,” Menninger (1960) further endorsed AA’s effectiveness:

I am glad of an opportunity to endorse the work of Alcoholics Anonymous. I respect and I admire the dedication of its members, their humility, their persistence and their adherence to the 12 steps particularly to the principle of helping one another. I have more than respect for the society and its principles; I have admiration and enthusiasm. I think AA has probably changed the direction—for the better—for more lives wrecked by alcohol addiction than any other one group of people. (pp. 14–15)

He also stated that AA may not benefit individuals equally, and distinguished the fellowship’s
philosophy from the scientific method:

…certain individuals of certain character structures seemed more likely to be helped by one method, different individuals of different character structures by another…the methods used by Alcoholics Anonymous are not medical methods. They are not scientific procedures. They are not professional activities. No one has anything for sale. No one pretends to be objective. The methods are the voluntary expression of love, sympathy and concern, by those who have suffered, for another who is suffering. They depend upon the mutual stimulation and example of group feeling in working toward a common high purpose. (pp. 14–15)

**Sandor Rado**

The Hungarian psychoanalyst Sandor Rado was cofounder of the adaptational school of psychoanalysis and an early pioneer in addiction studies (Breger, 2000). According to Vetter (1985), Rado attempted to move the psychoanalytic study of addiction “past the psychosexual significance of drug taking and the pharmacological properties” (p. 5). Believing addiction was a psychological disorder rather than a biological phenomenon (Ulman & Paul, 2006), Rado shifted focus away from the drug itself:

The psychoanalytic study of the problem begins…with recognition of the fact that not the toxic agent, but the impulse to use it, makes an addict of a given individual…. The drug addictions are seen to be psychically determined, artificially induced illnesses; they can exist because drugs exist; and they are brought into being for psychic reasons. (as cited in Wurmser, 1978, p. 18)

Rado stated in 1957 that drugs help reduce mental discomfort, resulting from continuous inner stimuli of the instincts, because they “supply that exactly which the mental organization
lacks—namely, as shield against stimulation from within” (as cited in Vetter, 1985, p. 449). Of intoxications, Rado said they reduced conflict within the ego and released inhibitions.

Rado (1928) differentiated effects of stimulants versus analgesics. He believed stimulants helped replace unpleasant tension with a pleasurable sense of being and heightened elation. He also thought that analgesics protected individuals from depression and anxiety (Rado, 1928). However, Rado believed the psychopathological process of addiction to be similar across the board, regardless of the addicts’ drug of choice (Vetter, 1985).

Following Freud’s thinking, Rado (1928) considered addiction as a substitute for sexual activity. He described drugs as providing sexual satisfaction throughout the entire body, citing the “orgastic effects of intoxicants,” producing what he called an “alimentary orgasm” (p. 313). By ingesting chemical substances, Rado said, an individual could constantly receive oral satisfaction:

In the pharmacogenic orgasm the individual becomes acquainted with a new kind of erotic gratification, which enters into rivalry with the natural modes of sexual gratification…once intoxication has become the sexual aim of the individual he has turned away from the reality principle into the dangerous region of a blind obedience to the instincts. (Rado, 1928, p. 306)

Rado wrote in 1933 that the first time individuals suffering from a “tense depression” used drugs, the pharmacogenic pleasure effect sensitized their pain and elevated mood (as cited in Wurmser, 1978, p. 45). However, he critiqued this solution (taking substances) as mirroring the manic depressive cycle, and declared it ultimately ineffective; the substances would initially help minimize mental health symptoms, but the night after using, “The emotional situation which obtained in the initial depression has again returned, but exacerbated, evidently by new factor”
(Rado, 1933, p. 9).

In “Narcotic Bondage: A General Theory of the Dependence on Narcotic Drugs,” Rado (1957) attempted to identify the underlining pathology behind all drug dependence. He concluded that chronic drug/alcohol use led to “false inflation of the self” and was an inferior replacement for sexual gratification. Rado cited the addict’s weakened ego and faulty attempt at self-medication as a “malignant form of miscarried repair, artificially induced by the patient himself” (p. 167).

Rado (1957) expanded his link between addictions and self-healing, describing a “narcotic super pleasure” or “narcotic intoxication” that aids the individual “by removing pain, relaxing inhibitory tensions, inducing pleasure and facilitating performance…” (p. 165). He stated this is more noticeable in narcotic drugs (as opposed to alcohol) because of their direct biochemical effects on the brain. According to Rado, this immediate super pleasure effect that drugs have on the addict often lead them to forgo normally enjoyable pursuits (sex, food, etc.), resulting in corrupted self-regulation. Rado started a paradigm shift away from seeing substance use and addiction through the lens of Freud’s drive theory and toward ego formulation, and what would later be called ego psychology.

**Robert P. Knight**

Robert P. Knight was an influential American psychiatrist and proponent of ego psychology. As a staff psychiatrist at the Menninger Clinic, Knight pioneered research into the borderline personality structure and treated alcoholics requiring institutionalization. Informed by this work, Knight (1937a) concluded that, “Alcohol addiction is a symptom rather than a disease…. There is always an underlying personality disorder evidenced by obvious maladjustments, neurotic character traits, emotional immaturity or infantilism” (p. 234).
Knight (1937b) addressed family members’ impact on addiction development and proposed that historical responsibility for addiction lay with the addict’s mother:

The mother knows she can quiet her (son’s) rage—which again means a relief of tension for the infant—by once more gratifying him orally…eventual weaning for such a child can only mean to him betrayal by the mother. She led him to expect indulgence.…. (p. 542)

He also wrote, “The father of the alcoholic is generally unaffectionate, domineering with his family, inconsistently strict and indulgent in regard to his son” (p. 541).

In “The Psychoanalytic Treatment in a Sanatorium of Chronic Addiction to Alcohol,” Knight (1938) defined two types of alcoholics in bipolar categories based on his work with 30 alcoholics at the Menninger Clinic: the *essential alcoholic* and the *reactive alcoholic*. Knight believed essential alcoholics had emotional and substance abuse problems since adolescence. These alcoholics possessed borderline personality traits and, like Glover (1932) had stated, navigated the line between neurosis and psychosis.

Knight (1938) identified reactive alcoholics as one-time social drinkers who had crossed into full-blown alcoholism: “In nearly every case there is a discoverable precipitating event which initiated the severe drinking” (p. 1444). He distinguished reactive alcoholics from essential alcoholics in terms of life accomplishments and capacity for recovery. For Knight, reactive alcoholics have achieved more, have exhibited the capacity to carry through a sustained effort in schooling or in jobs, and their attitude toward treatment is more sincere. If their relatives do not interfere and interrupt the treatment prematurely, the outlook for them is good. (p. 1444)
Their alcoholism was connected to life stressors, and Knight (1938) believed these alcoholics might successfully return to social drinking after stressors were removed and treatment occurred.

**Otto Fenichel**

The Austrian physician and psychoanalyst Otto Fenichel was best known for his classic encyclopedia, *The Psychoanalytic Theory of Neurosis*, which summarizes the history of psychoanalysis until World War II (Yorke, 1970). Fenichel (1945) discussed the psychopathology of drug addiction, focusing on libidinal considerations:

Addicts represent the most clear-cut state of impulsive…addicts are persons who have the disposition to react to the effects of alcohol, morphine, or other drugs in a specific way, namely, in such a way that they try to use these effects to satisfy the archaic oral longing which is sexual longing, a need for security…thus the nature and origin of addiction are not determined by the chemical effect of the drug but by the psychological structure of the patient. (p. 772)

Fenichel (1945) believed development of addiction is determined by the individual’s pre-morbid personality. He thought addictions served a purpose, releasing inhibitions and negotiating fears and anxieties:

The superego has been defined as the part of the mind that is soluble in alcohol…it has always been extolled for its power to banish care; obstacles appear smaller and wish fulfillments nearer; in some persons through the diminishment of inhibitions, in others through withdrawal from the reality of pleasure to daydreams. (p. 379)

To Fenichel, alcohol helped individuals negotiate id-superego conflicts, and gave them freedom to indulge in forbidden impulses (Levin & Weiss, 1994).

Fenichel highlighted narcissistic regression in addiction (Abandinsky, 1991). He saw the
addict abandon an objective world in reality (often filled with painful mental states and memories) for an inner world of fantasy in substances (Bratter & Forrest, 1985). Additionally, the addict’s libido development was orally fixated and prone to regression related to tension discharge. Fenichel (1945) spoke of the significance the drug had on individuals’ sexuality:

For them it means the fulfillment, or at least the hope of the fulfillment, of a deep and primitive desire, more urgently felt by them than are sexual or instinctual longings by normal persons…. The tendency toward such a development, rooted in an oral dependence on outer supplies, is the essence of drug addiction. (pp. 376–377)

His addiction beliefs echoed those of earlier analysts, including Sigmund Freud and Karl Abraham, specifically related to the connection of alcoholism to orality and homosexuality. Explaining the linkage, Fenichel (1945) wrote: “There are few points that are specific for alcoholism…difficult family consultations created specific oral frustrations in childhood…. These frustrations gave rise to oral fixations, more or less repressed homosexual tendencies” (p. 379). However, Fenichel’s belief in latent homosexuality’s connection with addiction differed from that of Abraham: “It is more probable that the latent homosexuals, seduced by social frustrations, are particularly affected by alcohol, and not that the latter, due to its toxic effects, lead to homosexuality” (p. 428).

Fenichel identified similarities between cycles of addiction and manic depression, and saw that chronic alcohol use occurred when individuals experienced significant id-ego conflicts (Levin, 1977). Fenichel (1945) said addiction was a self-protective function and that it “can be looked upon as a last means to avoid a depressive breakdown” (p. 380).

Paul Schilder

Paul Schilder was an Austrian psychiatrist known for work in the area of group
psychotherapy and conception of body image (Levin, 1990). He was clinical director of New York’s Bellevue Hospital and worked with what would now be considered dual-diagnosed clients (Levin & Weiss, 1994). In his 1941 paper, “The Psychogenesis of Alcoholism,” Schilder cited case studies to demonstrate relationships he saw between addicts’ ego deficits and families of origin (Levin & Weiss, 1994). Schilder said of the alcoholic’s family history,

The chronic alcoholic person is one who, from his earliest childhood on, has lived in a state of insecurity. This insecurity in childhood is necessarily insecurity in relation to parents and siblings. The child has felt ridiculed and pushed unto a passive position, sometimes by threat, sometimes by corporal punishment and sometimes by deprivation.... The punishing parent is particularly intolerant toward sex in any form”; men are generally influenced by their father’s judgment and “generally blame themselves for their ‘femininity’ and have to seek redress in ideals of heightened masculinity and strength. (as cited in Levin & Weiss, 1994, p. 146)

Of women, Schilder said they internalize judgment from their mother and “feel that they are not capable of fulfilling their feminine functions” (as cited in Levin & Weiss, 1994, p. 146).

Regarding both sexes, these factors create “social tension” within the alcoholic, and alcoholism attempts to “reverse this process” as it temporarily “gives social security and acceptance” (as cited in Levin & Weiss, 1994, p. 146).

Schilder (1941) believed society reinforces the addiction cycle by making alcoholism so readily available for consumption and promoting a culture of competition where alcoholics feels ill-equipped to compete. Schilder also believed the “community factor” was a vital component of addiction treatment:

Alcoholism is not only a problem of individual treatment but of social attitudes, and it
seems, therefore, that individual treatment has to be complimented by offering to the alcoholic a social group in which competition is diminished, and in which the use of alcoholic beverages is not foisted upon the patient. It seems, indeed, that all modern treatments of alcoholism stress the community factor. (as cited in Levin & Weiss, 1994, p. 146)

Harry Tiebout

The American psychiatrist Harry Tiebout saw addiction as a disease (Loose, 2002). Tiebout’s major contribution to addiction theory and treatment was coupling psychiatric knowledge about addiction with philosophies of Alcoholics Anonymous (Levin, 1977). Tiebout treated Bill Wilson, cofounder of AA, for depression; and it has been said that their ongoing conversations helped inform their respective work (Loose, 2002). Tiebout served on the AA’s board of trustees from 1957 to 1964, tirelessly promoting his theories on alcoholism within the psychiatric community (Loose, 2002).

Tiebout believed alcoholism started as a symptom and became a disease (Lobdell, 2004). In “The Role of Psychiatry in the Field of Alcoholism,” Tiebout (1951) cited the following as evidence:

Once the state of alcoholism has supervened, it seems to remove any later possibility of controlled drinking. This new element remains as if it was a sensitized phenomenon, sure to be touched off sooner or later if drinking is attempted. The alcoholic always harbors the disease potential once that potential has come into being. He is forever susceptible. (p. 55)

He focused on the addict’s grandiosity, and was certain this must diminish for recovery to take place (Levin, 1977). Tiebout (1944) viewed the alcoholic’s personality as including a
pathological desire to pursue pleasure, narcissistic traits, low frustration tolerance, feelings of omnipotence, and poor reasoning skills.

In “Therapeutic Mechanisms of Alcoholism,” Tiebout (1944) discussed how Alcoholics Anonymous helped combat these personal shortcomings:

It is my belief that the therapeutic value of [the] Alcoholics Anonymous approach arises from its use of a religious or spiritual force to attack the fundamental narcissism of the addict…the individual experiences a whole new series of thoughts and feelings which are of a positive nature, and which impel him in the direction of growth and maturity…this group relies upon an emotional force, religion to achieve an emotional result, namely the overthrowing of the negative, hostile set of emotions and supplanting them with a positive set in which the individual no longer need maintain his defiant individuality…

(p. 473)

In “Psychology and the Treatment of Alcoholism,” Tiebout (1946) described working with 250 alcoholics at the Blythewood Sanatorium in Connecticut. He articulated a conception of the alcoholic’s mind in relation to the outside world:

In incipient alcoholism…with each stage of further development of the alcoholism more and more gaps are closed until the alcoholic seems to have erected what may be called a barrier which permits only a minimum of interplay between the inner self and the environment. (p. 214)

**Ernst Simmel**

Ernst Simmel was a German neurologist and psychologist best known for his contribution to psychoanalytic psychosomatics and war neuroses research (Speidel, 1996). Simmel created the first alcoholism inpatient rehabilitation units in Berlin and New York because he believed an
increase in alcohol and drug intake would take place in the aftermath of World War II, and the demand would necessitate new facilities (Loose, 2002). In his 1949 piece, “Alcoholism and Addiction,” Simmel provided psychological justification for this prediction:

Addictions offer a perfect subterfuge for the postwar ego, which finds itself hopelessly entangled in a conflict between frustrating realities and impulses—particularly aggression—from the id, the controlling power of the superego having been rendered incapable of intermediating. (as cited in Levin & Weiss, 1994, pp. 273–274)

Simmel also stated that psychological factors caused alcoholism:

That the need to drink alcoholic beverages serves one person as a means of escape from reality, whereas it serves another as a means of mastering reality, proves that the biochemical effect of alcohol is not the decisive factor for its use but the psychological effect which the ego derives from it. (as cited in Levin & Weiss, 1994, p. 274)

In his book *The Hidden Dimension*, Leon Wurmser (1978) emphasized the role fulfillment of aggressive wishes played in Simmel’s substance use theory, quoting Simmel from 1929:

Ultimately the person whom the toxin poisons in these patients is the person from whom the threat of castration emanates, i.e., in the deepest stratum the introjected object longed for yet hated: the mother, the great castrator of the past on the anal and oral levels. (p. 45)

