ON THE ÆTIOLOGY OF DRUG-ADDICTION

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There are three main sources of psycho-analytic interest in drug-addiction. In the first place its ætiology is still obscure ; consequently the treatment of drug-addiction lags behind that of the psycho-neuroses. It is true the psycho-analyst is justified in asserting that the only radical approach to drug habits is through psycho-analytic treatment ; but he cannot remain content with such a general recommendation. He ought to be in a position to direct his psycho-analytic energies with more precision. There is a considerable difference between ' analysing ' a drug-addict and analysing ' drug-addiction '.

A second source of interest lies in the correlation of drug-addiction with various other psychopathological states. Owing to the close connection on the one hand between drug-addiction and the psychoses, and on the other between drug-addiction and social or sublimatory defence-reactions, it is probable that drug states will prove an essential link in the understanding of such different phenomena as paranoia, obsessional neuroses, open-air cults or even an addiction to scented soap.

The third source of interest is mainly domestic. Study of psycho-analytic views concerning alcoholism and other drug-addictions seems to me to illustrate very clearly the different tendencies which from time to time have dominated psycho-analytical research or doctrine. Those whose interest in psycho-analysis is comparatively recent, dating, say, from the publication of *Beyond the Pleasure-principle*, might be excused for thinking that sadism and the aggressive instincts are new discoveries. In a sense this view is not entirely without justification. Wider historical reading shows however that whereas in earlier times the importance of sadism was recognized clinically, its ætiological significance was to some extent obscured by a preoccupation with more predominantly libidinal factors. Indeed, there are some grounds for the view that psycho-analysts can be divided into those who, as it were, have been brought up on the doctrine of sadism and the aggressive impulses and those who are still strongly under the influence of earlier discoveries concerning libidinal impulses and frustration.

Now it is interesting to note that the first stage in investigating

drug-addiction coincided with a period when the tendencies of psycho-analytical research were more or less convergent. Psycho-analysis bore down on the problem armed with experience of transference neuroses, holding closely to traditions of libidinal disturbance, in particular, castration anxiety dating from the phallic phase of libidinal development. The result was a standard reconstruction of psychic events, originally sketched by Abraham [1] in the case of alcoholism and added to piecemeal by later investigators. The details of this reconstruction require no recapitulation. I need only recall the emphasis laid on fixation of libido at oral or anal levels, on the comparative weakness of adult heterosexual interest, the importance of unconscious homosexuality, the significance of alcohol and other drugs as symbols of the procreative power of the male (father, God), the secondary breakdown of sublimation, and the symbolic castration represented first by impotence and later by physical and mental deterioration.

Even in this short summary the bias of libidinal interest is unmistakable. But another equally important tendency is liable to escape attention. The approach to drug-addiction was (and still is) profoundly influenced by the concept of *regression*. The opposite view of a *progression* in psychopathological states has never been exploited to the same extent. The idea of progression implies that psychopathological states are exaggerations of 'normal' *stages in the mastering of anxiety* and can be arranged in a rough order of precedence. It is, of course, implicit in Freud's [2] original pronouncement regarding paranoid states: namely, that the symptom is in part an attempt at restitution, i.e. an advance from the unconscious situation it covers. Not only does it restore some link with reality, however inadequate, it performs also a protective function. The protective and restitutive aspects of other psycho-pathological states have not been given the same attention. For example, we have long known that obsessional mechanisms function comparatively well in the remissions of melancholia: nevertheless we are inclined to look askance at an obsessional neurosis *per se*, as a 'severe regression'. We think and talk of this neurosis as the result of a defensive flight backwards from the anxieties of an infantile genital system of relationships; rather than a remark-

[1] Abraham: 'The Psychological Relations between Sexuality and Alcoholism', *Selected Papers*, London, 1927.

