Sustaining Transference in the Treatment of Alcoholism

ROBERT UNGER

Psychoanalysis is not usually considered to be an effective tool in dealing with alcoholism. It is a therapy mode that is rarely sought by the alcoholic, and is looked on with disfavor by the alcoholism treatment community. The image is often of the cold, intellecutual and emotionless analyst, who is primarily interested in the past. Some of these preconceptions are true: the analyst is there to analyze rather than to gratify. People with impulse disorders, such as alcoholism, are likely to attribute coldness and lack of concern to anyone who is not gratifying.

Most treatment of alcoholics deals with trying to improve the alcoholic's life, and solving the problems created by the drinking. While this process may be gratifying enough to the patient to keep him in treatment for a while, the underlying impulse disorder is not addressed. I have found in my work that the alcohlic does need gratification from the analyst. If the analytic situation is experienced as too frustrating, the patient will either leave treatment prematurely, interminably continue the drinking pattern, or discover some new way of destructively acting out his impulses. Traditional analytic approaches need to be modified, then, so that sufficient gratification can be provided to prevent a more serious regression or termination of the treatment. The amount of gratification provided needs to be delicately balanced, however, between too little and too

much. If too many needs of the patient are met, the transference will not form, and the analyst will have lost the usefulness of that most important treatment tool.

The issue of gratification is closely tied in with the notion that alcoholism reflects an underlying impulse disorder. The alcoholic is compelled to drink in order to assuage his feelings rather than go through the uncomfortable process of experiencing unpleasant or negative feelings. The impulse to act, then, becomes the overwhelming feeling, and the alcoholic gets addicted to an impulsive manner of discharging feelings, as well as to the bottle itself. The addicted person feels unable to control himself, generating terrible feelings of shame and helplessness. Fenichel elaborates on the narcissistic needs of the addictive personality:

> Addicts ... are persons who never estimated object relationships very highly. They are fixated to a passive narcissistic aim and are interested solely in getting gratification, never in satisfying their partners, or for that matter, in the specific personalities of their partners.

In the psychoanalytic process, the analyst is not actively taking away the addiction, but is asking the person to experience the feelings underlying the addiction.

The alcoholic addictive process is described by Gitlow (1968). He states that alcohol is a sedative, a depressant of the central nervous system. It diminishes psychomotor activity, which in observable terms, reduces tension and anxiety. This effect usually lasts for about two hours, the time it takes for the blood alcohol level to begin to fall. The problem is that there is also a longer term effect, lasting about 12 hours, which increases psychomotor activity, thus producing more anxiety and tension. This is characteristic of all sedatives. Thus, a person who uses alcohol as a sedative, will need more alcohol to counteract the longer term effect after the short term effect has worn off. Very simply, this cyclical process leads to alcohol addiction.

The debate over whether alcoholism is a physiological disease or psychological problem arises out of the difficulty of dealing with the addictive process. The disease concept is the popular one among

people working in the field and with recovering alcoholics. The point of view of Alcoholics Anonymous (AA) is that alcohol is basically a physiological problem created by some systemic, hormonal, or genetic problem. This view has advantages. The alcoholic has been stigmatized as morally bankrupt, out of control and inferior. The disease concept helps him to feel less persecuted morally and psychologically. If alcoholics have no control over their drinking and can think that it results from physiological problems, they may be less prone to feelings of self-attack and worthlessness. In my experience, however, alcoholic patients do criticize themselves severely for their drinking problem, so I must conclude that there are few alcoholics who actually believe in the disease concept, although it is frequently invoked.

If the alcoholic believes that alcoholism is a physiological problem, why does he go to a psychotherapist? Most who go voluntarily seem to want to learn to adjust to their alcoholism. Psychotherapy is expected to serve a supportive function rather than to deal with the addiction. For modern analysts it is not important whether alcoholism is a disease or a psychological problem. As Spotnitz has often noted, many diseases are psychologically reversible. The important thing is learning how to treat the addiction psychologically.