Simmel also connected wish fulfillment with the urge to use: “The victim of a craving is a melancholic who makes his guardian superego drunk with the poison with which he murders the object in the ego” (as cited in Wurmser, 1978, p. 45).
Even before Freud’s *Dostoyevsky and Parricide*, Simmel spoke about gambling and gambling addiction, hypothesizing it as a regressive attempt to gain narcissistic supply. In one lecture, Simmel (1920) spoke of this origin:

The insatiable inordinate desire that will not rest in the endless vicious cycle until the loss becomes gain and the gain once more loss, originates in the narcissistic desire of the anal fantasies, to fructify himself, to devour his own excrement, gold, and to give birth to himself out of himself in immeasurable increase, replacing and suppressing his father and mother. (p. 353)

In 1949, Simmel voiced support of the self-help group Alcoholics Anonymous:

In studying a pamphlet of Alcoholics Anonymous, I was struck by the fact that the therapeutic principles employed in its psychotherapeutic endeavor correspond basically to psychoanalytic findings. This is not surprising because Alcoholics Anonymous was created by alcoholics for alcoholics and therefore originated from an unconscious awareness of the latent ID drives in alcoholism, and the tendency of the alcoholic ego to preserve itself against them. It cannot be a mere coincidence that the creator of Alcoholics Anonymous was a doctor who found a cure for himself by helping a fellow alcoholic to get cured. (as cited in Levin & Weiss, 1994, p. 288)

Simmel believed AA had therapeutic benefits rooted in traditional psychological beliefs, including the power of mass psychology to positively counteract alcoholics’ impulsive drives (Loose, 2002). Simmel saw “Alcoholics Anonymous as a defense and substitute formation…a new community spirit in a different but artificial society” (Levin & Weiss, 1994, p. 289). He believed collaboration between Alcoholics Anonymous and the psychoanalytic community offered the addict’s best chance to be cured (Levin & Weiss, 1994).
In handwritten notes attached to his “Alcoholism and Addiction” manuscript, Simmel spoke about the psychodynamics involved in the AA healing process: “The Alcoholic’s psychopathological formula of destroy and be destroyed is changed to save and be saved” (Levin & Weiss, 1994, p. 290). He asserted that the identification process in Alcoholics Anonymous was central to this work: “The Curer aims at becoming a healer through identification. Substitution of identification for addiction during abstinence makes the formulation of this new society possible. Devouring is replaced by identification with the group” (Levin & Weiss, 1994, p. 290).

**Summary**

This chapter summarizes psychodynamic theories on substance use and addiction from the early to mid-20th century. Initially, addiction was viewed similarly to other forms of psychopathology—the outcome of a patient’s difficulty managing sexual and aggressive impulses. Early psychoanalytic theorists described addiction as an oral regressive tendency connected to homoerotic impulses. Alcoholism was seen as a form of chronic suicide attempting to punish one’s parent for observed neglect.

As the century unfolded, ego-psychological formulations focused on the adaptive function of addiction. Psychoanalytic theories speculated on an addict’s perception of a drug’s benefits including mastering anxiety, controlling onset of psychosis, and functioning as a defense mechanism against perceived internal and external threats. The cycle of addiction was compared to that of manic depression, and tenets of what would later be known as the self-medication hypothesis were introduced.

Several psychodynamic theorists discussed ego deficits found in the addict as resulting from narcissistic disturbances of the ego. The deficits related to dysfunction in the addict’s
family of origin; drug use was seen as an attempt to restore the ego’s health. Grandiosity and pathological narcissism were identified as central dynamics in the addictive process, and addiction was labeled as a form of narcissistic regression.

Early object relational formulations described the addict’s inner world of representations. These object relations were identified as pathological, resulting from disruptions in the mother-infant unit. Theorists also explored the impact of disruptive family dynamics on the addict. Addiction was labeled a disease for the first time, and Alcoholics Anonymous was referenced as a support system in the self-help treatment community. The alcoholic’s distorted self-representation was presented, prompting exploration of the psychological factors causing alcoholism and fantasy role-playing in the addictive psyche.
Chapter 2:
Modern and Contemporary Psychodynamic Perspectives on Addiction

The objective of this chapter is to identify modern and contemporary psychodynamic theorists’ writings regarding the etiology of addiction. I will begin by discussing addiction from an ego psychology perspective that focuses on the adaptive functions of addiction while placing emphasis on the addicted persons’ struggle with affect tolerance. I will also include descriptions of the addicted persons’ fragile ego and the rigidity of their defenses.

I will then identify clinical writings from an object relations perspective. This will stress addicted persons’ difficulty integrating good and bad object relations and common representations of their fractured family dynamics. This section will highlight how pathological object relations contribute to engagement in addictive acts. It will also identify how disturbances in self-structure, formulated by maladaptive object relations development, lead to struggles in forming mature relationships.

As the chapter continues, I will examine addiction by using self-psychology theory, emphasizing how the addicted persons’ unmet developmental needs are caused by their failure to internalize selfobject functions as children. I will also introduce the self-medication hypothesis, which views addiction as a means to relieve psychological suffering, stressing the significance of an addict’s drug of choice. Then I will identify self-psychological principles that psychoanalytically inform addiction treatment and facilitate understanding of the effectiveness of Alcoholics Anonymous (AA).

Finally, I will address addiction using attachment theory by focusing on addiction as caused by addicted persons’ failure to form attachments with other human beings. I will describe
how addicts form attachments with their drug of choice and how this disconnects them from their internal and external worlds. I will also identify AA as useful in helping addicted persons form idealized attachments to the program and its values as well as increasing connectivity and dependence via interaction with group members.

**Modern and Contemporary Psychodynamic Theories**

**Addiction and Ego Psychology Theory**

This section identifies clinical writings describing addiction and addiction treatment from an ego psychology perspective. The ego represents the core of individuals’ personality, helping them negotiate between internal needs and the outside environment:

Ego psychology views people as born with innate capacity to function adaptively.

Individuals engage in a lifelong bio psychosocial development process in which the ego is an active, dynamic force for coping with, adapting to, and shaping the external environment. (Goldstein, 1995, xii)

In *Drug Dependence: Aspects of Ego Function*, Krystal and Raskin (1970) examined the personality structure of compulsive drug users, stating that drug use etiology is found in the “psychological structure and functioning of the human being” (p. 10). They believed the function of addiction is to manage overwhelming feelings and that addicts suffer from a defective stimulus barrier, making management of primitive and dominating affects challenging. Drug use is a “defense against affects,” allowing for the selective “numbing and blocking” of dangerous feelings (p. 73). Because of the addict’s vulnerability, “drugs are used to avoid impending psychic trauma in circumstances which would not be potentially traumatic to other people” (p. 31).
Krystal (1977b) believed addicts struggle with affect tolerance. He adopted the term “alexithymia” to label addicts who have difficulty naming, recognizing, and verbalizing emotions. Krystal considered alexithymia to be a precipitating cause of addiction; however, its severity varies among individual addicts.

In “Psychoanalytic Considerations of the Etiology of Compulsive Drug Use,” Wurmser (1974) hypothesized that the addictive cycle starts with patients experiencing a narcissistic crisis brought about by the superego’s harshness, resulting in decreased self-worth and increased anxiety. The narcissistic crisis emerges at “the point at which the conflicts and defects converge with a particular external situation and with the availability of the seeming means of solution: the drug” (p. 839). It includes “intense emotions like disillusionment and rage, depression, anxiety, in an actualization of a lifelong massive conflict about omnipotence and grandiosity, meaning and trust” (p. 826). The addict experiences threatening and overwhelming affects, and substance use helps individuals manage emotions such as pain and fear—giving users “manipulation and domination over one’s inner life” (p. 826). According to Wurmser, the main purpose of drug abuse is reduction or elimination of three affects: rage, shame, and abandonment.

Wurmser (1985) offered treatment recommendations consistent with ego psychology principles. He believed treatment should, in part, focus on an analysis of these defenses. He suggested coupling psychoanalytic treatment with self-help meeting attendance, supporting combination treatment that focused on each patient as an individual:

Most of all I would propose a future program which would go beyond confrontation of the individual with the lead symptom, go beyond the superficial view of looking at alcoholism or drug abuse as the disease, a program where the inner world is opened up…(as cited in Morgenstern & Leeds, 1993, p. 197)
Wurmser also believed that AA could be beneficial as an auxiliary program to traditional psychoanalysis.

In “Alcoholism, Borderline and Narcissistic Disorders,” Hartocollis and Hartocollis (1980) described addiction through an ego psychology formulation focused on defenses:

The fact that a person is addicted to alcohol indicates that his primary defenses have been weakened on one level, yet strengthened on another. Drinking comes to the rescue of a person whose basic mental mechanisms have begun to lose their adaptive power, being helpful not only by providing release from psyche pain (literally anesthesia), but by stimulating these mechanisms or defenses as well. (as cited in Levin & Weiss, 1994, p. 213)

Hartocollis and Hartocollis (1980) believed alcoholics struggle with expressing anger and denying sexual problems. Drinking is conducted in service of this denial: “Drinking serves the purpose of strengthening the denial of anger or of sexual impulses when the denial becomes weak and the anger or sexual impulse comes close to awareness” (as cited in Levin & Weiss, 1994, p. 213).

McDougall (1989) saw addiction as a defense mechanism against consciousness of pain, “a psychosomatic attempt to deal with distressful conflict by temporarily blurring the awareness of their existence” (p. 19). McDougall questioned the addict’s ability to handle heightened affect states. In Theatre of the Mind: Illusion and Truth on the Psychoanalytical Stage, McDougall (1985) wrote, “Such patients, because of their fragilities, were unable to contain and work through the powerful affect states that had been stirred up. Some would try to drown their feelings in addictive substances” (p. 155).
McDougall (1984) thought psychoanalytic treatment for the addict was useful but lengthy due to addicts’ defenses. She saw these defenses as contributing to addicted patients presenting a “psychic gap between their emotions and their mental representations” (p. 388). To McDougall, addicted patients “appeared pragmatic and factual, unimaginative and unemotional, in the face of important events, as well as in relationships with important people in their lives” (p. 388). Based on these findings, McDougall believed successful addiction treatment should reconnect addicts with their emotions, helping to create a renewed sense of authenticity, purpose, and self-identity.

Zinberg (1984) thought controlled drug users and non-controlled users differed in ego structure. He believed that the controlled user maintained a balanced ego; the non-controlled user struggled to maintain ego autonomy due to social isolation and drives produced by drug use. He described an addict’s environment as deprived of stimulus: “Accordingly, the addict has lost or been cut off from many sources of stimulus nutriment. He is alienated from his family and friends” (p. 181).

Khantzian (1981) described addicts as having ego function deficits. These deficiencies are related to self-care, relationship management, and affect tolerance (Director, 2005). The addict’s struggle to provide self-care is caused by compromised ego functions, such as “signal-anxiety, reality testing, judgment and synthesis,” and is the “result of failures to adopt and internalize these functions from the caring parents in early and subsequent stages of development” (Khantzian & Mack, 1983, pp. 227–228). Khantzian (1981) believed poor self-care functions caused by ego dysfunction leads the addict to have significant medical problems, difficulties obtaining and keeping employment, and a tendency to often engage in violent behavior.
In the tradition of ego psychology, Dodes (2009) stated addictive behavior is a displaced action, a defense mechanism against feelings of helplessness. For the addict, Displacements are psychologically necessary because taking a direct (non-displaced) action to respond to perceived helplessness (fighting back in some direct way) is usually inhibited as morally unacceptable or otherwise forbidden. The result of this is a compulsion to repeat the substitute action, which now carries the meaning and impetus to reverse helplessness. This final event is what is called the addiction. (p. 383)

Dodes believed that “Taking drugs is particularly suitable for the purpose of regaining a sense of control because drugs are an especially good way to choose one’s emotional state” (p. 382). In his view, drugs help individuals manage distressful emotions, acting as substitute action—the expression of aggressive drives that otherwise would not be permissible in society. They enable the individual to avoid dealing with psychologically painful affects or desires.

Ego psychology stresses the adaptive functions of addiction, asking what the addicted person has to gain from engaging in addictive behavior. In the next section, I will shift attention to object relations theory, focusing on addicted persons’ internal world of representations and their internalization of family dynamics.

Addiction and Object Relations Theory

This section identifies clinical writings describing addiction and addiction treatment through the lens of object relations theory. Describing the fundamental principle of object relations, British psychoanalyst Melanie Klein (1952/1975) wrote, “There is no instinctual urge, no anxiety situation, no mental process which does not involve objects, external or internal; in other words object relations are at the center of emotional life” (p. 53).
This theory centers on the relationships of “self” to “other” and the unconscious world of relationship representations located in individuals’ internal world. These representations of self and other are developed in childhood and maintained in adult relationships. Old object relations are repeated in adulthood in an effort to master them and expedite personal development.

Krystal (1977b) thought substance abusers suffered from pathological object relations. In “Self- and Object-Representation in Alcoholism and Other Drug Dependence,” Krystal (1977b) described the impact of pathological object relations on the addict: “He craves to be united with the ideal object, but at the same time dreads it. He thus becomes addicted to acting out the drama of fantasy introjection and separation from the drug” (p. 98). For Krystal, addicts’ disturbed object relations lead to disturbances in self-structure. Addicts feel ambivalent toward others because they have been let down by those who were suppose to nurture them (their parents).

In the discussion section of a paper written by several contemporaries called “Interactional Issues as Determinants of Alcoholism,” Hartocollis described the alcoholic’s instinctive needs: “It is rather obvious that the alcoholic behavior is determined by deeper instinctive needs, and these cannot be conceived as anything else than needs for object relations” (as cited in Steinglass, Weiner, & Mendelson, 1971, pp. 279–280). Hartocollis also identified similarities of alcoholic behavior and neurotic symptoms: “Alcoholic behavior like neurotic symptoms is determined by…unconscious and maladaptive object relationships” (as cited in Steinglass, Weiner, & Mendelson, 1971, p. 280).

In Borderline Conditions and Pathological Narcissism, Kernberg (1975) presented several object-related dynamics of addiction. The addict struggles with integrating good and bad object representation; drug use strengthens defensive splitting of these representations (Volkan, 1994). Drug use refuels the grandiose self in narcissism. It also replaces the all-good mother in
borderline personality disorder (Kernberg, 1975). Kernberg (1975) saw addiction as rooted in narcissistic disturbances caused by failures of parents in early caregiving. He believed addicts had similar personality structures as individuals with narcissistic and borderline personality disorders.

Wurmser (1978) thought early behavior of the addict’s family caused maladaptive object relations. This influences addiction development in which “symptom of drug taking on the child’s side is a derivative of the whole family’s attitude of inconsistency, self-centeredness, and, most importantly, of inner and outer dishonesty” (p. 277). Family lifestyles “vacillate between seductiveness and vindictiveness” (p. 276).

Wurmser labeled several additional commonalities found in families of drug-abusing patients, including overprotective parents and those preoccupied with their own successes. He stated, “Very often the parents themselves are deeply involved in using prescribed or not prescribed drugs and alcohol” (p. 277). Wurmser (1984) found that children often experience trauma in their outer reality, including “unusually severe real exposure to violence, sexual seduction, and brutal abandonment, and/or of real parental intrusiveness or secretiveness” (p. 253).