[2] Freud: 'An autobiographical Account of a case of Paranoia', *Collected Papers*, Vol. III, 1925.

able impulsion forwards, a striking advance on the discomforts of an unconscious paranoid organization. Indeed it has been left to the psycho-analytical anthropologist and in more recent years to the child-analyst to administer a corrective to the clinical pessimism which goes with a bias in favour of regression. As a matter of fact, if we study the numerous drug-habits which, owing to absence of dramatic individual or social consequences, are called 'idiosyncrasies' or 'indulgences' rather than addictions, we can see that drug-addiction is frequently a successful manœuvre. The point is of considerable therapeutic interest. Obviously if we can grasp the progressive relations of psychogenetic states, our therapeutic energies can be directed with greater accuracy. For example, the cure of an addiction or even of a severe obsessional state may depend more on the reduction of an underlying paranoid layer than on the most careful analysis of the recognized habit-formation or obsessional superstructure.

To return to our historical survey, the first discoveries concerning addiction were followed by a phase of stalemate. This deadlock coincided with the realization that what had been regarded as almost a specific libidinal factor could no longer be so regarded. The element of unconscious homosexuality had never accounted satisfactorily for variations in the structure of different addictions and it was gradually found to be non-specific. Flight from unconscious homosexuality had already been advanced to account for the systems of paranoia; it was regarded as an important factor in obsessional states; it was discovered to be a source of violent resistance in characterological analyses and it gave considerable trouble in the analysis of normal people. The attempts made to emphasize regressive libidinal aspects of homosexuality, in particular the reassurance obtained by flight from genital anxiety were not satisfactory: reassurance mechanisms alone do not constitute a complete etiology. Other efforts to maintain a purely libidinal etiology were not any happier, as for example, Schilder's [3] view that intoxicants brought about changes in the libido and artificially increased homosexual components.

On the other hand, fresh progress seems to have been made by paying more attention to the associated element of sadism and the reactions produced by the aggressive group of impulses. These reactions were first of all studied directly in the form of projections,

[3] Schilder: *Entwurf zu einer Psychiatrie auf psychoanalytischer Grundlage*, Wien, 1925.

reaction-formations, regressions or inhibitions of psychic and motor activities, and later indirectly by scrutinizing the super-ego apparatus which is responsible for using up certain sadistic quantities. But in spite of the fact that newer concepts of sadism and of the super-ego have been applied in the study of drug-addiction, and have increased our ætiological understanding, the amount of progress made has not been entirely satisfactory. And I consider this is due in part to a divergence of views as to the actual significance of sadism. The divergences can be detected not only in papers on drug-addiction, but throughout the field of psycho-analytic research. As I have said, sadism is no new discovery. The concepts of hate, aggression and sadism have always been implicit in the concept of ambivalence and an increasing appreciation of its importance can be detected historically in the emphasis laid on negative transferences. The sadistic factor in transference was obscured for a time by the correlation of the negative transference with the inverted Œdipus situation. But this stage did not last, and there must be few analysts who have studied unconscious homosexuality in recent years without forming the conclusion that the problem of unconscious homosexuality is, roughly speaking, the problem of sadism.

In spite of this fact, I maintain that a very clear divergence of opinion can be detected in recent writings on drug-addiction, and also, though less obviously, in papers dealing with the psychoses. For one group sadism is still viewed through transference neurotic spectacles and valued in terms of genital development. The theoretical importance of pregenital sadism is freely admitted, but in practice it is regarded as a potential reinforcement of late Œdipus ambivalence, brought into action by the mechanism of regression. Other workers are not content to trace the development of sadistic impulses from the earliest stages onwards; their aim is to establish definite correlations between a series of characteristic fusions of aggression and certain psychopathological states, pre-eminently the psychoses and addictions and to a lesser extent compulsive formations.

This difference in tendency can be brought out by a comparison of earlier with more recent views on paranoia. It is true that in Freud's latest paper on paranoia [4] the significance of death-wishes is emphasized, and it is true also, as has been stated, that aggression is implicit in the

[4] Freud: 'Certain Neurotic Mechanisms in Jealousy, Paranoia and Homosexuality', *Collected Papers*, Vol. II, 1924.

earlier conception of ambivalence. Nevertheless in the Schreber paper no direct mention was made of the aggressive impulses and the mechanism of paranoia was described mainly in terms of libidinal conflict and related to repression of the inverted Œdipus situation. Only a few statements in Freud's more recent writings help to modify the earlier emphasis on libidinal factors in paranoia, e.g. that the mechanism of projection depends on ambivalence,[5] or that in cases of homosexuality an exceedingly hostile aggressive attitude has been not only repressed but *transformed* into a love relationship[6]; implying thereby that a homosexual system can function as a defence against hate and aggression.[7] Considering that for the last fifteen years Freud has constantly emphasized the general importance of hate, aggression and destructive impulses in ego-development, it is all the more remarkable that these teachings have not yet been fully reflected in ætiological formulations concerning paranoia. Yet such is the fact.