This brings up a difficult question. Perhaps the reason for the popularity of the disease concept of alcoholism is that no one, neither patient nor therapist, really wants to deal with impulsive behavior because of the discomfort it gives rise to in the therapeutic relationship. Most alcoholics do not want to be analyzed—it is too painful to give up impulsive behavior. Should an analyst therefore attempt to analyze the patient if all he wants is supportive help? Should the analyst set up a situation in which the impulse disorder gets worked on, or should he ask the patient what kind of treatment he wants, whether he would like his impulsivity worked with? I experience the desire to be supportive, but the challenge is to be an analyst and work with the transference. Thus, just as the alcoholic drinks to become emotionally and physiologically comfortable, the therapist will often find some way to be supportive, giving, or gratifying to make himself more comfortable in the treatment

situation. Using a psychoanalytic approach, where thoughts, feelings, and wishes are basically explored rather than gratified might give rise to the uncomfortable feelings which both patient and therapist would like to avoid.

FORMING A RELATIONSHIP: INITIAL PHASES

The problem with how to conduct the treatment begins with the way in which patients enter treatment. Since most alcoholics do not enter treatment to deal with their alcoholism and may have been referred by somebody who has been affected by the drinking—family, the courts, an employer, or a doctor—they enter without internal motivation to change, or even to come. If the alcoholic agrees to come to treatment, it may be because of the threat of a major loss such as job or family. In my clinic, the largest referral source by far is the Department of Social Services, which requires people claiming to be alcoholic to be in treatment if they are to receive public assistance.

In many, if not most cases, the person does not feel he has a drinking problem, and if he does, he would prefer to resolve it without giving up drinking. The analyst must remember that alcohol provides the kind of gratification which is virtually impossible for a human relationship, particularly the kind which most alcoholics have previously experienced, to match. Alcohol ingestion usually provides an immediate feeling of security, well being, and tension relief. The patient has entered treatment because some aspect of his drinking behavior has become dystonic; the desire for the patient to isolate himself with the bottle has not necessarily diminished. If drinking is an important source of gratification or serves as a protection from experiencing undesirable feelings there is no reason to want to give it up unless the consequences of continued drinking become more dystonic than the thought of a sober life.

This situation makes it difficult to know how to proceed. I have a case now which is a good example. I work in the alcoholism clinic of a large hospital. D works in another department and is being considered for an important promotion. His department, aware of

his history of alcoholism, referred him to the clinic for a "checkup." D presented himself in a casual manner, assured me that his drinking problem was solved, that his wife was the main cause of his problem, and that he has had no desire to drink since leaving her. I am always suspicious when told that someone no longer has the *desire* to drink, since nothing has usually happened to make the desire (impulse) leave. The only thing I felt I could do was to be nonjudgmental about his feeling that his drinking problem had been solved, and we arranged to see each other for a few sessions. As we talked, always in a relaxed casual tone, D mentioned that he had been drinking more than he first led me to believe. It has become more and more apparent to me that his drinking problem is not yet solved.

The question now is, do I confront D with my feeling about his drinking problem? He obviously does not want treatment for it, so I can't see doing anything other than joining this resistance. My present plan is to try to have pleasant, enjoyable conversations with him, so that he will want to continue coming in to talk even after he has been cleared by his department. Resistance to dependency feelings will interfere with the patient remaining even when the sessions are comfortable and gratifying, so the psychoanalyst works to provide ego syntonic narcissistic gratification. Although there are no present crises in D's life, his promotion is coming up soon. It is apparent that he is going to want to leave treatment then. Eventually I will be contacted by his department for a progress report. I could at that time recommend that he continue in treatment, but since he does not feel that he needs treatment, this would not be respecting his resistance.

Generally, I find that a person who drinks does not want to deal with the drinking when coming for treatment, but would like specific problems to be solved by the therapist.

Because of the dependent nature of most alcoholics, they often appear to be immediately and intensely involved with therapy. They offer what sound like transference communications, and the analyst prides himself on getting a transference established quickly. Then, suddenly, the patient decides to leave treatment. It is important for the analyst to realize that, as with any narcissistic disorder, object transference takes time to develop. Narcissistic attachment must be used to help the person stay in treatment. The analyst should be on

guard for signs of resistance that threaten to destroy the treatment. The goal in the initial phases of treatment is merely to make the sessions comfortable enough to keep the patient returning.

The question that always comes up in my mind is to what degree you act in a supportive manner to solve or help solve the patient's immediate problems, and to what degree you concentrate on the long-range goal of forming and working with the transference. One of my first clinic patients was a woman who had several crises in her life which seemed to result in her drinking. Her son occasionally beat her up, relatives were trying to take her house away, and her boyfriend was also an alcoholic who needed a great deal of support. All of these problems led to drinking episodes. She was always overwhelmed by these situations and wanted me to help her solve them, assuring me that this would help her stop drinking. It took me quite some time to realize that these urgent situations were life-sustaining and my attempts to help her solve them were bound to fail because they threatened to remove her justification to drink. She solved this dilemma by leaving treatment.

