THE ADDICTIVE PROCESS

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In order to understand and treat addictions one must go beyond the specific agent and practice, one must understand the addictive process. The author bases his conceptualization of an addictive process on twenty-five years of naturalistic observation, individual and group psychoanalytic psychotherapeutic treatment and therapeutic trials of one hundred and thirty-three single and poly substance and behavior addicted patients. No single addictive personality (addict) exists. People become addictive because specific etiological and constitutional factors contribute to their vulnerability to the addictive process. This process can be defined and diagnosed. It involved common inter/intrapersonal psychodynamics. One must look for the addictive complement and trigger mechanisms which can initiate and perpetuate the process. The process has a life history and stages, which can be cyclic, periodic, or sporadic. The individual can shift from one addiction to another or sustain multiple addictions at different times. Understanding the above factors is essential to making an accurate diagnosis and to treatment.

A society's psychopathology has its roots in the nature of that society's changing familial, social, and goal-directed patterns as they shift and fluctuate over a span of time. Our society has become increasingly one of *polarized excess*. Our excesses and preoccupation with them are reflected in the rapid growth in a short time of the number of people in it who can be characterized as *addictive*.

The word "addicted" has become generalized and no longer confines itself to the World Health Organization's definition of addiction:

> a state of periodic or chornic intoxication produced by the repeated consumption of a natural or synthetic drug for which one has an overpowering desire or need (i.e., compulsion) to continue to take. . . to obtain. . . by any means with the presence of a tendency to increase the dose and evidences of phenomena of tolerance, abstinence and withdrawal, in which there is always psychic and physical dependence on the effects of the drug.

In common parlance we now extend addiction to relate to almost any substance, activity or interaction, as well as to drugs. People now refer to themselves as being addicted to food, smoking, gambling, buying, forms of work, play and sex.

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PSYCHIATRIC QUARTERLY, 54(3) Fall, 1982
0033-2720/82/1500-0149$02.75

Over the years much has been written about the "addictive personality" that is commonly found in these specific addictions. No single addictive personality type (i.e., addict) exists. Rather people become addicted because specific ethnic, familial, intra/interpersonal, peer, environmental, constitutional and genetic factors collectively contribute to their vulnerability to the *addictive process*. This process can be defined, diagnosed, and has common etiologies and psychodynamics. It has early, middle and end stages. The author bases these formulations on 25 years of diagnostic evaluation and naturalistic observation of addictive patients seen while Admitting Psychiatrist and Consultant to Alcohol and Drug Abuse Service at the Payne Whitney Out Patient Clinic, New York Hospital and in private practice. They have also been culled from fifteen years of individual psychoanalytic psychotherapeutic investigation and therapeutic experimentation with 133 patients addicted to drugs (alcohol, nicotine, caffeine, heroin, demerol, amphetamine, cocaine, barbiturate, polydrug), food (obese, anorexia nervosa, bulemia, compulsive vomiting), sex (hetero/homosexual, satyriasis and nymphomania), gambling and work, and on one year's group therapy (audiotaped) of (2) gambling, (1) gambling/food, (2) food/obese, (1) alcohol/smoking, (1) sex/amyl nitrate, and (1) work/sex addicts.

The addictive process must be distinguished from obsessional thoughts and compulsive acts and the obsessive-compulsive neurosis. Neurotic obsessions are repetitive, meaningless, unwelcomed, afford no pleasure, and produce loss of energy, ambivalence, and doubt that destroy mental functioning. Neurotic compulsions are repetitive, unwelcomed, alien, meaningless, trivial, or ritualistic behavior performed against one's will. The behavior can be silly or terrifying, and the individual usually consciously attempts either to free himself from it or to ensure its continuance. It gives no pleasure and is not necessarily dangerous to the psyche or body. In both neurotic obsessions and compulsions, there is always awareness of pain, dysfunction, and sometimes a conscious need to hide the thoughts and behavior because of shame or embarrassment. The individual often seeks help because of his admitted pain and awareness of the crippling nature of the disease. Compulsive acts and obsessive thoughts are not easily hidden, denied, suppressed, repressed, dissociated, or split off, but are consciously painful and are admittedly destructive to the self and others. There is no evidence of tolerance, withdrawal, or abstinence phenomenon, toxicity, or destruction to bodily functions.