A definite contrast is afforded by the views of Melanie Klein.[8] She asserts that the fixation-points of the psychoses are pregenital sadistic fixation-points: that the individual experiences paranoidal anxiety in the early anal-sadistic phase: that the fixation-point of paranoia falls in the phase of phantasied attack on the mother's body; that the individual's aggressive tendencies are transferred to the excretory systems, hence that fæces and urine and all associated organs are unconsciously regarded as possessing dangerous sadistic properties, the projection of which gives rise to anxieties of attack from without; that in particular the fear of poisoning can be related mostly to the individual's original anal and urethral sadism.

I do not suggest that the degree of emphasis laid on sadistic elements necessarily involves any contradiction between the two points of view described. And it has to be admitted that early work of Stärcke,[9]

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[5] Freud: *The Ego and the Id*, London, 1927.

[6] Freud: 'Certain Neurotic Mechanisms in Jealousy, Paranoia and Homosexuality', *Collected Papers*, Vol. II, 1924.

[7] Later, in *The Ego and the Id*, Freud takes the view that this transformation does not imply a transformation of hate into love, but is the result of a transfer of neutralized energy to the love aim. This later view does not detract from the defensive significance of the manœuvre.

[8] Klein: *The Psycho-analysis of Children*, Chap. IX (appearing shortly).

[9] Stärcke: 'The Reversal of the Libido-sign in Delusions of Persecution', this JOURNAL, 1920, I., 231; 'Psycho-analysis and Psychiatry', *ibid.*, 1921, II, 361.

Van Ophuijsen,[10] Abraham [11] and others to a certain extent foreshadowed the views expressed by Melanie Klein (e.g. Stärcke's view of the part played by ' negative libido ' in the psychoses). But there are definite differences, (*a*) in respect of the detail with which the sadistic phantasy-systems and defences of the earliest years are outlined (Melanie Klein's being presented with much greater detail), and (*b*) in regard to the exact nature of libidinal contributions in those early stages. The most important difference can be expressed by saying that if the ' genital incest—ambivalence—castration anxiety ' nucleus be taken as the model Œdipus situation, one must be prepared, following Klein's work, to discuss the existence of earlier Œdipus situations carrying a higher sadistic charge. It is true that in recent times writers on paranoia refer more frequently to sadistic factors, but they continue to link up those factors with an Œdipus situation of the model genital type (see e.g. Kielholz,[12] Feigenbaum [13] and others). The same applies to studies on delusions of poisoning and other poison phantasy-systems. Although both Kielholz and Fenichel [14] lay considerably more emphasis than usual on the sadistic significance of poisons and excretions, they end on a much milder note of pregnancy and castration phantasy. Here again the difference can be made clear by pointing out that if a representative group of analysts were asked to give a brief interpretation of a poison phantasy, many, including Fenichel himself, would simply describe it as an impregnation phantasy derived from the ' classical ' Œdipus nucleus ; others would regard a poison phantasy as a projection of the sadistic weapon by means of which the primitive ambivalence relating to early frustration at an oral-anal level is expressed, and in which a mainly prephallic view of the Œdipus situation is reflected.

The same divergence can be demonstrated in the case of drug-addiction. If one studies recent psycho-analytic literature on the

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[10] van Ophuijsen : ' On the Origin of the Feeling of Persecution ', this JOURNAL, 1920, I, 235.

[11] Abraham : ' A Short Study of the Development of the Libido ', *Selected Papers*, London, 1927.

[12] Kielholz : ' Giftmord und Vergiftungswahn ', *Internationale Zeitschrift für Psychoanalyse*, 1931, XVII, 85.