Blatt et al. (1984) found that opiate addicts struggle to form relationships “and therefore have selected an isolated mode for achieving the satisfaction and pleasures most people seek in intimate personal relationships” (p. 163). In comparison to the non-addicted population, Blatt et al. found opiate addicts have more significantly impaired object relation development.

McDougall (1985) believed the addict felt partially enslaved by the drug but internalized the addictive substance positively because it acted as protection against full-blown distress. She wrote, “The addictive object…is in the first instance invested as good, in spite of its sometimes
dire consequences…yet once absorbed the addictive substance is experienced as bad” (pp. 66–67). She also described the object relation pattern found in compulsive drug users’ histories:

One parent, usually the father, has died or left the family in the patient’s early infancy.

The mothers were frequently presented as overpossesive and over attentive while at the same time heedless of the child’s affective states. In other instances the mother seemed to have been psychologically absent because of depression or psychotic episodes. (p. 157)

McDougall believed the mother’s relationship with the infant is addictive, which leads to problematic object relations: “They encourage the babies to become dependent on them as an addict needs drugs, with total dependence on an external object—to deal with situations which should be handled by self regulatory psychological means” (p. 448).

Keller (1992) identified structural similarities between alcoholism and perversion that affected addicts’ object relations. In “Addiction as a Form of Perversion,” Keller (1992) described addictive substances as fetish objects:

In addiction, all the person’s energy, including sexual energy, becomes bound up by the relationship to the addictive substance until the person is no longer living in an object-related world. The function of transitional objects appears to be degraded into fetishism, resulting in a collapse of the ability to symbolize. The substance is used to achieve an omnipotent sense of illusory self-reliance and to deny realistic human dependency. (p. 225)

From an object relations perspective, Keller stated,

The addicted person uses the substance to manage and magically control multiple forms of anxiety and affect related to both interpersonal and intrapsychic situations, while the
fetishist uses a fetish object to relieve momentary castration anxiety so that sexual performance can occur. (p. 225)

The addict’s fetishistic substance use affects psychoanalytic psychotherapy’s role in addiction treatment:

This illusion precludes the development of a working alliance because the patient makes a primary emotional investment in the relationship to the substance…the space within which change can occur is constricted by the patient’s emotional investment in the closed relationship with the substance. (p. 227)

Director (2005) connected the addict’s maladaptive object relations to elements of omnipotence expressed in drug use:

Whatever the theoretical emphasis or nature of the source, all views of addictive disturbance that draw on object relations tacitly share a common belief: that the act of drug use appears as an omnipotent solution. Elements of omnipotence are self-evident in an act of chronic drug use itself. The mere act of getting high points to the seeming preeminence of the wish; the user’s drivenness attests to the fixity of intent; and the euphoria sought suggests an insistence on pleasure. (pp. 568–569)

Object relations theories on addiction stress how early maladaptive relationship representations affect an addicted person’s psyche and contribute to engagement in addictive acts. In the next section, I will discuss addiction and addiction treatment using the theory of self-psychology. This theory views addiction as a failed attempt at self-medication.

**Addiction and the Theory of Self-Psychology**

This section identifies clinical writings describing addiction and addiction treatment using the self-psychology theory. Founded by Heinz Kohut, self-psychology centers on an
individual’s subjective experiences. It is an extension of traditional psychoanalytic thought placing primary focus on self- and selfobject transferences. It proposes that attaining individual self-cohesion is the primary treatment goal in psychoanalytic psychotherapy (Ulman & Paul, 2006).

Self-psychology describes the self as an individual’s perception of their bio-psycho-spiritual identity in time and space (Kohut, 1984). Flanagan (2011) stated that the theory of self-psychology focuses on three concepts:

1) The importance of empathy not only as the main tool in clinical work but as the matrix within which all growth takes place, 2) the notion of the structure of the tripolar self, and 3) the existence and crucial role that selfobjects play in psychological development. (p. 165)

Selfobjects are persons or things physically existing outside the self, experienced as part of the self, and functioning in service of the self (Kohut, 1984). Self-psychology proposes that in order to achieve optimal mental health, an individual’s selfobjects needs must be met. The three most important selfobject needs that make this possible are the mirroring, idealization, and twinship functions. The mirroring need allows the infant to confirm her own specialness and establishes excitement for existence, and the idealization need allows the child to draw strength from a caregiver’s power and calmness (Goldstein, 1995). The twinship need helps individuals feel less isolated in the world by matching them up with another person like them (Levin, 2001).

In a 1959 paper entitled “Introspection, Empathy and Psychoanalysis,” Kohut wrote “addicts have to rely on drugs…as a substitute for (insufficient) psychological structure” (as cited in Ulman & Paul, 2006, p. 225). This insufficiency is caused by the self’s inability to fully
internalize and merge with self-objects during infancy and childhood. Addressing addiction specifically, Kohut (1977a) stated,

By ingesting the drug he [the addict] symbolically compels the mirroring self-object to soothe him, to accept him…the ingestion of the drug provides him with self-esteem, which he does not possess. Through the incorporation of the drug, he supplies for himself the feeling of being accepted and thus of being self-confident…. And all these effects of the drug tend to increase his feeling of being alive, tend to increase his certainty that he exists in the world. (p. vii)

The self becomes fragmented and vulnerable to anxieties. In this state, it is not surprising the addict is drawn to drugs or alcohol. Substances are ingested to simultaneously calm negative symptoms and create greater self-cohesion.

Kohut (1977b) spoke to this point in The Restoration of the Self. Referencing an addict, he wrote,

It is the structural void in the self that the addict tried to fill…it is the lack of self-esteem of the unmirrored self, the uncertainty about the very existence of self, the dreadful feeling of the fragmentation of self that the addict tries to counteract by his addictive behavior. (as cited in Ulman & Paul, 2006, p. 197)

Khantzian (1978), building off of Kohut, believed addicted persons failed to internalize self-care functions from early caregivers:

I shall stress how much of the addict’s self-disregard is not so much consciously or unconsciously motivated, but more a reflection of deficits in self-care functions as a result of failures to adopt and internalize these functions from the caring parents in early and subsequent phrases of development. (p. 194)
Khantzian (1997) developed the self-medication hypothesis, the theory that addiction is conducted to reduce psychological suffering and that an addict’s drug of choice is psychopharmacologically significant. Khantzian (1997) viewed substance abuse in self-psychological and ego-psychological terms, focusing on the addict’s deficits rather than conflicts. In “The Self-Medication Hypothesis of Addictive Disorders,” Khantzian (1985) stated, “The drugs that addicts select are not chosen randomly. Their drug of choice is the result of an interaction between the psychopharmacologic action of the drug and the dominant painful feelings with which they struggle” (p. 1259). He also provided an example of his position: “Narcotic addicts prefer opiates because of their powerful muting action on the disorganizing and threatening affects of rage and aggression. Cocaine has its appeal because of its ability to relieve distress associated with depression, hypomania, and hyperactivity” (p. 1259). For Khantzian, “Addicts are attempting to medicate themselves for a range of psychiatric problems and emotional states” (p. 1263).

In “Alcoholics Anonymous and Contemporary Psychodynamic Theory,” Khantzian and Mack (1989) used self-psychology principles to underscore the necessity of building interdependence and how AA can help improve addicts’ self-governance skills. They believed AA “provides a context for examination, containment, and/or repair of core vulnerabilities involving affects, self regulation, and self governance” and is filled with “practical tools, suggestions, guiding slogan, and an expanding network of relationships,” helping the alcoholic with self-governance (as cited in Levin & Weiss, 1994, p. 348). This self-governance is formed in participation with others in AA:

Alcoholics Anonymous capitalizes on this process, recognizing that certain group activities and processes profoundly influence a person’s capacity to govern himself, often
far more than is possible in an individual psychotherapeutic relationship, and still more so when it occurs in a content of religious experience and values. (as cited in Levin & Weiss, 1994, p. 350)

In their work together, Khantzian and Mack (1989) found that AA addresses participants’ “character defects” in step work and group meetings. Character defects “develop in a person’s character structure as a function of environmental deprivation, inconsistency, trauma and neglect” (as cited in Levin & Weiss, 1994, p. 351). These character defects referred to in AA more than any other aspect of a person’s life seem to refer to the qualities and flaws in personal organization associated with narcissism and narcissistic development, that is, the aspect of life having to do with self-love. (as cited in Levin & Weiss, 1994, pp. 352–353)

Khantzian (2007) supported AA, viewing the program as having specific characteristics uniquely designed to treat addicts’ needs.

In their book The Self Psychology of Addiction and Its Treatment: Narcissus in Wonderland, Ulman and Paul (2006) stated that using drugs and alcohol are selfobject experiences. Using the self-psychological perspective, they defined three categories of addicts: manic addict, depressive addict, and manic-depressive addict. In the manic addict, substances numb the pain of a fragmented self. The depressive addict uses substances to inflate self-experiences. For the manic-depressive addict, substances relieve anxiety and stimulate power of the self.

In “Addiction as a Psychological Symptom,” Dodes (2009) wrote that it is “the narcissistic rage at helplessness that gives addiction its most significant clinical properties” (p.
This is the emotional drive behind addiction; use of the phrase “narcissistic rage,” popularized by Heinz Kohut in the early 1970s, was purposeful:

The extent of this rage corresponds to the severe narcissistic injury inherent in overwhelming helplessness, and it is accurately called “narcissistic rage.” Notably, narcissistic rage has specific characteristics which are identical to those of addiction….

Substituting the word “addiction” for the term “narcissistic rage” in this description creates a near-perfect clinical picture of addiction. (p. 383)

Dodes believed that “The specific forms of helplessness are highly individualized and always reflect what is most emotionally important to that person” (p. 391). He described several causes of helplessness in the addict: “They include developmentally early deprivation/attachment failures, conflicts around control and competitiveness with corresponding feelings of humiliation and narcissistic injury (shame), and indeed every variation and level of psychopathology” (p. 382).

Levin (2001) applied Kohut’s self-psychological perspective to psychoanalytic addiction treatment. Levin’s book *Therapeutic Strategies for Treating Addiction* offered insight into Kohut’s work and the psychotherapist’s role in treating the addicted client. He believed that the therapist’s chief task is deciphering what type of selfobject transference the client needs at specific treatment intervals. From a self-psychology perspective, Levin believed the clinician operates as part of the addict’s missing selfobject functions. Through transmuting internalization, the addict’s psychic structure will be strengthened, and hopefully she will then seek out relationships that lead to continued nurturing selfobject experiences.

Using self-psychological concepts, Flores (2004) supported psychoanalyst Jerome Levin’s theories on AA and self-object functions:
AA provides a predictable and consistent holding environment that allows addicts and alcoholics to have their selfobject needs met in a way that is not exploitative, destructive, or shameful…. Because of unmet developmental needs, addicts or alcoholics have such strong and overpowering needs for human responsiveness they feel insatiable and shamed by their neediness. (p. 97)

The theory of self-psychology states that addiction is primarily rooted in the addicted persons’ failure to internalize selfobject experiences and self-care functions from their primary caregiver during infancy. Treatment, be it through AA or psychoanalytic psychotherapy, requires that these selfobject needs be met.

In the next section I will discuss addiction using the principles of attachment theory. Attachment theory views addiction as being caused by an inability to form healthy attachments with other human beings.

**Addiction and Attachment Theory**

This section identifies clinical writings describing addiction and addiction treatment from an attachment theory perspective. It focuses on the work of Karen Walant and Philip Flores.

John Bowlby developed attachment theory by observing children in their natural environments (Flores, 2004). Bowlby studied the science of motherly love, believing the success of future relationships (attachments) is dependent on the relational bond between the infant and his primary caregiver (Walant, 1995).

This perspective shifts from Freud’s drive theory to an attachment and relational approach focused on how unmet attachment needs affect an addicted person’s psyche. Flores (2001) described attachment theory as articulated by Bowlby:
Attachment theory holds firmly to the position that the pains, joys and meanings of attachment cannot be reduced to a secondary drive. Attachment is recognized as a primary motivational force with its own dynamics, and these dynamics have far-reaching and complex consequences. (p. 65)

Attachment theory explains how the child–adult relationship emerges and how this relationship directly influences adult relationships. In short, children who grow up with secure attachments in their youth tend to have secure attachments in adulthood; conversely, children who grow up in insecure environments in their youth tend to have insecure attachments in adulthood. Unmet childhood attachment needs lead to adults attaching to destructive and dissatisfying relationships. Since the child with unmet attachment needs has only experienced insecure relationships, he is unconsciously attracted to dissatisfying connections (Kohut, 1984).

Believing that devaluation of attachment needs throughout the life cycle contributes to addiction, Walant (1995) critiqued modern-day emphasis on autonomy:

The 20th-century emphasis on self-reliance and individuation has greatly affected the psychological conditions most frequently requiring psychotherapeutic treatment later in life, including personality disorders and addiction…. Our society’s longstanding denial of merger phenomenon throughout the life cycle has actually increased the likelihood of personality disorders and addiction, precisely because autonomy and independence have been encouraged at the expense of attachment needs. (pp. 1–2)

Walant (1995) considered addiction to be caused by individuals’ unmet attachment needs. She believed parents of addicts often ignore their empathetic parental instincts, and this normative abuse creates adults who feel detached from the outside world. For these individuals,
“The transformational aspects of drugs and alcohol, then, help the user to feel connected and indeed immersed in his life and his relationships” (p. 275).

In “Addiction as an Attachment Disorder,” Flores (2001) wrote of an “inverse relationship between addiction and healthy interpersonal attachment” (p. 64). Certain individuals are susceptible to developing substance use disorders because of intra-psychic conflicts or developmental deficiencies. Afflicted by weakened capacities for attachment, their predicament is made worse by substance use:

Because of the potent emotional euphoric “rush” that alcohol and drugs produce, they are powerfully reinforcing and inhibiting the more subtle emotional persuasions in a person’s life. Consequently, the vulnerable individuals’ attachment to chemicals serves both as an obstacle to and as a substitute for interpersonal relationships. (p. 64)

Flores (2001) proposed that addicts struggle to negotiate transactional demands of interpersonal relationships. Addicts’ relationships are “exploitative, masochistic or sadomasochistic,” and drug use helps by “providing temporary relief by helping lubricate an otherwise cumbersome inadequacy and ineptness in their interpersonal attachment styles” (p. 64). This solution is short-lived—chronic substance use decimates the “neuropsychology functioning and erodes existing structure” (p. 64). Flores believed that this solution’s end result leaves the addict unable to manage relationships and searching for more drugs to compensate.

In his book Addiction as an Attachment Disorder, Flores (2004) described how attachment theory informs addiction treatment:

Addiction from an attachment theory perspective holds one basic and simple premise about treatment: until substance abusers develop the capacity to establish mutually satisfying relationships they remain vulnerable to relapse and addiction. To succeed in
treatment, the addicted individual must learn how to establish healthy relationships. (p. 35)

Flores believed successful treatment necessitates the reparation of an addict’s self-structure. He believed addicts avoid attachment needs; instead of forming humanizing relationships with others, they form dehumanizing relationship with drugs. But Flores also found that “Close interpersonal contact can provide an effective alternative to drugs as a means of altering and stabilizing one’s neurophysiology” (p. 6).