THE ISSUE OF SOBRIETY

If the therapist does concentrate on the long range goal of forming a transference relationship, there is a chance that the patient may continue drinking longer, or may have more slips than when a directive approach is used. This makes for difficulties, particularly in an agency, where successful treatment is usually judged primarily on the basis of the patient attaining and maintaining sobriety. The therapist risks being seen as a failure by the agency, the patients, and himself if sobriety is not achieved.

This always leads me to ask myself how directly I should deal with the sobriety issue. I think the feeling of being a failure is an induced feeling originating from the alcoholic and affecting most people in a treatment agency. The feeling is that the patients always seem to be challenging me to get them to stop drinking. The drinking has a rebellious tone. The patients can't function in certain ways so they drink—they're out of control and they want the therapist to give them enough so that they don't have to go out and

drink. I find it draining to always be trying to give the patient enough so that he doesn't have to go out and drink. The induced feeling is that you should do something—the patient's impulse to act gives the therapist the impulse to act. My question is, should the therapist work specifically to get the patient not to drink, which might be acting on the induced impulses, or is it more important to demonstrate that the therapist can act non-impulsively, even if it means that the patient will drink for some period of time after treatment begins?

I feel the therapist should only act directly when the patient's drinking becomes directly treatment destructive. If the patient is so ill that drinking could result in death or hospitalization, or if drinking could result in jail, loss of job, loss of family, or anything else which might interrupt treatment, then the drinking should be dealt with as a treatment destructive resistance. In one sense, drinking can be thought of as always being treatment destructive, but this is not always so clear. I have one patient who suddenly stopped drinking and taking pills, and became so disoriented from withdrawal that he missed several sessions. In this case, stopping drinking was treatment destructive.

TRANSFERENCE AND COUNTERTRANSFERENCE

I have reviewed my work with alcoholics to try to pinpoint some patterns that have emerged, particularly the kind of transference-countertransference relationship to be expected in alcoholism treatment. The most consistent feeling I experience is that I can never do enough for the patient, that I'm failing and there's really not much hope in working with the person so I may as well lend a supportive ear and help organize his life and not bother analyzing him. To understand this situation it helps to consider the transference-countertransference that occurs when an alcoholic is in treatment. The alcoholic may be regarded as suicidal. Excessive intake of alcohol over an extended period of time systematically destroys the central and peripheral nervous system, liver, heart, muscles, and the gastro-intestinal tract (HEW 1971). The alcoholic is choosing to destroy himself rather than tolerate the emotional-physiological sensations which would arise without drinking. The

drinking behavior serves to protect those around the alcoholic from his murderous impulses. This helps to explain the difficulty in using the transference to treat alcoholics. Spotnitz (1976) notes that people in a relationship induce feelings in each other. If the alcoholic is experiencing intense suicidal, angry, or helpless feelings, these feelings may be induced in the therapist through the transference relationship. So the only thing for me to do is to continue feeling uncomfortable, frustrated, and like a failure, and not try to get the patient to induce different feelings in me. I find this problem with many alcoholic patients; I have an impulse to get the patient to give me different feelings, and have to be careful not to act on the impulse.

I have one patient who demonstrates this problem, particularly around the issue of initial engagement. The patient, B, an 18 year old boy, was referred by the courts for a drinking-related arrest. Working with drinking adolescents is more difficult than working with drinking adults because of the greater strength of the denial system. Most adolescents experience a great deal of peer pressure to engage in impulsive behavior, yet are scornful of those who admit losing control while engaged in these activities. In addition, adolescents receive mixed messages from adults who superficially disapprove of drinking but present it as "adult" behavior. Much liquor industry advertising is directed towards young people.

I have been seeing B for about a year, and we almost never discuss drinking. At first, he was so uncomfortable that he could only stay for about 15 minutes of the session. I then discovered that he liked sports, so we talked about basketball. Gradually, he became more comfortable, and after about 4 months was able to stay for the whole session. Since I felt that I was supposed to deal with his drinking if I was doing my job, I decided to try an experiment. I told him that I was working with another youngster who was only interested in talking about mathematics, and asked him if I should broach the topic of drinking. B told me that if the kid was talking only about mathematics he probably was not ready to talk about drinking and I shouldn't bring it up. Since this incident, B occasionally asks me how this kid is doing.