DEFINITION OF THE ADDICTIVE PROCESS

The individual in whom the addictive process is operant has an overpowering desire or need for a substance, object, action/interaction, fantasy and/or milieu that produces a psychophysiologic *high*. This desire or need is repetitive, impulsive and compulsive in nature. The high is a pleasurable coping mechanism to any physical/psychic pressure, conflict, stress or pain. Over the life span of the process the high diminishes. The individual experiences progressively

less relief with increasing degress of tolerance,* abstinence** and withdrawal*** phenomena. In the end stages there is no relief, masking, coping or resolution of the pain and only vestigial pleasure derived from the process.

Symptom formation, *hangover* phenomena (i.e., tension, anxiety, depression, withdrawal, guilt, paranoid reactions, fear, mood swings, somatizations, physical deteriorations, etc.) occur to contradict ongoing repression, denial and rationalization. Hangover phenomena must inevitably emerge because of increased usage of the addictive agent(s) and/or the consequent deteriorations in life style (survival), and destructive confrontations and relationships.

Psychic and physical dependence occurs because of disturbed ego and superego functioning. Character defects (dishonesty, manipulation, blaming others, insatiability, irresponsibility, grandiosity, etc.) can provoke or emerge from the process itself. The process can be continuous, cyclic, sporadic or periodic depending upon the individual's life history. It remains predictable based on specific historical, psychodynamic and environmental *trigger mechanisms* (See Table 1). Shifts can occur from one addiction to another or several can coexist. An individual can become an *addictive complement* (i.e., provocateur), not necessarily addicted to an agent, but nonetheless an integral part of the process.

I define *addictive complement,* as any person, group, or environment that keeps the addictive process alive. For example, a work-addicted, nagging parent with an excessive superego becomes the complement of a drug-addicted or play-addicted child, who is subject to no control or consciously ignores and denies the parent's practices and controls. Another is the spending-addicted wife who keeps her husband's work addiction alive. Many an addict finds a person whose addiction feeds into and seems to justify his own. The addict also needs people who can provide what he feels is lacking in himself or with whom to make exchanges of what each lacks. He becomes bound to such people—relatives, spouses, lovers, peers—with his addictive substance or practice as the catalyst.

When an addict finds a subculture, he finds not only partners to support his addictive cycle, but a steady source of complements. He spends more and more time with peer addicts who will trigger increased addictive behavior by making it seem more valid.

Sometimes an addict finds his complement in just one person with whom he forms a closed and symbiotic relationship, removed from the mainstream of life. Although able to rationalize each other's and their own behavior, they cannot deal with rejection and hostility from others around them. This only deepens the

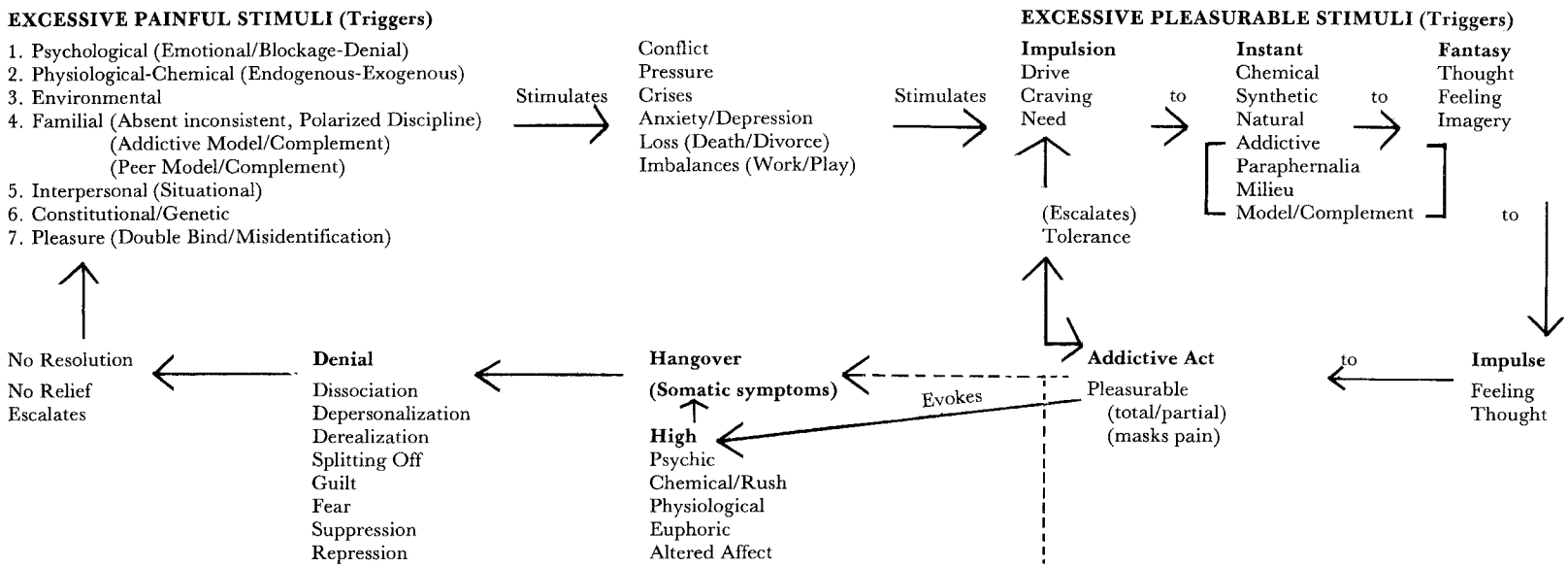
*Tolerance is increasing resistance to the effects of a drug, the need for increasing dosage to maintain or recapture the desired drug effect. In general, the more saturated body cells become with any substance, the longer the period required to rid them of all traces of a drug. Related to physical dependence—it involves the need to have some quantities of drug present within the body, or at least within some of its cellular elements. In addictions other than drugs, the term refers to a need for increasing amounts of addictive agent, interaction, or activity with less and less satisfaction taking place. The ability to endure without ill effect increasing amounts of addictive agents with decreasing effects of continued use of the same dose of the drug.