[13] Feigenbaum : ' Paranoia und Magie ', *Internationale Zeitschrift für Psychoanalyse*, 1930, XVI, 361.

[14] Fenichel : ' Uber respiratorische Introjection ', *Internationale Zeitschrift für Psychoanalyse*, 1931, XVI, 234.

subject, it is clear that in spite of copious reference to hate and sadism, early fixations, psychotic components, etc., drug-addictions are ultimately assessed in terms of late genital anxieties. Even where attempts are made to establish deeper roots for the fixations of addiction the tendency is to look for them in phases of development when psychic structure must be of the most rudimentary order. Thus Rado,[15] although correlating drug-addiction and abstinence with a manic-depressive sequence, looks for the basic fixation in a phase of 'alimentary orgasm' on which a pharmacotoxic orgiastic system is built up. It is true he does not exclude entirely a psychic organization based on this alimentary system, but he has so far attached no specific content to this psychic system. On the other hand he goes on to say that later guilt systems have no specific relation to drug-addictions: that they play no greater part in these addictions than in other pathological states. Simmel [16] in a recent paper shews both tendencies. He ultimately relates drug-addiction to melancholia but only as a secondary regression following a primary obsessional mechanism; as one might gather from his interest in obsessional factors in addiction, he expresses the anxiety factor mainly in terms of castration anxiety. And he follows Rado in seeking for a fixation factor in a phase antedating organized psychic structure, viz. a stage of primal intestinal narcissism. Incidentally, like many other writers, he introduces the 'death instinct' as a factor, a course which always seems to me to beg the question of the actual history of sadistic and destructive impulses.

Stimulating as these contributions are, they exhibit an almost reactionary tendency. Pre-structural factors of this type can be adequately valued as 'constitutional' or 'predisposing' without employing the term fixation. This has always been the practice in estimating the importance of erotogenic zones. Granted that close attention should be paid to dispositional factors in drug-addiction, it seems unduly pessimistic to lay stress on these elements to the exclusion of later guilt-mechanisms. And granted that the latest guilt-systems cannot be regarded as specific, there seems no reason to exclude earlier specific guilt-reactions.

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[15] Radó: 'The Psychic Effects of Intoxicants', this JOURNAL, 1926, VII, 396; 'The Problem of Melancholia', *ibid.*, 1928, IX, 420.

[16] Simmel: 'Zum Problem von Zwang und Sucht', *Bericht über den fünften allgemeinen ärztlichen Kongress für Psychotherapie*, 1930.

The opposite tendency, viz. search for a specific etiology of drug-addiction of a kind that is primitive without being pre-structural is hard to find in psycho-analytic literature. Drug-addiction has been treated on the whole as a step-child of the psychoses. I have on previous occasions [17] referred to the mechanism of one type of alcoholism as an ' inverted paranoia ' and have said regarding drugs in general that they represent the poisons and elixirs wherewith the sadistic aftermath of early libidinal relations is treated. But the only specific reference I can find in the literature is in the form of a speculative suggestion made by Melitta Schmideberg.[18] Writing on psychotic mechanisms, and in particular on the means whereby dangerous ' introjected ' objects (or their substitutes) can be countered, she describes how a dangerous substance can be transmuted into a beneficent substance, also how friendly substances can be used to neutralize or expel malignant substances. She goes on to link this system with medicinal treatment in general and adds : ' Probably this mechanism is at work in morbid cravings ; the drug would signify the good father who is to fight against the bad introjected father . . . soon it comes to signify the bad father against whom nothing avails but the taking of more drugs '. This is ' reinforced by the pharmacological effect of drugs as opposed to medicines that really heal '.

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In the last few years I have had fresh opportunities of studying some drug-addictions and have compared my recent impressions with former experiences of drug-habits. In particular I have tried to find some precise relation between drug-addiction, psychotic states, obsessional neuroses and neurotic character peculiarities. I have also tried to estimate the relative importance of the phallic Œdipus organization and of more primitive types where, it is held, pregenital sadism dominates the picture. The methods of valuation were on the whole empirical, namely, observing the type of mental mechanism employed in different states of anxiety, and the amount of reduction of anxiety that could be effected by following various lines of interpretation.