B has gradually revealed more of his feelings about himself and

his family, and particularly about his father, who raped one of B's sisters before leaving the home. He is finding it helpful to talk about his home life, which troubles him greatly. Recently I changed agencies, and B decided to come along. As part of the intake procedure, we had to fill out some forms which included questions about drinking. B was still reluctant to talk about drinking, and I felt it necessary to deemphasize this area.

After a year, B comes to appointments regularly, and a transference does seem to be slowly forming. I still find myself experiencing feelings of futility, particularly surrounding the drinking problem, as the treatment inches along. B, in the meantime, has become involved in a job training program, and his life does seem to be stabilizing.

SPECIAL PARAMETERS: ARE ACTIVE TECHNIQUES NECESSARY?

Since beginning work with alcoholics, I have been asking myself how to modify my techniques to treat drinking problems. It has become clear that alcoholics need much more active participation by the analyst than is usually provided because drinking is so immediately gratifying that the alcoholic learns to drink at any point of discomfort. This creates a cycle; the more he drinks, the more the ability to withstand frustration decreases, resulting in increased drinking. Assuming that in some way this discomfort emanates from or results in problems in interpersonal relationships, the analytic relationship is potentially the source of great discomfort.

I have found that it is particularly important in the beginning of treatment for the analyst to be aware of the patient's need for gratification and stimulation. In most cases, to provide the correct amount of stimulation, the analyst bases the frequency of his communications on the direct contacts made by the patient; that is, he essentially talks to the patient only when the patient asks him to. This principle might have to be modified with alcoholic patients, however. Many alcoholics have not yet learned to use words to get what they want for themselves. That is, they cannot necessarily ask the psychoanalyst for what they want and may become extremely uncomfortable with a silent analyst while not being able to ask him

to change. If the analyst senses that this is happening, he should provide enough verbal gratification to help the patient be more comfortable in the session.

The patient usually has strong preconceived feelings about the analyst as another in a long line of people who want to change his behavior and do not understand that his drinking is necessary. If the patient enters treatment voluntarily there are usually mixed feelings. He would like to learn to drink socially, or clear up the life problems surrounding the drinking, but would still prefer to drink.

The alcoholic's preconception about the therapist's wanting to control his behavior would probably not be considered actual transference because it is not yet personalized. It is a characterological transference-like feeling and elicits a strong set of reciprocal feelings: most therapists get the feeling that they should be controlling the alcoholic's drinking; the alcoholic probably wants the therapist to try to control his behavior. The fact that it is usually impossible to control the alcoholic's behavior suggests that the alcoholic wants the therapist not only to try, but to fail. This would reenact the early parent-child relationship, where the parents were probably failures in providing the right model for impulse control. It thus seems helpful to demonstrate an understanding of the patient's desire without acting on the impulse to control; that is, it is okay for the patient to want the analyst to control his behavior, but the analyst doesn't necessarily have to do it unless it is mutually agreed. To test this out, I have sometimes asked patients if they would like me to order them to stop drinking. This is an attempt on my part to get the patient's conscious participation in any control I might assert over him. I have never had a patient give me permission to order him to stop drinking. Patients usually change the subject or say they are not interested at this time. They are not interested in cooperating consciously in my ordering them to do something, even though I get the induced feeling that I should attempt to control their behavior. If I get their permission to order them to stop drinking, and exploration reveals they need a command, the order is part of a cooperative venture.

GRATIFYING THE PATIENT

Another issue is gratification. Nothing is quite as gratifying as a drink, but if the therapist can provide some interpersonal gratification, the patient may begin to want to come in on his own initiative. If the analyst is too frustrating, the patient may have to leave to protect himself; and if he cannot leave, the excessive frustration may lead to increased drinking. Most alcoholics are very uncomfortable when sober, particularly in the presence of other people. They are particularly uncomfortable in the presence of an authority figure like a therapist.