**Abstinence is voluntarily refraining from the use of an addictive agent, interaction or activity. It is the denial of gratification that comes from physiological and/or psychological dependence.

***Withdrawal is abstaining from an addictive agent interaction, or activity on which the patient has become dependent. It produces physiological and/or psychological symptoms.

TABLE 1: The Addictive Process

Cycles



process. The addictive agent/process can also be utilized as a means of dealing with untreated and painful psychotic symptoms often masking the psychosis or bringing temporary relief.

THE ETIOLOGY OF ADDICTIVENESS

Shifting etiologic factors at different stages of a person's life breeds addictiveness. These factors become complex and elusive once vulnerability evolves into a full-blown identifiable addiction. The process is then autonomous and self-perpetuating. The initial causes often remain unrevealed and unrelated to the perpetuation of the process, which has developed a life of its own.

The constitutional background of a person and his and others' reactions to it can be important determinants of addictive proneness. These factors can result in a person perceiving himself as excessively inferior or reactively superior to others. The consequence can be feelings of isolation and alienation which are provocative of the process.

The most common early history of an addict is that of a person who has experienced one or many *polarized excesses, inconsistencies,* and/or *deprivations* in the following significant areas: intimacy, discipline, parental role models (gender-erotic), passivity-aggressivity, work-play functions, frustration tolerance and ability to delay gratification or to live with moderation. The impairment of the development of these functions is responsible for varying degrees of destruction of ego (self-esteem) and superego (control) that exist. The child identifies with one or both parents' and/or siblings' inability to monitor excess. He does not learn that appropriate reward emerges from disciplined sustained and ordered effort. Failure and frustration ensue. Relief is sought within the addictive process. Polarized excesses and deprivations also result in the individual's experiencing either too many, too few or no options to cope with pain, conflict, pressure or stress. Self-monitoring becomes impaired or is absent because of exposure to and identification with the commonly present addictive family member(s) and/or peer(s). There also can be a reaction against the specific familial addictive practice with a choice of another form of addiction. In the addict-prone individual's earliest years he is usually unable to practice a familial addiction such as drinking, smoking, gambling, sex, etc. He can then become addictively involved with food, compulsive work or in recent years more easily available drugs than existed for the parent. When the parent himself is a victim of the addictive process, he can inappropriately depend upon the child to either support or control his addiction. The child becomes the parent's addictive complement within the process.