Flores (2004) proposed that addicts could form idealized attachments to the AA program, prompting a “reparative experience if the substance abuser internalizes the admired values expressed in the philosophy of the program” (p. 92). These values are in “direct confrontation with the tenants held by the drug and alcoholic subculture”; when alcoholics start idealizing AA program values, they become “less enamored with drinking and drug use” and “develop a healthy dependence on those they idealize” (p. 92). Usually alcoholics find members of AA to be more reliable and caring than those in their drug culture or their neglectful parents. For AA members, this may ultimately be the most attractive and reparative feature of the program.

Attachment theorists believe addiction is caused by addicted persons’ inability to foster connections and dependence. Through the perspective of attachment theory, the primary focus of addiction treatment should be helping addicted persons learn to trust other human beings.

Summary

This chapter identifies modern and contemporary psychodynamic writings from the schools of ego psychology, object relations, self-psychology, and attachment theory.

Discussing addiction using ego psychology theory includes examining it as an adaptation, a defense against addicted persons’ difficulties with affect tolerance. Addiction is
conceptualized using an ego psychology framework focused on addictive behavior as a defense against consciousness of psychic pain and as a displaced action in response to feelings of helplessness and aggression. It highlights the fragility of the addicted persons’ egos including struggles with ego autonomy and ego deficits. Treatment recommendations include analyses of the addicted persons’ inner world and examining the rigidity of their defenses and enhancement of self-knowledge.

The chapter then explores addiction from an object relations theory perspective. It addresses how early relationship representations affect addicted persons’ psyches and contribute to engagement in addictive behavior. The struggle of addicts in integrating good and bad object representations is presented, most relevantly in their seemingly contradictory feelings regarding substance use. The addicted persons’ family dynamics are described as inconsistent, unstructured, and dishonest, often including exposure to violence. Similarities are drawn between addiction and perversion, with addictive substances described as potential fetish objects. The omnipotent feelings an addicted person experiences engaging in drug use and its connection to maladaptive object relations are also recognized.

Addiction is then discussed using the theory of self-psychology, focusing on addicted persons’ reliance on drugs as substitution for deficits in psychological structures. The etiology of addiction is presented as rooted in infants’ inability to internalize the selfobject functions of idealization, mirroring, and twinship needs. Addicts’ weakened self-care functions are explored, emphasizing their struggles in anticipating danger and navigating interpersonal relationships. The self-medication hypothesis is also defined, which is the theory that addiction is conducted to reduce psychological suffering and that an addict’s drug of choice is psycho-pharmacologically significant. Self-psychological principles are used to provide clinical rationale for the
effectiveness of Alcoholics Anonymous with a focus on fostering interdependence, building self-governance, addressing character defects, and helping addicted persons meet previously unmet selfobject needs. Narcissistic rage at one’s own helplessness is presented as one of the principle drives behind addictive acts.

The chapter concludes by describing addiction from the perspective of attachment theory, presenting how the devaluation of attachment needs throughout the life cycle contribute to the onset of addiction. It describes how addicted persons, lacking connectivity and dependence, use drugs to feel linked to their internal and external worlds. Attachment theory is presented as informing addiction treatment by emphasizing the development of addicted persons’ capacity to develop healthy interpersonal relationships. Rebuilding self-structure is highlighted through the replacement of addicted persons’ dehumanizing relationship with drugs with the humanizing relationships of other people. AA is described as helping addicted persons form idealized attachments to the program and healthy attachments to group members, standing in sharp contrast to the culture surrounding their addictive acts.
Chapter 3:
The Origins of Alcoholics Anonymous

The objective of this chapter is to identify the origins of Alcoholics Anonymous (AA) and the intersecting chains of personal relationships and events leading to its creation. Regarding the group’s origin, AA researcher William White (1998) wrote,

The historical thread that leads to the birth of the largest fellowship of recovered alcoholics in history begins in Zurich, Switzerland, winds through Oxford Group Meetings in New York City and Akron, Ohio; and settles on a meeting between two desperate men struggling to find a way out of the alcoholic labyrinth. (p. 127)

I will begin by discussing principles of the Oxford Group (OG), an evangelical Christian fellowship credited with influencing the philosophies and practices of AA. I will then describe Rowland Hazard’s and Ebby Thacher’s histories with alcoholism, their involvement in the OG, and how their brief successes in treating alcoholism via OG participation led to AA cofounder Bill Wilson’s involvement in the fellowship.

The chapter continues, discussing Bill Wilson’s family history and struggles with alcoholism, identifying how alcoholism negatively affected Wilson’s personal and professional life. I will describe Wilson’s failed attempts at sobriety at the Charles B. Towns Hospital, a substance abuse treatment center, under the care of Dr. William Duncan Silkworth. I will then explore the historic November 1934 meeting between Ebby Thacher and Bill Wilson. I will identify why Wilson credited this meeting with beginning his recovery from alcoholism and inspiring the core healing component of AA. I will also describe Wilson’s spiritual conversion stemming from his initial OG meeting and his last stay at Towns Hospital.
The chapter continues, describing Wilson’s failed early attempts to treat other alcoholics. I will include a discussion of Wilson’s early work via the OG and their substantially different philosophical approaches to alcoholism treatment.

I will then discuss AA cofounder Dr. Robert (Dr. Bob) Smith’s history with alcoholism and its impact on his medical practice. This includes his failed attempts at sobriety via detox and OG participation and the severity of his alcoholism upon first meeting Bill Wilson.

The chapter continues, describing the impact of the May–June 1935 meetings between Bill Wilson and Dr. Bob. Bill helped Dr. Bob gain lasting sobriety, and their meetings marked the creation of the Alcoholics Anonymous (AA) fellowship. The chapter concludes with identifying key historical moments in the beginning of AA and citing statistics supporting that AA is an internationally recognized self-help fellowship.

The Oxford Group

AA was greatly influenced by the Oxford Group (OG), an evangelical Christian fellowship flourishing in the United States and England in the early 20th century. In Not-God: A History of Alcoholics Anonymous, Kurtz (1991) wrote, “It was a non-denominational, theologically conservative attempt to recapture the spirit of what its members understood to be primitive Christianity” (p. 9). OG members focused on abolishing sin from daily life and having members engage in shared transformational spiritual experiences.

Under the name “The Layman With a Notebook” (1934), the OG described its organization:

You cannot belong to the Oxford Group. It has no membership list, subscriptions, badge, rules, or definite location. It is a name for a group of people who, from every rank,
profession, and trade, in many countries, have surrendered their lives to God and who are endeavoring to lead a spiritual quality of life under the guidance of the Holy Spirit. (p. 6)

The OG also identified principles informing their beliefs: “The Oxford Group has four points, which are the keys to the kind of spiritual life God wishes us to lead. These points are: 1. Absolute Honesty. 2. Absolute Purity. 3. Absolute Unselfishness. 4. Absolute Love” (The Layman With the Notebook, p. 8).

The group’s focus on members sharing their experiences with one another, making amends, taking self-inventory, and engaging in prayer later became staples of Alcoholics Anonymous. Describing the group’s link to AA literature, David Patton (2004) wrote,

The Oxford Group was the basis for all Twelve-Step Groups, and much of the early Alcoholics Anonymous literature is based directly on Oxford Group teachings. In fact all of the AA authors were or had been members of the Oxford Groups. The AA writings reflect the shift in purpose from redemption from sin to recovery from alcohol. (p. 4)

In Alcoholics Anonymous Comes of Age, AA cofounder Bill Wilson (1957), under the name “Bill W.,” supported this position: “Early AA got its ideas of self-examination, acknowledgement of character defects, restitution for harm done, and working with others straight from the Oxford Groups and directly from Sam Shoemaker, their former leader in America, and nowhere else” (p. 39). Several OG members struggled with alcoholism, and their interactions with each other led to a chain of events that resulted in the creation of Alcoholics Anonymous.

The Influence of Rowland Hazard on Bill Wilson

Rowland Hazard was a successful Rhode Island businessman and self-identified alcoholic. He had aggressively attempted to treat his alcoholism with limited success. In 1926, he
traveled to Zurich, Switzerland, seeking treatment from the Swiss psychiatrist Carl Jung. Hazard then went home, after close to a year of treatment, hopeful that his drinking problem was solved. He quickly relapsed and returned to Zurich in December 1927 for additional treatment (White, 2005).

Bill Wilson (1968) published a 1961 correspondence with Jung in which Rowland Hazard’s intervention with him was revealed:

My recollection of his account of that conversation is this. First of all, you frankly told him of his hopelessness, so far as any further medical or psychiatric treatment might be concerned…. When he then asked you if there was any other hope, you told him that there might be, provided he could become the subject of a spiritual or religious experience—in short, a genuine conversion. (pp. 26–27)

Wilson believed Jung’s advice influenced AA philosophy: “This candid and humble statement of yours was beyond doubt the first foundation stone upon which our society has since been built” (pp. 26–27).

Hazard moved to New York City in January 1931 and joined the Oxford Group American headquarters. He maintained sobriety for several years, receiving “the conversion experience that released for the time being his compulsion to drink” (Wilson, 1968, pp. 26–27). In 1945, Hazard died from an alcohol-related illness but not before introducing his friend Ebby Thacher to the Oxford Group.

The Influence of Ebby Thacher on Bill Wilson

Ebby Thacher was born into an influential political family in Albany, New York. In high school he struggled academically, and his parents decided to enroll him at Burton and Burr Seminary, an independent boarding school in Manchester, Vermont. Over the next decade his
struggles continued, and by age 21 Thacher was a full-fledged alcoholic. After his parents’ sudden deaths and the loss of their family fortune, Thacher’s drinking spiraled out of control: he was arrested three times while intoxicated, including once for crashing his car into a house (Mel, 1997; White & Kurtz, 2008).

In August 1934, OG members contacted Thacher after his third arrest, one of whom was his friend Rowland Hazard. The OG members convinced the court to parole Thacher, and he was placed under Hazard’s care (Kurtz, 1979). In early November 1934, Hazard taught Thacher the power of one alcoholic talking to another and how spiritual conversions could help an alcoholic maintain sobriety. With Hazard and the OG’s support, Thacher achieved brief sobriety.

Like Hazard, Thacher struggled with alcoholism for the rest of his life, dying from a stroke at age 69 in 1961. His significant contribution to AA occurred in late November 1934, when, fresh off of several months of Oxford Group-inspired sobriety, he knocked on Bill Wilson’s door (Mel, 1997; White & Kurtz, 2008).

**Bill Wilson, the Cofounder of Alcoholics Anonymous**

Bill Wilson was born in Dorset, Vermont, in 1895. His father, Gilman Wilson, deserted his family in 1905; his mother, Emily Wilson, moved to Boston shortly afterward. Wilson and his sister Dorothy stayed in Vermont, living with their maternal grandparents, Fayette and Ella (Thomsen, 1975). Kurtz (1991) described Wilson spending his childhood failing to connect with his Grandpa Fayette, who, compared to Gilman, was a “taciturn and introverted man, a too quiet person” (p. 10). Wilson had few friends, and his high school love Bertha Banford died suddenly following her “surgery at (a) Fifth Avenue hospital” (p. 12).

Wilson’s first alcohol drink occurred in 1917 while he was enrolled in the army as a second lieutenant stationed in Fort Rodman, Massachusetts (Bluhm, 2006). Over the next decade
Wilson became a heavy drinker. He also became a wealthy Wall Street stockbroker, and in 1918 he married his sweetheart, Lois Burnham. His life changed when he lost all his money in the 1929 stock market crash (Cheever, 2004). Wilson coped with his financial stressors by increasing his drinking:

Liquor ceased to be a luxury; it became a necessity. “Bath-tub” gin, two bottles a day, and often three, got to be the routine…. I began to waken very early in the morning shaking violently…. A tumbler full of gin followed by half a dozen bottles of beer would be required if I were to eat any breakfast. (Alcoholics Anonymous, 2001, p. 5)

In 1929, Wilson, aged 34, was living with his wife at her parents’ house in Brooklyn, New York. Over the next year, his life unraveled: “The house was overtaken by the mortgage holder, my mother-in-law died, my wife and father-in-law became ill” (Alcoholics Anonymous, 2001, p. 5). He had no “real employment for five years” and was an “unwelcomed guest at brokerage places” (Alcoholics Anonymous, 2001, p. 4). Potential business opportunities presented themselves but were quickly spoiled by a “prodigious bender and the chance vanished” (Alcoholics Anonymous, 2001, p. 5).

From 1933 to 1934, Wilson was hospitalized four times at Towns Hospital on the Upper West Side of Manhattan (Cheever, 2004). He was under the care of the medical chief, Dr. William Duncan Silkworth, who believed alcoholism was a physical allergy and mental obsession, a concept Wilson would later adapt for AA. Dr. Silkworth believed alcoholism was a disease and not a failure of will. Still, at this time, Dr. Silkworth’s theories could not help Wilson abstain from alcohol (Kurtz, 1991).

**When Ebby Met Bill**
In late November 1934, Ebby Thatcher arrived at 182 Clinton Street in Brooklyn, New York, hoping to spread the Oxford Group message to his friend Bill Wilson (Thomsen, 1975). Wilson had attended high school with Thacher in Vermont, and they had frequently engaged in drinking binges in the following decades. Wilson was happy to see him, expecting their past drinking escapades to continue:

I pushed a drink across the table. He refused it. Disappointed but curious, I wondered what had got into the fellow. He wasn’t himself. “Come, what’s all this about?” I queried. Ebby looked straight at me. Simply, but smilingly, he said, “I’ve got religion.”

(Alcoholics Anonymous, 2001, p. 11)

Ebby Thacher described to Bill Wilson how a spiritual conversion had helped him quit drinking:

But my friend sat before me, and he made the point-blank declaration that God had done for him what he could not do for himself. His human will had failed. Doctors had pronounced him incurable…. Then he had, in effect, been raised. (Alcoholics Anonymous, 2001, p. 11)

Wilson was not a religious man (Alcoholics Anonymous, 2001), saying, “I honestly doubted whether the religions of mankind had done any good,” to which Thacher responded, “Why don’t you choose your own conception of god?” (p. 12). This concept changed Wilson’s relationship with God; he now thought, “It was only a matter of being willing to believe in a power greater then myself” (p. 12).

In 1966, Wilson spoke at Thacher’s funeral, where he described this meeting’s impact on him:
On a chill November afternoon in 1934 it was Ebby who had brought me the message that saved my life. Still more importantly, he was the bearer of the Grace and of the principles that shortly afterward led to my spiritual awakening. (Wilson, 1966)

Ebby’s message of faith would become an integral factor in helping Wilson eventually maintain sobriety. It would also become the spiritual underpinning of the Alcoholics Anonymous fellowship.  

The Spiritual Conversion of Bill Wilson

For several weeks after meeting with Ebby, Wilson’s drinking continued. Then, in December 1934, an intoxicated Wilson attended a meeting at the Oxford Group American headquarters at Reverend Sam Shoemaker’s Calvary Rescue Mission (Bluhm, 2006). Wilson observed alcoholics like him and became inspired. In My Name Is Bill: Bill Wilson: His Life and the Creation of Alcoholics Anonymous, Cheever (2004) described the meeting:

After a few hymns and prayers, the preacher called for all those who had been saved by Jesus to come to the rail of the church…. Bill jumped up and started forward. Half-drunk, he launched into a testimonial about salvation and the way he had given his life to god.