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[17] Glover : ' The Etiology of Alcoholism ', *Proceedings of the Royal Society of Medicine*, 1928, XXI, 45 ; ' The Prevention and Treatment of Drug-Addiction ', *ibid.*, 1931, XXIV.

[18] Schmideberg : ' The Rôle of Psychotic Mechanisms in Cultural Development ', this JOURNAL, 1930, XI, 387 ; ' A Contribution to the Psychology of Persecutory Ideas and Delusions ', *ibid.*, 1931, XII, 331.

I am bound to say that as between the tendencies I have described in the earlier part of this paper, recent experience biases me in favour of the second. I agree that interpretations of a nuclear complex existing prior to the mainly genital Œdipus phase are to a certain extent suspect, that they are subject to the charge of being '*rückphantasieren*' products, that they may exploit regression instead of uncovering it. In short, I agree that the onus of proof is on those who attempt to modify existing systematizations. But I cannot find any adequate explanation of drug-addiction which does not assume an active Œdipus situation at a stage when object relations are little more than the psychic reflection of organ relations; when sadistic and libidinal functions overlap considerably and before libidinal systems—chiefly the oral, excretory and early genital systems—have established a stable balance between psychic representation and repression.

The justification for appropriating the term 'Œdipus' in this context would take us too far afield. I have the impression that objections to this course are to a certain extent pedantic. A psychic situation contains the essential ingredients of an 'Œdipus' complex provided: (1) a state of instinctual frustration exists, (2) this state of frustration is related by the subject to more than one object (or part-object, i.e. organ-object), (3) some degree of genital interest exists (whether directly frustrated or not), and (4) the state of frustration evokes an aggressive reaction to one or more objects (or part-objects). The first and fourth conditions have never been in dispute. The second stipulation has many advantages. By using the term 'part-object' or 'organ-object', we are able to take cognizance of the fear and conflict brought about by serial frustration of different components of infantile sexuality. And we avoid the necessity of presuming a completely organized set of imagos of both parents. Moreover, it enables us to appreciate more fully the amount of conflict existing at a stage when libidinal interests are almost exclusively directed towards mother-imagos and the drive towards father-imagos is limited to one organ-system (real or phantasied). Thus it makes one particular phantasy-system more comprehensible, viz. the phantasy of the 'woman with the (father's) penis'. And it meets the case of the posthumous (fatherless) child where the possibility of actual 'primal scenes' is excluded: the early stages of the child's conflict (including primal scene phantasies) can then be worked out in reference to different maternal organs or zones of gratification and frustration (real or phantasied). The main objection to adopting this second condition

is that it renders the term inverted Œdipus complex ' less precise than is the case at present. The terminological issue rests on the third condition. Genital interest exists from the first year of life in both sexes, and is bound to play a part directly or indirectly in all frustrations. In this sense all frustrations have an Œdipus component. If the argument is advanced that in early stages the genital element is quantitatively negligible, there is no objection to the use of some other term, e.g. ' Œdipus prototype ', or ' forerunner ', ' pre-Œdipus ', etc. There would, however, be a very definite objection if such terms were used to gloss over the dynamic significance of the earlier conflicts. If we can shew that earlier conflicts play a part in the etiology of, say, the psychoses, similar to the part played by the model genital Œdipus situation in hysteria, why not reduce complications by calling all infantile conflict over frustration ' Œdipus ' conflict ? [19]

In supporting these views, which are in most essentials the views of Melanie Klein, I do not intend to suggest that the importance of later and more organized infantile systems can be glossed over in drug-addiction. It is impossible to neglect, for example, the extremely obvious homosexual phantasy-systems observed in, say, cocaine-addictions. It is equally impossible to overlook later ' positive Œdipus ' anxieties (i.e. typical castration anxiety) ; or for that matter the importance of stimuli of a much later date. In one case of cocaine-addiction the final determinant of the habit was without any doubt a fascinated interest in Sherlock Holmes, the publication of whose ' Adventures ' coincided with the addict's pubertal phase of masturbation. Incidentally the patient modified the Sherlock Holmes technique in so far as he injected the drug into the root of the penis. I need not go into all the genital Œdipus determinants of this habit, or enumerate the elements of curiosity, sadism, guilt and punishment represented by identification with a detective. The fact remains that, although interpretation of this familiar type produced signs of anxiety, both in the positive form of discharge and in the negative form of resistance, these reactions could not be compared with the intense resistances shewn when a more primitive reading of the situation was given, viz. in