What seems to work is providing words. I know therapists who talk a lot to alcoholic patients, but in a way that is supportive—they answer questions, provide a lot of personal information, and help patients with problems. This appears to make patients momentarily comfortable, but I think it makes long-range progress impossible, and also offers a degree of intimacy that can be anxiety-producing for the patient. Many alcoholics report a pattern of becoming intensely involved with people, only to break off relationships when things get too close or gratification isn't readily available. The analyst can provide a quantity of words, but must carefully choose what he says so that the patient's ego boundaries are not impinged upon, remembering that the long-range goal is the formation of the transference.

I am still somewhat uncomfortable doing much talking to alcoholic patients. The basic analytic model is to be quiet, to listen and to reflect questions. Sometimes this is obviously intolerable to the patient, and more talking is clearly called for. How much more is a subtle matter—it's not always clear whether my desire to talk is my subjective discomfort, or an induced feeling from the patient. What I try to do is to provide the quantity of words needed to maintain an acceptable level of gratification, without providing the quality of words that inhibits transference. I feel that attachment to the treatment is achieved when the patient begins to participate more in directing the conversation. A patient, for example, who had difficulty saying anything, picked up on a discussion we were having

about her son's school, and began talking, without questions from me. I felt her anxiety decrease as she became comfortable talking.

I try to keep discussions as object oriented as possible, and to balance my talking with the amount of patient talking that will decrease tension. Many therapists feel that it is important to get the alcoholic to talk about his feelings about himself and drinking, but I have found that that often results in excessive stimulation and narcissistic concern. It is generally more useful not to encourage the alcoholic to become involved in his feelings, but to engage in comfortable casual communication.

STIMULATION AND DEPRESSION

Another concept I have employed in trying to understand how to treat alcoholics is that of stimulation. In a recent workshop led by E. G. Clevans (1978) on the subject of depression in children, it was noted that many children grow up with and seem to become addicted to a great deal of stimulation—television, violence, and sexual stimulation. Most alcoholics I treat report stimulating lives; drinking itself is stimulating. Most of these patients report crises and urgent situations they must constantly contend with. No matter what the social class, drinking usually provokes family, medical, economic, and legal problems. There always seem to be emergencies which have to be resolved immediately. There is too much to handle so the person must drink.

There seems to be a vested interest in maintaining this level of overstimulation. Many patients report overstimulating lives as youngsters; they were either too gratified or too deprived, or exposed to drinking, fighting, and sexual activity by their parents. If stimulation is removed, depression often surfaces. It is common knowledge that people who stop drinking usually go through a period of depression; suicide may be attempted or another drug substituted for alcohol. In treatment, if a basically nonstimulating environment is provided, the patient may become very depressed and continue drinking or leave treatment to deal with the depression. The rationale for the analyst talking is to provide enough stimulation so that the patient does not become too depressed too early in treatment.

If the analyst has to keep providing stimulation, how does he work with the impulse problem? I think that a goal of treatment is to gradually reduce stimulation so that the patient can begin to feel measured doses of depression. One problem is that the alcoholic is used to drinking anytime he has a feeling he doesn't like and the analyst will have little effect outside the sessions. The analyst, then, should help the patient find an activity that provides enough stimulation so the analyst can work towards reducing stimulation in the sessions. As treatment continues and the transference forms, the patient incorporates more of the analyst into his psychic structure, and the effects of the sessions will be more ongoing.

The best example of an environment which provides enough stimulation to deter drinking is Alcoholics Anonymous. AA does not claim to be a therapeutic organization—its goal is to help people stop drinking. AA provides gratification through sympathizing, identifying, socializing, and other activities which provide a stimulation substitute for the alcoholic. Meetings take place around the clock; the alcoholic has a sponsor who can be called anytime there is danger of drinking. If the analyst is successful in getting the patient involved in AA and other activities which provide substitute gratification for drinking, he can gradually reduce the stimulation in the sessions and allow the feelings underlying the impulsive behavior to surface.

Many patients resist becoming involved in AA. Some are afraid of the interpersonal contact or do not like to identify with other alcoholics. Many realize that involvement with AA spells the end of their drinking. I find the best way to deal with this is to treat it like any other resistance, since AA involvement is almost always a positive indication for successful treatment. If the patient refuses to become involved in AA, other activities which are gratifying and stimulating can be substituted.

I have found group therapy valuable too. Many alcoholics prefer group treatment because they get to identify with others like themselves—it is much like AA in this sense. Also, the intimacy of the one-on-one relationship can be threatening, particularly with a non-alcoholic therapist. Most alcoholics prefer to be in groups composed of alcoholics because they feel threatened by non-alcoholics.