(p. 117)

The meeting ended, and Wilson walked right past the 23rd Street bars without stopping in for a drink. Wilson and his wife spent the evening discussing how his drinking problem had been solved; however, when morning came, the drinking resumed:

For three days, days of internal struggle and bleak futility, Bill Wilson lay abed at home, unable to eat, drinking only enough to stave off the pin of withdrawal. Suddenly on an impulse, with no clear plan beyond “more thinking,” Wilson decided that he could figure this all this out more sharply if he dried out. (Kurtz, 1991, p. 19)
On December 11, 1934, Wilson checked into Towns Hospital under Dr. Silkworth’s care (White & Kurtz, 2008). At Towns, Wilson claimed he had a spiritual experience that cured his obsession with alcohol: “I felt lifted up, as though the great clean wind of a mountain top blew through and through. God comes to most men gradually, but His impact on me was sudden and profound” (Alcoholics Anonymous, 2001, p. 14). As Wilson’s despair lifted, the seeds of AA grew: “While I lay in the hospital the thought came that there were thousands of hopeless alcoholics who might be glad to have what had been so freely given to me” (Alcoholics Anonymous, 2001, p. 14). He would spend the rest of his lifetime building a fellowship committed to this objective.

**Bill Wilson’s Early Attempts to Help Alcoholics**

Wilson was discharged from Towns Hospital and began spending time at the Oxford Group. In *Bill W.: A Biography of Alcoholics Anonymous Co-Founder Bill Wilson*, Francis Hartigan (2001) wrote,

Bill emerged from Towns armed with enthusiasm, energy and determination to succeed. Unfortunately he had no experience in trying to convince another alcoholic that he should, or could, quit drinking. For Bill, the Oxford Group was the place to learn. (p. 67)

The OG believed Wilson’s dramatic spiritual conversion made him an attractive spokesman for its group, and he was “frequently called on to give witness at New York Area meetings” and “to travel to other cities along the eastern seaboard to speak at OG events” (p. 67). Still, Wilson and the OG had their differences. The group saw drinking alcohol, smoking cigarettes, and womanizing as sins to be abolished. Wilson “did not see drinking as a sin, and did not share the OG’s view of human failings, either” (p. 68). Wilson wished to focus on alcoholism rather than abolishing sin.
In 1935, OG members began meeting at Wilson’s home in Brooklyn (Cheever, 2004). These meetings showed Wilson that “alcoholics struggling against their obsession seemed to do better if they spent time with others engaged in the same struggle” (Kurtz, 1991, p. 25). But the results were poor. Wilson stayed sober while other OG members did not. The OG religious principles, combined with discussions about Wilson’s spiritual experience, had not helped fellow alcoholics stay sober. Meanwhile, Wilson’s wife, Lois, was supporting the family, which created tension within the household (Cheever, 2004; Thomsen, 1975). Wilson began to consider the consequences of his new missionary lifestyle.

In early May 1935, Wilson received an opportunity to work on a business venture in Akron, Ohio. Shortly after he arrived in Akron, the venture collapsed (Cheever, 2004; Thomsen, 1975). On May 11, 1935, at the Mayflower Hotel in Akron, Wilson feared he might drink:

His self-pity and resentment began to rise. He was lonely…. Now began the personal crisis that was to set in motion a series of life-changing events for Bill. There was a bar at one end of the lobby, and Bill felt himself drawn to it … the idea was loaded with danger…. For the first time in months, Bill had the panicky feeling of being in trouble.

(Alcoholics Anonymous, 1984, pp. 135–136)

Wilson “suddenly realized that in order to save himself he must carry his message to another alcoholic” (Alcoholics Anonymous, 2001, p. xvi). That alcoholic was Dr. Robert (Dr. Bob) Smith, an Akron-based proctologist. Their meetings from May to June 1935 are credited as the official start dates of Alcoholics Anonymous (White & Kurtz, 2008).

**Dr. Bob, the Other Cofounder of Alcoholics Anonymous**

In 1879, Robert Holbrook Smith was born to parents Judge and Mrs. Walter Perrin Smith in St. Johnsbury, Vermont (Alcoholics Anonymous, 1980b; Mel, 1997). He grew up in a
religious household and attended Sunday school five days per week, which, he described, “had the effect of making me resolve that when I was free from parental domination, I would never again darken the doors of a church” (Alcoholics Anonymous, 2001, p. 12).

Smith enrolled at Dartmouth College, where he rebelled against his parents: “I was graduated ‘summa cum laude’ in the eyes of the drinking fraternity, but not in the eyes of the Dean” (Alcoholics Anonymous, 2001, p. 172). He then attended Rush Medical School in Chicago, where “his life in school became one long binge after another, and he was no longer drinking for the sheer fun of it” (Alcoholics Anonymous, 2001, p. 25). In Chicago, Smith experienced physical tremors and accompanying symptoms associated with alcoholism. In 1910, facing expulsion, he managed two semesters of sobriety and graduated (Alcoholics Anonymous, 1980b).

Dr. Bob, as he was now known, moved to Akron, Ohio, and established himself as a respected physician. He interned at a renowned local hospital and maintained a practice in the city’s downtown district. Soon he developed a chronic stomach problem and “discovered that a couple of drinks would alleviate my gastric distress, at least for a few hours at a time” (Alcoholics Anonymous, 2001, p. 28). His drinking spiraled, and from 1910 to 1914 he was admitted to detox at least 12 times. In 1914, he received a court order to stay in bed for two months under supervision. This helped him stay sober for 1 year, and on January 25, 1915, Dr. Bob married his wife, Anne Ripley, in Chicago (Kurtz, 1991). Over the next 3 years, Dr. Bob maintained sobriety. His practice grew, and in 1918, his son, Robert, Jr., was born (Alcoholics Anonymous, 1980b).

The pressure of his new family and growing practice increased, and Dr. Bob’s drinking subsequently resumed. Over the next 15 years, his alcoholism became increasingly obvious
(Kurtz, 1991). In 1933, the impact of the Great Depression and Dr. Bob’s frequent absence from work threatened his family’s financial security. His wife, Anne Ripley, brought Dr. Bob to an Oxford Group meeting, which had established a substantial presence in the Akron community.

Dr. Bob observed the members: “They spoke with great freedom from embarrassment, which I could never do, and they seemed more at ease on all occasions” (Alcoholics Anonymous, 2001, p. 178). Despite appreciation for the members’ straightforwardness, Dr. Bob recalled that “I was self-conscious and ill at ease most of the time, my health was at the breaking point, and I was thoroughly miserable” (Alcoholics Anonymous, 2001, p. 178). For the next 2.5 years, he regularly attended OG meetings but drank every night. In May 1935, his life changed after meeting Bill Wilson at the Mayflower Hotel (Thomsen, 1975).

When Bob Met Bill

Wilson reached out to local OG participants, hoping to find an alcoholic to help. Henrietta Seiberling referred Wilson to Dr. Bob Smith. On May 13, 1935, Wilson called Dr. Bob, and they met that same day at the Mayflower Hotel (Cheever, 2004; Thomsen, 1975). In their account of the event, White and Kurtz (2008) wrote,

The call from the Mayflower Hotel was the first incident in AA history in which an alcoholic picked up a telephone rather than a drink, affirming the potential of replacing dependence upon a drug with interdependence between members of a recovering community. This event also set the basic relationship within AA as one in which no member could claim moral superiority over another. (p. 7)

Wilson described to Dr. Bob his alcohol history, meeting with Ebby Thacher, and Dr. Silkworth’s hypothesis that alcoholism was a physical allergy and mental obsession (Cheever, 2004). Wilson’s words affected Dr. Bob:
He gave me information about the subject of alcoholism, which was undoubtedly helpful. Of far more importance was the fact that he was the first living human with whom I had ever talked, who knew what he was talking about in regards to alcoholism from actual experience. In other words, he talked my language. He knew all the answers, and certainly not because he had picked them up in his readings. (Alcoholics Anonymous, 2001, p. 180)

After the talk Wilson thanked Dr. Bob, stating, “I needed you, Bob, probably a little more than you’ll ever need me. So, thanks a lot for hearing me out. I know now that I’m not going to take a drink, and I’m grateful to you” (Alcoholics Anonymous, 2001, p. 29).

For the next three weeks, Bill lived at Dr. Bob’s house, helping him maintain sobriety. Bill returned to New York, and in early June Dr. Bob attended a medical convention in Atlantic City and relapsed. Bill returned to Akron and helped Dr. Bob taper off from alcohol and avoid physical tremors. On June 10, 1935, Dr. Bob drank for the last time. This is considered to be the founding date of Alcoholics Anonymous (Cheever, 2004; Hartigan, 2001; Kurtz, 1991).

And the Rest Is History

Bill Wilson and Dr. Bob Smith would establish first-generation Alcoholics Anonymous groups in New York and Akron. These groups would be founded on the principles of one alcoholic helping another and the need for alcoholics to take sobriety one day at a time. From 1935 to 1939, these first-generation AA groups would exist under the umbrella of the Oxford Group. Eventually Wilson and Dr. Bob would distance themselves from the OG because of its focus on abolishing sin and the need to reach out to other groups of people who did not subscribe to evangelical Christian-based teachings. On May 18, 1939, the first Alcoholics Anonymous group formed independently from the Oxford Group in Cleveland, Ohio (Thomsen, 1975).
In 1939, the first edition of *Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered From Alcoholism* (a.k.a. *The Big Book*) was written. This book included the AA twelve steps, which became the fellowship’s core healing components. The AA fellowship gained national attention resulting from several newspaper articles in the *Cleveland Plain Dealer* and a 1941 issue of the *Saturday Evening Post* written by Jack Alexander. These articles spoke of AA’s popularity in helping alcoholics in Cleveland, Ohio (Cheever, 2004; Thomsen, 1975; White & Kurtz, 2008). In 1940, John D. Rockefeller, Jr. hosted a dinner for AA members at the exclusive Union Club in New York, garnering AA further favorable publicity.

In 1943, Wilson began traveling to cities across the United States promoting the AA fellowship. In June 1944, the *AA Grapevine*, the unofficial AA newsletter, was first published in New York City. In 1945, the Knickerbocker Hospital, under the direction of Dr. Silkworth, began using Alcoholics Anonymous meetings to help treat patients. By 1950, the first international convention of Alcoholics Anonymous would take place in Cleveland, Ohio, and AA had spread across the United States and into parts of Europe (Cheever, 2004; Hartigan, 2001; Kurtz, 1991; Thomsen, 1975).

The General Service Office of AA has estimated that there are more than 2 million AA members worldwide; it also estimated that there are more than 100,000 AA groups existing in at least 150 countries worldwide (*Alcoholics Anonymous*, n.d., “AA at a glance,” as cited in Straussner & Byrne, 2009). Because AA is an anonymous organization, it is difficult to measure the accuracy of these statistics; however, it is abundantly clear to even the most casual observers that the fellowship Bill Wilson and Dr. Bob Smith founded in Akron, Ohio, in 1935 has become an internationally recognized self-help fellowship that is profoundly influential in helping alcoholics achieve and maintain sobriety.
Summary

This chapter described how the Oxford Group (OG) fellowship focused on shared experiences between group members and transformational spiritual conversions as well as influenced the philosophies and practices of the Alcoholics Anonymous fellowship. Rowland Hazard’s and Ebby Thacher’s alcoholism led them to become involved with the OG, setting up a chain of events that in turn led to AA cofounder Bill Wilson’s recovery from alcoholism.

Rowland Hazard’s treatment under the care of Swiss psychiatrist Carl Jung helped Wilson understand the necessity of a spiritual transformation for alcoholics to maintain sobriety. The November 1934 meeting between Ebby Thacher and Bill Wilson was a seminal moment in Wilson’s recovery from alcoholism and treatment approach, helping him recognize the significance of one alcoholic helping another and the importance of believing in a higher power of his own conception.

The chapter identified Wilson’s history with alcoholism and his failed attempts at sobriety. Wilson stayed often at Towns Hospital under the care of Dr. William Silkworth, who believed alcoholism was a mental obsession and physical allergy. Wilson’s spiritual conversion followed his meeting with Ebby Thacher and his last stay at Towns Hospital.

Wilson’s early attempts at helping alcoholics recover resulted in his disagreement with the OG, which focused on abolishing sin and curtailing perceived undesirable behavior (womanizing, gambling, smoking) other than drinking. Wilson struggled to formulate approaches to alcoholism treatment within the context of the OG.

This chapter also described AA cofounder Dr. Bob’s alcoholism history and its impact on his practice as a proctologist in Akron, Ohio, and his physical health. Dr. Bob participated in OG meetings, but he was unable to stop drinking.
The May–June 1935 meetings between Bill Wilson and Dr. Bob began the AA fellowship. This chapter described how Wilson and Dr. Bob perceived these meetings and how Wilson helped Dr. Bob stop drinking by living in his home for three weeks.

The chapter concluded by identifying initial historical events central to the beginning of the AA fellowship, including disengagement from the OG, formation of independent AA groups in New York and Akron, the writing of AA’s *Big Book*, and AA’s inclusion in hospital-based addiction treatment. AA has expanded nationally and internationally, becoming one of the most influential self-help fellowships in the world.
Chapter 4:  

What Is Alcoholics Anonymous?

The objective of this chapter is to identify and analyze the Alcoholics Anonymous (AA) recovery program and fellowship. This includes an overview of Alcoholics Anonymous, a description of AA membership, an analysis of the structure and different types of AA meetings, an exploration of the roles spirituality and God play in AA, an examination of AA sponsorship, and the identification of commonly used AA literature.

An Overview of Alcoholics Anonymous

Alcoholics Anonymous is an international fellowship of men and women who have a drinking problem. It is the “largest community-based mutual-help program for alcohol-related problems” (Greenfield & Tonigan, 2013, p. 553). The majority of substance abuse treatment programs in the United States are based on the AA twelve-step program (Slaymaker & Sheehan, 2008; Substance Abuse and Mental Health Services Administration, 2008).

AA believes that “alcoholism is an allergy (in other words, alcoholics’ bodies simply cannot tolerate alcohol) that affects some individuals and not others, and it cannot be cured” (Franken, 2014, p. 24). In “A.A.—44 questions.” Alcoholics Anonymous (1952) wrote, the illness, a progressive illness, which can never be cured but which, like some other illnesses, can be arrested…the illness represents the combination of a physical sensitivity to alcohol and a mental obsession with drinking, which, regardless of consequences, cannot be broken by willpower alone. (p. 4)
While not giving a formal definition of alcoholism, AA (1984) labeled it “a physical compulsion, coupled with a mental obsession” (p. 9). Swora (2004) also described AA’s view that alcoholism is an “incurable and progressive disease of the body, mind and spirit…” (p. 188).

Alcoholics populate AA groups, placing center stage AA cofounder Bill Wilson’s theory that “one alcoholic could affect another as no nonalcoholic could” (Alcoholics Anonymous, 2001, p. xvi). AA members have cited the “telling and retelling of stories” (Kurtz, 1991, p. 68) as one of the most significant healing components of the fellowship. Dickerson (2006) elaborated on this sentiment, writing, “The therapeutic significance of program manifests itself at these regular meetings through identification, association, and individual and group socialization” (p. 70).

AA’s individual recovery program and its group philosophies are identified in its *Twelve Steps and Twelve Traditions* (Alcoholics Anonymous, 1981). The twelve steps cover a “program of abstinence from alcohol, acceptance of being alcoholic, honest self-examination, atonement for past wrongs, spiritual reflection, and service to other alcoholics” (Humphreys, 2000, p. 496). The twelve traditions apply “to the life of the Fellowship itself. They outline the means by which AA maintains its unity and relates itself to the world about it, the way it lives and grows” (Alcoholics Anonymous, 1981, p. 15).