[19] Since this was written Freud has made an important pronouncement on the question of terminology (' Female Sexuality ', this JOURNAL, p. 281) : he says, *a propos* of pre-Œdipus stages, that there is no objection to attaching a wider significance to the term Œdipus complex ; it can be regarded if need be as including all the relations of the infant to both parents.

terms of sadistic attack on the parents followed by sadistic counter-attack. Only when the situation was reduced to the common ground of a battle between the organs of the parents and the organs of the child, with terrifying excretory substances as weapons, was any adequate response evoked. Only then did an existing compulsive system of inventive and creative work—which had hitherto been singularly unsuccessful and by means of which the patient frittered away time and money—begin to lose some of its compulsive power and at the same time become more effective. I do not say that a quantitative difference in reaction can be invariably detected in giving such interpretations, because of course the factors of timing and dosage must be taken into account. Nevertheless observations of this kind suggest that we are not justified in sticking rigidly to the idea of a *fixed* nuclear system. There is some reason to assume that what in the case of the neuroses has been called the ' nuclear complex ' could be more usefully described as a ' polymorphonuclear ' complex. My impression is that in drug-addiction we can detect, perhaps more clearly than in well-defined neuroses or psychotic states, the existence of a *series* of nuclear ' Œdipus ' situations, to each one of which there is an appropriate symptomatic or para-symptomatic (social) response. In general the changes in the series may be attributed to two factors, (1) a quantitative factor relating to the charge of aggressive impulses carried, and (2) a qualitative factor contributed from erotogenic sources. At different levels one seems to find not only varying confluences of genital with pregenital libido, but different fusions of each libidinal component with aggression. Moreover, the different varieties of drug-addiction seem to suggest that the earliest nuclear formations are not arranged simply in a *consecutive* series but rather in a *cluster* formation. This cluster formation represents a group of component interests and develops into a consecutive series only after what we call the anal-sadistic phase has been established. To express the same idea in terms of anxiety and frustration we might say that drug-addictions are a caricature of the normal processes whereby a number of earlier infantile psychotic (or as Stärcke would call them palæopsychotic) anxiety states are carried over into and submerged by social adaptations of an ' ingestion ' order (reading, taking medicines, etc., etc.).

Like all other systematizations, the foregoing has to be judged mainly in terms of descriptive convenience ; in other words, the aptness of what Freud has called ' the metaphorical expressions peculiar to psychology . . . of the deeper layers '. Some apparent differences

can be greatly reduced if we consider that earlier psycho-analytical formulations were based on one or two important cross-sectional views of mental development, whereas recent investigation is more in the nature of an examination of longitudinal sections. There are, however, certain theoretical consequences to be considered. Acceptance of an early polymorphous ego-organization involves some recasting of existing rather rigid descriptive views of narcissism ; or at least some distinction of the problem of narcissistic *energies* from (*a*) the problem of narcissistic *topography*, and (*b*) the clinical problems of narcissistic *feeling* or reaction. For example, a good deal of what has hitherto been considered as belonging to a narcissistic organization would have to be relegated to a system of object-relations. The term ' part-object ' though to some extent helpful seems to me to beg the question of the narcissistic boundary. On the other hand the term ' fixation ' would require to be used with more precision. To say that a person has an ' oral fixation ' is much too vague and throws too much emphasis on the constitutional factor. It would be much more helpful to be able to say that owing to instinctual urges and frustration (occurring at a time to be estimated for each individual) a person is fixated to one or more of a series of nuclear positions. But we must be careful in the use of the term series. It seems to me that difficulties in establishing the fixation-points of psychoses are due in part to a bias in favour of a consecutive series. The complex clinical picture of dementia præcox itself suggests a possible combination of nuclear fixations. And, as I have said, the same appears to be true of drug-addictions.