FOSTERING OBJECT RELATIONS

Group therapy affords, as well, a good opportunity to work on object relations. Many therapists use groups to focus on an individual alcoholic's problems, and encourage the others to identify. This, however, encourages the person to think about himself and ignores the group. In groups I try to emphasize the idea of people merely talking to each other—about anything, not necessarily their problems. Most group members are surprised when I tell them they do not have to talk about their problems; they think that is all they are supposed to do. I try to focus on group resistances, such as silent or monopolizing members, or treatment- or group-destructive resistances such as absence or lateness.

Two experiences with alcoholic groups come to mind. One group was depressed and could not sustain any interaction. Every two or three weeks, however, the members would realize what an inadequate therapist I was and berate me. During these attacks they came alive, interacted and were satisfied with the group. Even though there was an element of sadism, by projecting inadequacy feelings, the group functioned much better during these periods. In another group, members were friendly on the outside, mostly in AA, and consequently talked easily with each other and ignored me. I found that whenever I said anything it didn't seem to contribute much. I discovered that my feelings of being left out caused me to want to talk. Even though the content of the discussions remained superficial and the group did not seem to be moving forward very quickly, the members were, in fact, talking to each other with increasing ease and comfort. I decided to resist the impulse to talk, and instead remained silent. Helping group members to feel comfortable talking to each other sometimes takes precedence over giving them understanding about their problems.

RESOLVING COUNTERTRANSFERENCE RESISTANCE

The treatment of alcoholics lends support to the concept that the transference-countertransference relationship can be used to cure a disorder with physiological components. Much revolves around the feelings generated between the patient and analyst. The alcoholic's impulse to drink induces such strong impulses in the analyst to act that the feeling of needing to do something is quite uncomfortable. I have one patient who constantly tells me that he can't sleep and has nightmares; he suffers so much that I have a tremendous urge to provide relief for him. The solution is to provide something verbally. Because of the feeling of not being able to do anything, I want to do more. If I don't do the right thing he is going to drink, and I'm not sure what the right thing is, or even if there is a right thing because nothing is quite as fulfilling as a drink. I always have the impulse to try to be as soothing as the drink. If I don't, something terrible will happen—he will fail and I will fail. He called the other day to tell me he had his first slip after three months of sobriety and I felt *relieved.*

I find, in fact, that one of the hardest things in working with alcoholics is getting used to feeling like a failure. I think that this is a necessary feeling, however, because in one sense you are failing—failing to provide the gratification patients feel they need, and certainly failing to provide as much gratification as alcohol provides.

Many therapists avoid the feeling of failure by placing responsibility for the success of the treatment on the patient. While this may be acceptable for a more advanced patient, in the beginning and intermediate stages of treating an alcoholic, it is advisable for the analyst to take full responsibility for any failure in the therapy. Just as an infant is not responsible for his own upbringing, the severely regressed alcoholic should not be responsible for his therapy. This will ultimately help the patient to stop attacking himself and focus on the object (analyst). Treatment progresses when the patient can complain in words rather than action.

I have also learned from working analytically with alcoholics that impulsive behavior takes many forms besides obvious ones like drinking. The analyst is capable of acting impulsively in subtle ways,

and it has been challenging to attempt to weed impulsiveness out of my communications with patients. I have also begun to learn that an addiction is really a horrible thing. The addicted person feels unable to control himself, generating terrible feelings of shame and helplessness. In the analytic process, the analyst is not actually taking away the addiction, but asking the person to experience the feelings underlying the addiction by relinquishing the drinking behavior. The transference has to be firmly established to work this through. Almost every alcoholic patient I have treated has told me that he wanted the desire to drink to go away. I don't know if the impulse goes away when the addiction is finally resolved or whether the person just learns to control the impulsive behavior.

I think that working with alcoholics provides a great opportunity to learn about the relationship between psychological and physiological disorders. We already know that diseases such as ulcers and other stomach disorders are, in part, psychologically induced; alcoholism too may be classified as one of the diseases with psychosomatic components. The challenge for the analyst is to focus on how talking helps the alcoholic to control his impulsive behavior, and to use the transference in this endeavor. We can see now the possibility of altering bodily functioning with emotional, verbal communication. The understanding of this will have brought us a long way towards scientifically using emotional communication to affect the body.

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