One must look beyond the family to discover the cause of the addictive process. Even if a defective self-esteem and superego system has not been overt it is certain to emerge once the process has been set into motion. Excessive early social isolation is common and provocative of a paucity of intimate nurturing relationships. The individual finds relationships progressively more painful, resulting in a high incidence of provoked, imposed or actual rejections. As a reaction to his isolation, there is a development of patterns of excessive dependency and/or ineffectual independence in collusion with an addictive family member or peers. Separation and individuation during adolescence is

ineffective. The adolescent becomes involved in the addictive process as his means of rebellion. There is evidence of excessive needs to overcontrol and/or to shift to being overcontrolled by others because of excessive dependency needs. Sadomasochistic interactions can emerge in those with an underlying rigid superego. There are conscious and unconscious needs to be punished for addictive behavior or to punish those who interfere. These interactions become a vicious cycle. There is always a high degree of narcissism and shifting from overevaluations to self-contempt as a defense to society's reactions to the addictive practice and identity and to the progressively destructive consequences of the process itself. It is not easy to determine which came first, the current destructive interpersonal interactions and self-contempt or the addictive practice. In any event, the process is perpetuated by these polarized excesses in inter/intrapersonal interactions and self-perceptions.

The peer group can be a central etiologic factor of the addictive process. A need to establish peer status and to be accepted by one who has been afraid or unable to identify with his peers can provoke emergence into the process. Where a youngster has been excessively passive he is vulnerable to peer pressures that can initiate and perpetuate addictive practice. The practice can also occur from a need for peer leadership which he is unable to attain. If there had been a past history of success that no longer exists after having moved into a more competitive peer group, the practice can become a form of pseudo-leadership. Problems in an adolescent's ability to establish, identify and cope with a society's prototypic gender and erotic role and currently valued sexual practices can be a core provocative factor of the process. Not uncommonly the individual is introduced into his addictive practice in a one-to-one secret addictive peer collusion in order to deal with fear, guilt, or anxiety.

A host of socioeconomic factors can play a role in contributing to addictiveness. Failure to achieve the familially proscribed or desired socio-economic status, rapid, frequent and frustrating shifts upward or downward from one level to another during crucial developmental periods of a person's life, or the painful awareness that opportunities exist for others but not for themselves (being ghettoized) are the most common. The addictive process can for some become an identity, a life style, or the very means of securing economic/social status, which is reinforced when the individual becomes a member of an addictive subculture.

The media contribute to the addictive process by promoting addictive practices as the best ways to cope with or to resolve pain, conflict, pressure, stress or to attain all forms of success. The media often reflect the many parental polarized excesses by delivering double-bind contradictory messages. The public is inundated with both the values and dangers of addictive agents and practices. Typical is the promotion of the joy of smoking, which appears with a white label in small print noting that cigarettes are carcinogenic.

THE PSYCHODYNAMICS OF ADDICTION

When an individual develops an addiction, he develops along with it a set of trigger mechanisms both pleasurable and painful which make the addiction self

perpetuating. These mechanisms emerge from any physical, psychological, inter/intrapersonal or environmental stimuli, conflicts, pressures, or crises which in turn provoke a desire leading to a fantasy and impulse to obtain an addictive agent (i.e., engage in an addictive act). The sequence becomes circular; each trigger leads to an addictive act and each addictive act sensitizes the individual to future triggers. The process escalates because the act provides only temporary relief and coping through the high, but ultimately requires increasing or steady amounts of the agent without resolution or satisfaction of the original stimuli. Initially the anticipation of the peasure and of the act removes any awareness of what might have triggered it.

Denial, repression and rationalization are major mechanisms of the addictive process. Denial of the nature, depth, and duration of one's addictiveness can be obscured by poor reality testing. Inability to account for the amount of time spent in addictive acts or fantasies with resultant generalized distortions of time occur.

The emotional excesses, deprivations and swings to which the addicted person was subject as a child, with the resultant imbalanced ego and superego, always leave him with dependency problems of varying degrees. He usually is unaware of how dependent he is and how insatiable his needs appear to people. He looks for a person as well as a substance or a practice to help him satisfy his dependency needs. Often he is aware only of a series of painful rejections when they are not met.

CONCLUSION

In order to understand and treat addictions, one must go beyond the specific agent and examine the multivariant etiologies, dynamics and interpersonal interactions. One must examine the *addictive process.* This process can be defined and diagnosed. It entails common etiologies and psychodynamics. It always involves more than the addictive person and agent. One must look for the *addictive complement* and *trigger mechanisms.* The process has a life history in which there may be shifts from one addiction to another or multiple addictions at different stages. Understanding of the above factors is essential to establishing a diagnosis and engaging in effective treatment.

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