Alcoholics Anonymous believes acceptance of a power greater than oneself is necessary to gain and maintain sobriety (Alcoholics Anonymous, 2001); however, AA does not align itself with any religious organization. Still, six of the AA twelve steps refer to God, and the final step refers to a spiritual awakening that may help AA members sustain sobriety and that reportedly leads to profound life changes (Alcoholics Anonymous, 1981).
Transformation of self-identity is a central feature of AA. This is epitomized in Kurtz’s (1982) “Why AA Works”: “The Alcoholic who accepts and voices his identity in the AA rooms, ‘My name is… and I am an alcoholic’” (p. x). Cain (1991) explained this concept further: “AA draws on a body of culturally shared knowledge about what it means to be an alcoholic, what typical alcoholics are like, and what kind of incidents have marked a typical alcoholic’s life” (pp. 210–211). Through sharing experiences, AA participants undergo a “transformation of their identities, from drinking non-alcoholics to non-drinking alcoholics, and it affects how they view and act in the world” (p. 210).

**Alcoholics Anonymous Membership**

Describing the population of its members, Alcoholics Anonymous (1984) wrote, “We in A.A. are men and women who have discovered, and admitted, that we cannot control alcohol. We have learned that we must live without it if we are to avoid disaster for ourselves and those close to us” (p. 7). Common characteristics of AA membership include frequent AA meeting attendance and having or being a sponsor and reading AA literature.

In practice, anyone can self-identify as belonging to AA, which creates an inclusive environment. AA attendance includes the added benefit of being “free to its members, which means it does not prohibit individuals from attending based on financial resources” (Sharma & Branscum, 2010, p. 4).

Alcoholism affects a wide cross section of the world’s population, resulting in AA being “open to anyone regardless of race, sexual preference, color or creed” (Dickerson, 2006, p. 69). Members coexist despite often coming from vastly different professional and socioeconomic backgrounds. Addressing this fact, Franken (2014) wrote,
There is trust and compassion between two recovering alcoholics in a way that may not exist between an alcoholic and a social worker, counselor, or parole officer. Thus, two recovering alcoholics, one of which might be a CEO and the other a construction worker, are of equal status in the realm of AA. (p. 24)

Group cohesiveness is often created by AA members’ common struggles with alcohol:

We are people who normally would not mix. But there exists among us a fellowship, a friendliness, and an understanding which is indescribably wonderful…. The feeling of having shared in a common peril is one element in the powerful cement which binds us.

(Alcoholics Anonymous, 1976, p. 17)

AA members are encouraged to prize group empowerment over individual autonomy: “In A.A., no one is ‘above’ or ‘below’ anyone else. There are no classes or strata or hierarchies among the members. There are no formal officers with any governing power or authority whatsoever…” (Alcoholics Anonymous, 2001, p. 15). These organizational structures help support AA’s claim that it is a “fellowship of equals” (Alcoholics Anonymous, 2001, p. 15).

Alcoholics Anonymous Meetings

This section identifies the structure and different types of Alcoholics Anonymous meetings.

Overall structure of AA groups. AA meetings take place in various locations, including churches, basements, schoolrooms, community centers, and clubhouses. They vary in size; in bigger cities there may be up to 50 members in a group, while meetings in more rural sites may only have 2 or 3 members. In an AA group: “Any two or three alcoholics gathered together for sobriety may call themselves an A.A. group, provided that, as a group, they have no other affiliation” (Alcoholics Anonymous, 1981, p. 189). There is no formal application to join
because it is a fellowship of self-identification: “You are an A.A. member if and when you say so” (Alcoholics Anonymous, 1980a, p. 4).

Individual AA groups connect with the larger AA fellowship via the Alcoholics Anonymous General Service Office (GSO):

The General Service Office is a repository for A.A.’s shared experience. It fulfills our primary purpose by: (1) providing service, information and experience to groups worldwide; (2) publishing literature; (3) supporting the activities of the General Service Board of A.A.; and (4) carrying forward recommendations of the General Service Conference. (Alcoholics Anonymous, 1990, p. 30)

Each group is encouraged by the AA GSO to have a chairperson, a secretary, and a treasurer. These service positions are assigned to make “sure that the necessary services are performed with a minimum of organization” (Alcoholics Anonymous, 1990, p. 19). While the AA GSO offers recommendations on elections, ultimately individual AA groups decide who takes these positions.

The structure of Alcoholics Anonymous meetings. An AA meeting begins with the chairperson calling the meeting to order. Frequently, the chairperson will then recite the serenity prayer: “God grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference” (Alcoholics Anonymous, 1981, p. 41). This is followed by different readings of AA literature. The chairperson will “stress the importance of preserving the anonymity of A.A. members outside the meeting room” (Alcoholics Anonymous, 1990, p. 19).

Next, initial introductions take place. This is considered an important aspect of the AA socialization process:
Each person in the room will introduce themselves, stating their name and their disease (alcoholic, addict, overeater, etc.). After all have been introduced, the chairperson will ask if there are any newcomers (anyone with less than thirty days of sobriety). These people will introduce themselves again, so all in the meeting know to reach out to them. (Clausen, 2013, p. 17)

A sign-in sheet may be passed around the meeting room. Members can sign in by giving their first name and last initial, but there is no requirement to sign. Alcoholics Anonymous (1990) wrote that while it always makes an effort to respect anonymity, “Some groups keep a list of names and telephone numbers volunteered by their members, and may provide phone lists—but for the eyes of the group members only” (p. 9).

There may be a short break in the middle of the meeting. At this time, a collection box may be passed around the group members, the funds of which will be used to offset the meeting’s administrative costs. The meeting usually closes with a brief section of AA literature read aloud.

**Different types of Alcoholics Anonymous meetings.** Common types of AA meetings include beginner, closed discussion, open, and literature meetings (Alcoholics Anonymous, 2001). Certain meetings may also exist for groups of only women, men, teenagers, young adults, or gay/lesbian populations. These AA meetings are the only ones with designated exclusion criteria.

Beginner meetings are open to anyone who thinks they have a problem with alcohol. AA members with long-term sobriety chair these meetings. Regarding this, Alcoholics Anonymous (1975) stated,
These are usually smaller than other meetings, and often precede a large meeting…in some places; these meetings are a series of scheduled discussions or talks about alcoholism, about recovery, and about A.A. itself. In others, the beginners’ meetings are simply question-and-answer sessions. (p. 77)

Beginner meetings allow newcomers to become more familiar with AA and are an “excellent place to ask questions, to make new friends, and to begin to feel comfortable in the company of alcoholics who are not drinking” (p. 78).

Closed discussion meetings are “for A.A. members only, or for those who have a drinking problem and ‘have a desire to stop drinking’” (Alcoholics Anonymous, 1990, p. 11). These meetings focus on aspects of the recovery program. Before a general group discussion, a “member who has volunteered in advance may lead off the meeting by telling briefly of his or her own alcoholism and recovery” (Alcoholics Anonymous, 1975, p. 79).

Open meetings are “available to the public—whether visitors, newcomers, regular members of AA, family, or friends” (Strobbe, Thompson, & Zucker, 2013, p. 54). People who don’t identify as alcoholics may attend open meetings as observers. At these meetings, two or three designated speakers are chosen to tell the group about their alcoholism, including “what we used to be like, what happened, and what we are like now” (Alcoholics Anonymous, 2001, p. 58). Additionally, “One of the big benefits of attending such open meetings is the opportunity to hear a wide variety of actual case histories of alcoholism” (Alcoholics Anonymous, 1975 p. 78). This benefit allows AA members to hear the “symptoms of the illness” (Alcoholics Anonymous, 1975, p. 78) and decide for themselves if they are alcoholics.
Literature meetings focus on analyzing different sections of AA literature, including the *Twelve Steps and Twelve Traditions*, otherwise known as *The Big Book*. Literature meetings are usually closed meetings attended by the same AA members each week:

Many A.A. groups hold weekly meetings at which one of the Twelve Steps of the A.A. program is taken up in turn and forms the basis of the discussion. A.A. Twelve Traditions, the Three Legacies of A.A., A.A. slogans and discussion topics suggested in A.A.’s monthly magazine, the *Grapevine*, are used for this purpose. (Alcoholics Anonymous, 1975, p. 79)

Over time, AA members frequently identify a “home group” that they are encouraged to attend. The home group is “where [members] accept service responsibilities and try to sustain friendships” and is considered to be “the strongest bond between the A.A. member and the Fellowship” (Alcoholics Anonymous, 1990, p. 15). AA members often find their sponsor and sober support network in this group.

AA meetings differ in structure, content, and, most important, tone. This makes choosing a home group or attending any group an exercise in trial and error. Regarding this fact, Alcoholics Anonymous (1990) wrote, “Each group is as unique as a thumbprint, and approaches to carrying the message of sobriety vary not just from group to group but from region to region. Acting autonomously, each group charts its own course” (p. 11). This sentiment is enforced by AA, which states, “With respect to its own affairs, each A.A. group should be responsible to no other authority then its own consciousness” (Alcoholics Anonymous, 1981, p. 146). AA newcomers are encouraged to keep attending AA meetings until they find one in which they feel comfortable.

The Role of Spirituality and God in Alcoholics Anonymous
AA identifies surrendering to a higher power and the occurrence of an individual spiritual awakening as cornerstones of an alcoholic’s recovery (Alcoholics Anonymous, 2001). AA members “believe that we have found the solution to our drinking problem not through individual willpower, but through a power greater than ourselves” (Alcoholics Anonymous, 1980a, p. 4). Step 2 states that “we came to believe a power greater than ourselves could restore us to sanity” while Step 12 affirms that “Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs” (Alcoholics Anonymous, 2001, p. 59).

In explaining AA’s tenets, Kurtz (1991) wrote, “the fundamental and first message of Alcoholics Anonymous to its members is that they are not infinite, not absolute, not God” (p. 3). Regarding an alcoholic’s first step toward recovery, Bill Wilson in AA’s (2001) Alcoholics Anonymous wrote, “First of all we had to quit playing God” (p. 25). AA asks members to rely on their higher power and “trust infinite God rather than our finite selves” (Alcoholics Anonymous, 2001, p. 68).

Belief in a higher power is enforced by AA’s non-hierarchical organizational structure. It has “no president having authority to govern it, no treasurer who can compel the payment of any dues, no board of directors who can cast an erring member into outer darkness…” (Alcoholics Anonymous, 1981, p. 132). On the topic of God, Alcoholics Anonymous (1981) also wrote, “For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern” (p. 132).

AA recognizes that definitions of spiritual awakening vary among members; however, what it finds to be universally true among its membership is the impact spiritual awakening has on individual self-efficacy:
When a man or a woman has a spiritual awakening, the most important meaning of it is that he has now become able to do, feel, and believe that which he could not do before on his unaided strength and resources alone. He has been granted a gift, which amounts to a new state of consciousness and being. (Alcoholics Anonymous, 1981, pp. 106–107)

This spiritual awakening sets an individual AA member on a “path which tells him he is really going somewhere, that life is not a dead end, not something to be endured or mastered” (Alcoholics Anonymous, 1981, p. 107). It gives members motivation, inspiration, and guidance to spread their newfound clarity and purpose to alcoholics still in the throes of addiction. This responsibility to help other alcoholics in need is considered a vital aspect of the AA fellowship.

AA members are encouraged to use their “own conception of God” (Alcoholics Anonymous, 2001, p. 47) as a spiritual tool in obtaining and maintaining sobriety. In 101 Common Clichés of Alcoholics Anonymous, Tolin (2014) described how AA members, when having trouble utilizing the concept of God in protecting their sobriety, liberally adopt the G.O.D. acronym:

AA teaches that our higher power does not have to be the God as taught to us by organized religion…. It is a power greater than ourselves. It can be as simple as Good Orderly Direction from a sponsor, a support, or another member in AA…. I have heard numerous alcoholics say they believe that God speaks through others at the tables, especially their friends in AA (a Group of Drunks). (p. 23)

In Back to Basics, Wally P. (2006) wrote,

We’re free to call this Power by any name we wish, as long as it is a “Power greater than ourselves.” The “Big Book” authors use many different names for this Power including
“Creative Intelligence,” “Universal Mind,” “Spirit of the Universe,” “Creator,” and “Great Reality,” among others. (p. 45)

In other words, AA members reference God by any name they are comfortable with.

Alcoholics Anonymous (2001) refers to itself as a “spiritual program of action” (p. 85). The organization also believes that “Each Alcoholics Anonymous Group ought to be a spiritual entity” (p. 563) and further states that “We find that no one need have difficulty with the spirituality of the program” (p. 568), provided they stay open toward spiritual concepts and remain honest regarding their alcoholism.

An Examination of Sponsorship in Alcoholics Anonymous

The sponsor-sponsored pairing was intended to mirror the relationship of equals formed between AA cofounders Dr. Bob Smith and Bill Wilson, both of whom thought the success of “Alcoholics Anonymous began with sponsorship” (Alcoholics Anonymous, 2010, p. 7).

Regarding this, Alcoholics Anonymous (2010) stated in its literature that “Essentially, the process of sponsorship is this: An alcoholic who has made some progress in the recovery program shares that experience on a continuous, individual basis with another alcoholic who is attempting to attain or maintain sobriety through A.A.” (p. 7). In AA, “sponsorship is voluntary and initiated by the one seeking help” (p. 53). Chappel (1994) agreed, stating, “The initial choice is usually based on someone who appears to be a good role model” (p. 103) for the sponsored.

Sponsorship is of particular importance to the AA newcomer, and the sponsor “frequently tells parts of their own or others’ stories to make the points they feel a neophyte A.A. member needs to hear” (Humphreys, 2000, p. 496). Sponsorship is designed to help the AA newcomer transition into a sober lifestyle:
It assures the newcomer that there is at least one person who understands the situation fully and cares— one person to turn to without embarrassment when doubts, questions, or problems linked to alcoholism arise. Sponsorship gives the newcomer an understanding, sympathetic friend when one is needed most. Sponsorship also provides the bridge enabling the new person to meet other alcoholics—in a home group and in other groups visited. (Alcoholics Anonymous, 2010, p. 11)

In practice, the sponsor is usually “an ‘expert’ senior member to whom initiates can turn for advice during the course of recovery” (Kassel & Wagner, 1993, p. 224). With this in mind, the sponsor supports the sponsored in guarding against possible relapses. In this situation, Dickerson (2006) wrote, “When in trouble or besieged by a craving to drink or use drugs, a member will make contact with the sponsor” (p. 72).

Sponsors also help AA members increase socialization within the AA fellowship. Regarding this, Kassel and Wagner (1993) wrote,

Newer members are encouraged to arrive at meetings early, help make coffee, and, most importantly, befriend their fellow group members… interaction with other members often extends beyond the confines of the meeting as well, and may play a role in a member's recovery. (p. 224)

Sponsors help place AA members in service work within AA groups. Examples of this work include greeting members at AA meetings, making coffee, organizing the AA literature display, giving talks at meeting, and engaging in sponsorship. In further explaining this role, Alcoholics Anonymous (1990) stated,

You often hear A.A. members say that they first felt “like members” when they began making coffee, helping with the chairs, or cleaning the coffeepot. Some newcomers find
that such activity relieves their shyness and makes it easier to meet and talk to other members. (p. 16)

The service work in which sponsored members engage is usually determined by the amount of time they have abstained from alcohol and other drugs (Kurtz, 1991).

AA service work is conducted to counteract the psychopathology associated with addiction (Chappel, 1994). In reinforcing the benefits of service work, Alcoholics Anonymous (1984) wrote,

Work with other alcoholics who turned to A.A. for help was an effective way of strengthening our own sobriety. Whenever possible, we tried to do our share, always keeping in mind that the other person was the only one who could determine whether or not he or she was an alcoholic. (p. 15)

This legacy of alcoholics helping one another, beginning with the AA cofounders, is epitomized in AA members’ commitment to service work.

**Commonly Used Literature of Alcoholics Anonymous**

Alcoholics Anonymous (1975) recognized that “there are many good publications on alcoholism,” but “AA neither endorses nor opposes anybody else’s publication” (p. 73). AA-approved conference literature includes *Alcoholics Anonymous (The Big Book); Twelve Steps and Twelve Traditions; As Bill Sees It; Dr. Bob and the Good Oldtimers; Pass It On; Living Sober; Experience, Strength and Hope; Daily Reflections; Came to Believe;* and *A.A. in Prison: Inmate to Inmate* (Alcoholics Anonymous, 1975). The *AA Grapevine*, known as the “meeting in print,” is considered to be the international journal of Alcoholics Anonymous. It is a collection of articles written and edited by AA members around the world (Kurtz, 1991). Additionally, AA
conference-approved pamphlets can be found on the official Alcoholics Anonymous website at AA.org.

The most commonly used AA literature include *Alcoholics Anonymous (The Big Book)* and *Twelve Steps and Twelve Traditions*, both written by Bill Wilson. The following section describes these texts.

*Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism (The Big Book).* The first paragraph identifies the book’s purpose: “To show other alcoholics precisely how we have recovered…” (Alcoholics Anonymous, 2001, p. xiii).

*The Big Book* was first published in 1939. Three updated editions were published in 1955, 1976, and 2001 (Kurtz, 1991). Over the years, the book increased dramatically in circulation:

The first edition appeared in April 1939, and in the following 16 years, more than 300,000 copies went into circulation. The second edition, published in 1955, reached a total of more than 1,150,500 copies. The third edition, which came off press in 1976, achieved a circulation of approximately 19,550,000 in all formats. (Alcoholics Anonymous, 2001, p. xi)

Today, more than 25 million copies of *The Big Book* have been sold, and it has been translated into 48 languages (Sheff, 2013).

The first section of *The Big Book* includes an introduction from Dr. William Duncan Silkworth, Bill Wilson’s former doctor. In it, Dr. Silkworth cited the effectiveness of a spiritual program for alcoholism treatment and his theory of alcoholism as a physical allergy.
The Big Book contains chapters describing Bill Wilson’s and Dr. Bob Smith’s struggles with alcoholism and the early days of AA. It includes a description of how AA meetings work and short versions of the twelve steps and twelve traditions. Other subjects and chapters found throughout the book include “Two Wives,” “Agnostics,” and “Employers.”

The book’s second section highlights individual alcoholics’ experiences, describing their alcoholism history and the influence Alcoholics Anonymous had on their recovery. The individual alcoholics identified and the stories they tell change with each new edition (Alcoholics Anonymous, 2001).

Twelve Steps and Twelve Traditions. This book contains 24 essays on the principles of individual recovery and group unity in the AA fellowship (Alcoholics Anonymous, 1981). The book’s foreword states that “It presents an explicit view of the principles by which A.A. members recover and by which their Society functions” (p. 15).

Twelve steps. The twelve steps are individual actions that AA believes its members should undertake to “obtain sobriety and make the spiritual transformation necessary to create a sober life worth living” (Davis & Jansen, 1998, p. 171). AA members engage in sequential step work, or “the process of systematically working each of the 12 steps” (Greenfield & Tonigan, 2013). Chappel (1994) stated that “Each step has its own purpose, and each contributes both to sobriety and to continued personal growth and development” (p. 102). Alcoholics Anonymous (1981) described the process further, stating that “AA’s Twelve Steps are a group of principles, spiritual in their nature, which, if practiced as a way of life, can expel the obsession to drink and enable the sufferer to become happily and usefully whole” (p. 15).

The following table lists the twelve steps of Alcoholics Anonymous:
1. We admitted we were powerless over alcohol—that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

(Alcoholics Anonymous, 1980a, p. 7)
In *An Exploratory Investigation of the Alcoholics Anonymous Sponsor*, Stevens (2013) wrote,

These steps lay out a series of tasks that progress the individual from the initial step of problem acknowledgement, to providing service and finally to assist others in coping with SUD [substance use disorder]. For the individual pursuing a change from using AOD [alcohol and other drugs], to becoming abstinent, and proceeding in recovery, these steps provide a framework that is often iteratively reworked. (p. 6)

*Twelve traditions.* AA’s twelve traditions define the group’s philosophies, ensuring that individual AA groups adhere to the larger fellowship. The twelve traditions were originally published in the April 1936 issue of the *AA Grapevine* and adopted at AA’s first international conference in Cleveland, Ohio, in 1950 (Kurtz, 1991). Stevens (2013) believed that the twelve traditions “emphasize the singular purpose of AA, which is sobriety or abstinence, but also promote the need for AA to stay independent of external influences, and to protect the nature of relationships within it which are ultimately non-hierarchical” (p. 6).

The following table lists the twelve traditions of Alcoholics Anonymous:

1. Our common welfare should come first; personal recovery depends upon A.A. unity.

2. For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.

3. The only requirement for A.A. membership is a desire to stop drinking.

4. Each group should be autonomous except in matters affecting other groups or A.A. as a whole.
5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.

6. An A.A. group ought to never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.

7. Every A.A. group ought to be fully self-supporting, declining outside contributions.

8. Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.

9. A.A., as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.

10. Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.

11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.

12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities. (Alcoholics Anonymous, 1980a, p. 6)

The primary reasons AA must remain anonymous are identified in the twelve traditions: 1) to protect members against having their identity publicly revealed and 2) to prevent the program’s principles from being exploited or altered by inside or outside entities (Alcoholics Anonymous, 2001).

Summary
This chapter provided an overview of Alcoholics Anonymous (AA). AA is a mutual help program for alcoholics looking to recover from alcoholism. AA meetings take place in group settings; it is a nondenominational spiritual fellowship focused on the transformation of self-identity.

AA members were identified as being a diverse population of alcoholics from varying cultural and socioeconomic backgrounds. The group is considered to be a fellowship of equals where members from dissimilar backgrounds bond over their common struggles with alcoholism.

The chapter described the structure of typical AA meetings, the protocols of which are outlined by the AA General Service Office (GSO), but the group practices and content are determined by the individual groups. AA comprises various types of groups, including beginner, closed discussion, open, and AA literature meetings.

This chapter identified the role of spirituality and God in AA, which states that belief in a power greater than ourselves and the occurrence of a spiritual awakening are necessary components of sustained sobriety. AA stresses no affiliation with any religious organization, encouraging individuals to gain strength and healing from a God of their own conception.

This chapter also described AA sponsorship. Sponsors help the sponsored understand the practices and philosophies of AA and increase socialization with AA members. Additionally, sponsors connect the sponsored to service work and aid them during times of increased stress. It is of particular importance to AA newcomers.

The chapter concluded by identifying commonly used AA literature, including *Alcoholics Anonymous (The Big Book)* and *Twelve Steps and Twelve Traditions*, which are used extensively in the AA recovery program. *Alcoholics Anonymous* is the founding text of AA and establishes
how AA meetings work, describes the stories of the AA cofounders’ battles with addiction and recovery, and states the original twelve steps and twelve traditions.

In *Twelve Steps and Twelve Traditions*, the twelve steps are identified as AA’s individual recovery program and explored; the twelve traditions are identified as AA’s group philosophies and practices and explored as well.
Chapter 5:

Findings and Recommendations

The objective of this chapter is to suggest how the application of specific psychoanalytic theories (ego psychology, object relations, and self-psychology) may enhance the fellowship of Alcoholics Anonymous (AA). In relation to analyzing AA, attachment theory and self-psychology have significant overlap. As such, after dealing with a few important terms, the chapter consists of the following key parts: AA and ego psychology, AA and object relations theory, and AA and self-psychology.

This chapter will identify psychoanalytic theorists’ key writings on AA or related issues and what message this conveys to AA leaders about their fellowship. I will also offer my observations on how these theories can inform and enhance the work of AA as we know it.

In examining AA, the terms recovering alcoholics and newcomers will be used. For the purposes of this dissertation, recovering alcoholics are members who have been in AA for more than a year, while newcomers are members who have newly joined. These terms are repeatedly used in AA meetings, but the time in AA needed for members to be placed in these categories is subjective.

The word alcoholic is not intended to have a negative connotation. It represents an individual who has the illness of alcoholism and, more significantly within the AA fellowship, someone who has affirmed a positive alcoholic identity indicating an effort to begin leading a productive and purposeful life.

The word recovery is used throughout this chapter; it is employed in many twelve-step programs and is the route through which alcoholics gain abstinence and “undergo the self-
help/mutual aid journey to heal the self, relations with others, one’s higher power, and the larger world” (Borkman, 2008, p. 16).

The terms *abstinence* and *sobriety* will also be used. For the purpose of this dissertation, abstinence is the avoidance of alcohol consumption, and sobriety is the avoidance of alcohol consumption and completion of the twelve steps (leading to enhanced emotional and spiritual growth). These terms are also repeatedly used in AA meetings, but their definitions are likewise subjective.

**Alcoholics Anonymous and Ego Psychology**

This section examines AA using ego psychology theory. It describes AA members’ transition from using a primitive defense mechanism (splitting) to a mature defense mechanism (altruism). It identifies how newcomers manage emotions in early recovery and may benefit from being treated by a mental health professional later in recovery, how members decrease grandiosity by increasing humility, and how members obtain sobriety though completing the twelve steps with a sponsor.

**Defense mechanisms.** To avoid suffering substantial mental conflict, alcoholics use primitive defense mechanisms such as denial, acting out, and splitting. AA members often transition from primitive defense mechanisms to mature defense mechanisms such as humor, anticipation, and altruism.

Wurmser (1978) believed alcoholics utilize splitting (*primitive defense mechanism*) to manage their anxieties, which stem from an inability to integrate individuals or themselves into a unified whole. In meetings, AA newcomers witness recovering alcoholics reveal shocking testimony of past behaviors. Moments later, they also witness those same recovering alcoholics support members who have recently relapsed.
This confuses newcomers, as they’ve spent a lifetime placing others and themselves into separate categories: either all good or all bad. Early participation helps members internalize others as multidimensional while ongoing participation helps members internalize themselves as multidimensional. AA teaches members to look beyond their primitive categorizations and focus on a person as a whole human being.

As AA members intensify their fellowship involvement, they become skilled at utilizing mature defense mechanisms such as altruism. When alcoholics reach out to support one another, their focus shifts away from themselves. This is exceptionally helpful when alcoholics struggle with obsessive negative thinking. Since alcoholics can always convince themselves that they need a drink, shifting focus to another person can prevent relapses. Recovering alcoholics describe this concept as “Getting out of yourself.”

Managing emotions. Krystal and Raskin (1970) believed alcoholics have defective stimulus barriers, which suggests alcohol is consumed to defend against overwhelming affects. In the earliest stages of recovery, AA recognizes that active emotional exploration is dangerous. Newcomers are by definition vulnerable and can struggle in abstaining from alcohol if emotions are significantly triggered; therefore excessive stimuli are to be avoided. For this reason, newcomers benefit from focusing on their behaviors rather than on their emotions. This includes attending the next meeting, getting a sponsor, and starting step work. Recovering alcoholics describe this approach to early recovery as “Doing the next right thing.”

Krystal (1977b) stated that alcoholics suffer from alexithymia: difficulty recognizing, naming, and verbalizing emotions. Once members are acclimated into the fellowship, emotional exploration is safe; however, alexithymia makes this difficult. Not having a strong emotional vocabulary or awareness may make forging connections and finding commonalities with others
difficult. These difficulties can induce anxiety when speaking at meetings, make socializing with members intimidating, make connecting with sponsors choppy, and make completing step work extremely challenging.

I recommend that AA members with emotional awareness deficits receive treatment from mental health professionals, who can enter alcoholics’ inner world, helping them recognize how past experiences have affected their psyche and motivated their behavior. In mirroring clients’ affects, these professionals help them recognize and verbalize their emotions.

Such insights will help members increasingly benefit from AA practices (e.g., meetings, sponsorship, step work). Most important, improved emotional awareness provides members with the tools to make secure attachments with other AA members, and this becomes the vital ingredient in helping them achieve sobriety.

Improving emotional awareness, and as McDougall (1984) suggested, breaking the rigidity of defense mechanisms, are important goals for mental health professionals when working with AA members. I recommend that the mental health professional and the member’s sponsor regularly communicate; this may help reduce the alcoholic’s utilization of splitting to avoid mental conflict.

**Increasing humility.** Tiebout (1951) considered the alcoholic’s character formulation to be rooted in grandiosity characterized by false pride and self-centeredness. Alcoholics Anonymous helps increase the humility in which individuals address their alcoholism.

In accepting Step 1, members concede loss of personal agency: “We admitted we were powerless over alcohol and that our lives had become unmanageable” (Alcoholics Anonymous, 1981, p. 21). When they admit their dependency through giving up pretenses of the ability to control their drinking, members effectively employ reality testing (ego function), minimizing
their use of denial as a defense mechanism. In accepting Step 1, alcoholics’ egos are deflated; this allows them to internalize the helpful words of recovering alcoholics with long-term sobriety.

Crosstalk is not permitted during AA meetings; therefore, alcoholics must practice restraint. They must wait until a peer has finished speaking to communicate their thoughts; it usually takes a while before an eager member can be “given the floor.” AA encourages members to resist singularly focusing on their own story and instead listen to peer shares to draw common connections.

When members share, they are given feedback, which frequently occurs post-meeting. Recovering alcoholics (members with significant time in AA and who have completed step work) may critique any new member’s recovery plan (e.g., sponsorship, step work, meeting attendance). These conversations ask members to find credibility in others’ opinions and admit to themselves that they do not have all the answers.

Completing the twelve-step program helps expand alcoholics’ humility. Step work necessitates that members establish belief in a higher power and how this power can be used to achieve sobriety. This is often one of the most challenging tasks for AA members. Alcoholics frequently have had antagonistic relationships with authority figures, making them leery of giving up control. I recommend AA leaders stress to AA members the importance of adopting for themselves what their higher power is and how it should be used.

Recovering alcoholics explain this process as “turning it over”: members surrender their false sense of omnipotent control and, as stated in Step 3, make a “decision to turn our will and lives over to the care of God as we understood him” (Alcoholics Anonymous, 1981, p. 34). Members discover that following their higher power aids them in overcoming obstacles that
formerly stood in their way. Acceptance of a higher power helps members complete the remaining step work, including conducting a moral inventory of oneself, assessing and making amends for past wrongdoing, and helping other alcoholics who are suffering (Alcoholics Anonymous, 1981).

Members rely on their sponsor for assistance in completing these twelve steps, which may be difficult to work on alone. Doing step work with a sponsor becomes an exercise in humility; it is difficult to accept truths from and reveal truths to an individual who, just days ago, may have been a stranger. Personally, it is humbling to recognize the impact that one’s alcoholism has had on family and friends, and likewise when AA members recall times in the past where they were dishonest or acted immorally. Completing the twelve steps provides members with evidence that their sobriety is fragile; should they disengage from AA and fellow recovering alcoholics, they may return to drinking.

Through peer shares, received feedback, and step work, members understand that their connection with fellow alcoholics makes their recovery possible. Increasing humility provides members with the capacity to develop strong interpersonal relationships with other AA members. These relationships become increasingly powerful when members face life stressors and relapse triggers that could potentially derail their sobriety.

**Alcoholics Anonymous and Object Relations Theory**

This section examines Alcoholics Anonymous utilizing object relations theory. It focuses on member participation, AA as a holding environment, and how members formulate internal mental representations of AA. Alcoholics often have a poorly developed inner world of representations primarily stemming from their dysfunctional family dynamics. AA addresses these realities by providing a nurturing holding environment that supports their recovery.
**Member participation.** Wurmsen (1978) proposed that alcoholics were raised in family environments where their primary caregiver’s actions were inconsistent. If this is the case, then AA members profit from consistency in their recovery program. In the short term, newcomers can address these deficits by attending 90 meetings in their first 90 days (a practice promoted by AA but in reality rarely followed by AA members).

Attending 90 meetings in their first 90 days aids newcomers in gaining rapid familiarity with AA philosophies and practices. Such AA immersion helps them witness a variety of peer shares, determine which meetings are value-added, and facilitate weekly routines for meeting attendance. This immersion helps newcomers speedily form relationships with recovering alcoholics; these relationships become helpful in resisting relapse triggers.

In the long term, members find consistency in joining home groups, which act as extended families, providing members with the emotional steadiness they often did not receive from their families. This becomes a reparative experience for members, perhaps helping them address the impact of deficits in their families of origin.

Home groups are small and intimate, as opposed to the large, open “drop-in groups.” Members see the same faces weekly in home groups, allowing for significant relationships to form over an extended period of time. They have witnessed each other’s early days of alcoholic abstinence and are profoundly invested in each other’s sobriety.

I recommend that AA leaders articulate the value of joining a home group in the next edition of *The Big Book*. Additionally, members should state whether they attend a home group during introductions. These additions would underscore how important home group membership is in advancing AA members’ sobriety.
**Holding environment.** According to Flores (2004), alcoholics often lacked the experience of a nurturing *holding environment* during their childhood. Their primary caregivers were often incapable of providing them the emotional security desired for optimal personal development. Alcoholics may drink to lessen tensions associated with the empathetic failures of these parental figures.

In AA, newcomers witness recovering alcoholics empathetically relating to each other; this normalizes their own thoughts and feelings. Realizing that their circumstances are not singular gives newcomers the emotional security necessary for them to authentically share with the group. They are then able to benefit from the unconditional acceptance group members provide with their feedback.

AA is an anonymous fellowship; this element strengthens members’ confidence in revealing themselves to the group. Alcoholics benefit from this anonymity because they’ve often been raised in constricted familial environments where authentic expression is discouraged or used against them. Witnessing members routinely state, “What is said in this room stays in this room,” providing assurance that everyone can speak their truths without receiving negative consequences.

Members benefit from predictability in the scheduling and practices of meetings. Ideally, meetings take place in the same location and occur at the same time each day. Ideally, meeting practices are constant, including readings of the serenity prayer, the twelve steps/twelve traditions, and, during introductions, repeating the declaration “My name is _____ and I am an alcoholic.” These practices help shift members’ focus away from alcohol and toward AA.

If meetings are regularly in upheaval regarding start times, switching locations, altering protocols, AA becomes less effective in establishing nurturing holding environments for
members. Alcoholics are creatures of habit, and their recovery program must necessarily provide the same regularity that their drinking gave them.

To reinforce emotional safety, AA leaders should emphasize respect for boundaries, which members should not cross. Violation of boundaries includes showing up to meetings intoxicated, engaging in disruptive cross-talking, and endorsing behavior objectively at odds with AA’s philosophies. Such behaviors threaten the safety and security of members’ holding environment.

**Forming internal mental representations.** Over an extended period of time, recovering alcoholics begin to internalize AA philosophies through hearing group shares, completing step work, and engaging in service. This internalization process necessitates profound commitment from members; it also allows recovering alcoholics to sense the power of AA, even when not participating in AA-related activities (*object permanence*).

When encountering challenging environments that could jeopardize their recovery, members recollect each other’s in-meeting shares, recall meaningful slogans, and reaffirm belief in their higher power. It can be helpful for members to carry physical reminders of AA philosophies; these include coins signifying abstinence and meaningful images associated with sobriety. These physical reminders could be seen as transitional objects and may help AA members feel safe and secure that their sobriety is protected outside AA meetings. They also may help increase members’ confidence in resisting relapse triggers, leading them to believe it is safe to decrease their weekly meeting attendance.

Recovering alcoholics with long-term sobriety should feel confident in attending fewer meetings. This is particularly true when meetings are replaced by other sobriety-related activities, including sessions with psychotherapists, socializing with positive peers, and engaging
in athletic activities. Newcomers with nominal abstinence time should exercise caution when considering such reductions and consult with their sponsor and group members, recalling that long-term sobriety is, in part, achieved through continuously bearing live witness to the struggles and successes of fellow alcoholics.

**Self-Psychology and Alcoholics Anonymous Self-Object Needs**

Kohut (1977a) believed alcoholics drink to repair developmental deficits caused by unmet selfobject needs. Selfobjects are persons or objects felt as part of the self or used in service of the self, the functions of which help individuals regulate affect, maintain self-esteem, and aid in self-soothing.

Alcoholics Anonymous endeavors to fulfill these unmet needs by creating environments where members feel valued (mirroring), merge with an admirable object (idealizing), and experience alikeness with others (alter ego) (Robinson, 1997). This section analyzes how mirroring, idealization, and twinship experiences are observable in AA. In relation to analyzing AA, attachment theory and self-psychology have significant overlap.

**The mirroring selfobject need.** The mirroring need refers to the validation felt when other people acknowledge one’s qualities and accomplishments. If a child doesn’t adequately receive what Kohut (1971) called the “gleam in the mother’s eye” (p. 116), they develop difficulties with self-esteem regulation. Alcoholics Anonymous builds and maintains members’ sense of self-worth, permitting their capacities and talents to be recognized. This is evidenced in AA anniversary meetings, which present occasions for members to be honored for their accomplishments. Members who have abstained from alcohol (for 1 month, 3 months, 6 months, 1 year, etc.) are the focus of these meetings and are given sobriety coins; peers then reflect on these members’ personal growth. Such encouragement provides members the necessary
mirroring selfobject functions (self-worth and value), which they are incapable of accomplishing alone.

While drinking, most alcoholics garnered considerable attention from family and friends. Paradoxically, when they stop drinking, they receive far less attention, often making them feel invisible. Anniversary meetings place the spotlight back on celebrated members; they are validated and appreciated by the AA community. Now that they are accepted for positive instead of negative actions, they are confident in pursuing new ambitions outside of AA.

When recovering alcoholics invite family and friends to attend open anniversary meetings, it is highly recommended that they attend. These meetings provide loved ones with a rich comprehension of the alcoholism illness and the work alcoholics do to begin recovering.

The idealization selfobject need. The idealizing need concerns the longing of individuals to feel linked with an object (person or thing) they admire. When children are consistently protected by a respected parental figure, they internalize that figure’s strength and stability. Children without these involvements generally feel unsafe; this leads to problems of modulating feelings and diminished ambitions. AA becomes an idealized object addressing members’ unmet idealization needs from childhood, demonstrated in the sponsor relationship (Robinson, 1997).

Sponsors become sources of wisdom for less experienced members. Through encouragement and confrontation, sponsors educate members on AA practices, motivating them to have faith in the recovery process while regulating their emotions surrounding change. This relationship is reminiscent of the parent–child bond. Just as children benefit from discovering how their parents overcame challenges, members are empowered in learning how their sponsors stopped drinking; they gain the knowledge that their mentor has “been there” and “done that.”
I recommend that members be discerning when selecting a sponsor, perhaps choosing someone with whom they share commonalities other than being alcoholics. Members may benefit from choosing sponsors whom they have the potential to emulate. When members can see themselves in their sponsors, they envision what their lives might resemble if they achieve sobriety.

**The twinship selfobject need.** The twinship need is described as the “need to experience alikeness from the moment of birth to the moment of death” (Kohut, 1984, p. 194). Children sense alikeness with their same-sex parent, adolescents discover parallels with peers, and adults find commonalities within organizations and groups. Alcoholics, not having appropriate twinship experiences, become detached from others. AA addresses this need, bringing together peers with common histories and placing focus on the healing effects of the group (Robinson, 1997).

AA members are given opportunities to develop relationships with individuals attuned to their emotions; these relationships normalize their alcoholism illness. Emphasis on shared experiences and repeatedly asserting that alcoholics will not get better alone creates a culture of honest self-disclosure. Flores (2004) suggested that this interrupts the alcoholic’s habits of isolation and provides corrective relational experiences that may benefit future relationships. Indeed, Smith and Tonigan (2009) believed that involvement in AA brings about changes in members’ overall attachment styles; this is associated with increasing secure attachments and lowering levels of avoidance-ambivalent attachments.

AA is a widespread, worldwide fellowship, which further enhances members’ feelings of alikeness with one another. In cities across the world, members attend meetings day and night. Rural areas have local meetings; even if there aren’t daily meetings, there typically exists a cluster of recovering alcoholics who regularly socialize. AA members share a common language
that transcends geography, providing a wide safety net and lessening feelings of isolation. Across the globe, AA provides its members with a 24-hours-a-day support system. This geographical and time flexibility provides plenty of opportunities for members to form beneficial, sober relationships.

The fellowship’s leaders should preserve the belief that members’ alikeness is what ultimately links them. This is true regardless of whether an individual has drunk the previous night or has been abstinent for 25 years. The foundational principle of Alcoholics Anonymous is that no member is greater than the collective. The success of AA rests in its members’ ability to “Look for the similarities, not the differences” in another.

Newcomers should attend meetings offering optimal selfobject experiences; clinicians should identify which meetings have benefited their clients, emphasizing the potential to form attachments with those attending. In helping their clients choose meetings, clinicians should have a strong understanding of the AA culture in their communities.

Summary

At the start of the chapter, AA was examined from an ego-psychological perspective. Members transition from using primitive defenses to mature defenses, reduce splitting (primitive defense) through the reorganization of self-concepts and the concept of others, and intensify their altruism (mature defense) by helping other alcoholics in recovery. This altruism diminishes their obsessive thinking. AA explains this action as “getting out of yourself.”

AA is identified as improving members’ skills in managing their emotions. Recovering alcoholics instruct newcomers to de-emphasize the value placed on these emotions and instead concentrate on “doing the next right thing” (attending the next meeting, not drinking, getting a
sponsor, etc.). AA members with ongoing emotional vocabulary awareness deficits are encouraged to seek treatment from mental health professionals.

AA is recognized as helping increase members’ humility when addressing their alcoholism, which is achieved through meeting involvement and undertaking step work. Newcomers listen to and internalize recovering alcoholics’ shares, making connections with their own lives and leading them to consent that they are powerless over alcohol (Step 1). When newcomers share, they permit their points of view to be confronted.

Undertaking step work with a sponsor is also described as reinforcing members’ humility with specific attention placed on the importance of belief in a higher power and relinquishing self-will. Members’ humility is increased via the ability to reveal truths to another (sponsor), admitting the impact alcoholism has had on family/friends, and identifying times when they acted dishonestly or immorally because of their illness.

The next section of this chapter examined AA utilizing object relations theory. Newcomers are identified as benefiting from attending 90 meetings in their first 90 days of AA. Home groups are identified as settings where members are uniquely invested in other members’ wellness. These tactics facilitate immersion in AA practices/philosophies and weekly recovery practices.

AA is explained as providing a nurturing holding environment for members. In meetings, newcomers’ thoughts and feelings are normalized as they witness recovering alcoholics empathetically relating to them and each other. This collective atmosphere provides a culture of unconditional acceptance further enhanced by the fact that AA is an anonymous fellowship. AA members are acknowledged as benefiting from the predictability in meeting scheduling (time and location) and meeting practices (introductions and reading).
Recovering alcoholics are recognized as being able to form an internal mental representation of AA when not directly participating in AA-related activities and therefore protect their sobriety. These members should feel confident in decreasing their meeting attendance per week; in contrast, newcomers wishing to decrease meetings should consult peers and sponsors.

The chapter’s final section examined Alcoholic’s Anonymous using self-psychology theory. It concentrated on the selfobject experiences (mirroring, idealization, and twinship) that members accumulate in AA.

The mirroring need is evident in anniversary meetings where members are honored for their recovery achievements. Members’ self-worth increases as they recognize that they are validated and appreciated by the AA community. Members’ family and friends may benefit from attending anniversary meetings that are open to the general public.

Next, the idealization need is demonstrated in the sponsorship relationship. Sponsors act as sources of wisdom for less experienced members. This relationship is reminiscent of the parent–child bond, often substituting for experiences missed in childhood. Members are encouraged to choose sponsors with whom they have the potential to emulate.

Lastly, the twinship need is addressed via AA, bringing together individuals with common histories and highlighting the therapeutic effects of the group. Members form relationships with peers attuned to their emotions, helping to normalize the illness and break patterns of isolation.

Members’ experiences of alikeness with others are accentuated due to AA being a widespread, worldwide fellowship. Meetings occur across the globe, day and night, providing members plenty of chances to form beneficial sober relationships.
Recommendations

Professionals in the mental health and addiction fields should be trained in the psychoanalytic theories of addiction and how these theories support the use of AA as a treatment option. Many professionals in the treatment community believe AA solely focuses on members abstaining from alcohol. As stated in this chapter, AA is so much more; indeed, as Khantzian and Mack (1989) believed, it is a “sophisticated psychological treatment whose members have learned to manage effectively and/or transform the psychological and behavioral vulnerabilities associated with alcoholism” (p. 68). This strength is most clearly evidenced in AA’s ability to provide its members with selfobject experiences (e.g., mirroring, idealization, twinship); these experiences help provide and sustain a cohesive sense of self.

The following is a list of recommendations put forward in this chapter:

- Mental health professionals should treat AA members with ongoing emotional awareness deficits.
- AA newcomers should attend 90 meetings in their first 90 days of AA.
- AA leaders should articulate the value of joining a home group in the next edition of *The Big Book*.
- AA members should state whether they attend home groups during meeting introductions.
- AA leaders should emphasize respect for boundaries that members should not cross in AA meetings.
- AA leaders should maintain consistency in where and when meetings take place and how they function.
• AA newcomers should discuss decreasing the amount of meetings they attend per week with their sponsor and peers.

• AA members’ family and friends should attend anniversary meetings to provide them with a greater understanding of the alcoholism illness and the effort it took for their loved ones to stop drinking.

• AA members should be discerning when choosing a sponsor, focusing on working with individuals with whom they share commonalities.

• Mental health and addiction treatment professionals should be diligent in deciphering which AA meetings match their clients’ individual needs and focusing on the likelihood that they will form attachments with those in attendance.
References


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