The following case illustrates some of the points already discussed. A woman came for treatment who appeared at first sight to be suffering from a severe obsessional neurosis with some accompanying anxiety-hysteria and some conversion symptoms mainly affecting the alimentary tract. Preliminary analysis did not alter this diagnosis, although it was noteworthy that the obsessional system seemed to have effected less distortion of ideational content than usual: the ceremonial systems were as to one part almost unmodified homosexual representations, in which however a phantasy element of hermaphroditism was introduced, e.g. obsessional pictures of possessing a penis, sometimes of fantastic shape, by means of which contact was made either with a female figure having a fantastic penis or with a male figure with a fantastic vagina. These pictures provoked typical obsessional ceremonials. Outside the range of obsessional systems there was no manifest homosexual interest. It soon became apparent that, under

cover of sedative medicinal treatment, she had established a strong drug-addiction of the paraldehyde type. She had been treated by various doctors for several years previously, all of whom had either initiated some medicinal treatment or sanctioned existing hypnotics. One naturally rescrutinised the history for evidence of earlier addiction tendencies, and found that evidence not only in the form of medicine-taking but in various social habits concerning eating. A hunt for paranoidal mechanisms was not successful. Tracing all these elements separately in the subsequent analysis, it became possible to reconstruct the symptomatic course of events as follows: an active phase of neurosis formation could be established between the age of 2 and 3½. This corresponded to the period between the birth of the first rival sister and the first rival brother. Infantile anxiety reactions and tantrum scenes in which the beating of animals or inanimate objects played a part were followed by a stage in which it was not clear whether anxiety phobia-formations or obsessional mechanisms would obtain the upper hand. Eventually obsessional technique won the day; animal phobias gave place to obsessional fears, and by the age of three the child was practically an adult obsessional neurotic with obsessional fears of contamination and attack together with obsessional precautions affecting thought, speech and action. For a short period at about the age of 5, hysterical conversion symptoms dominated the picture and recurred occasionally in later years. It was clear that the later alternations corresponded to fluctuations in unconscious homosexual and conscious heterosexual interest, stimulation and frustration. But only for a few months, at about 25, after an important change in work, emotional relations and social surroundings, was the neurotic activity effectively suspended. The rest of the time obsessional systems and defences were constantly increasing, one contamination fear giving place to another with always an increasing element of psycho-sexual preoccupation or cover (e.g. masochistic pregnancy-phantasies). At puberty some organic illnesses obscured the picture but, on the emergence of faint homosexual interests and more intense reactive brooding over the problem of homosexuality in general, the obsessional systems became more extensive. An alarming cannibalistic element entered into them at about 18, and from then on to the forties the ego was almost completely absorbed by acute obsessional systems, ringing every possible change on a disguised sadistic contamination theme together with a manifest infantile homosexual theme. As regards the addiction system, the earliest compulsive interest uncovered was

concerned with the taste of the first rival baby's bottle feed ; that was at the age of 2. Later (at about 8) a phobia of tea made its appearance. Still later (at 10) an anxiety-free ceremonial concerning reading and eating developed, but was soon linked up with contamination-affect concerning teeth and tartar. Still later (at 15) the obsessional hermaphroditic systems became attached to the mouth. Pressure of upper on lower teeth, or of teeth on gums or of tongue on teeth could function as substitutes for more manifest sexual content. Contamination anxiety then spread to anæsthetics. At 18, as has been noted, cannibalistic fears attacked the eating process, and at about 26 the first sedative was given by the father. For some years afterwards, the fears were associated with impulses to take medicine of all sorts in order to combat infections and the patient veered between physical illness requiring medicine and hysterical vomiting. During the first years of addiction, a reduction of the acuteness of ingestion fears coincided with a spread of complicated ceremonial to eating in restaurants.

Applying the usual clinical standards, it could be said that there were no paranoidal formations, although study of the phobia systems both early and late shewed significant reactions ; first, the involvement of ' pursuing ' animals in the phobias and later a tendency to expand obsessional phobias to cosmic dimensions, together with a sense of personal doom in relation to any natural disturbances.

During the course of analysis but particularly in its later phases, the patient voluntarily undertook courses of abstinence which were mostly abortive. Complete reduction of a lesser bromide habit was ultimately effected, but at the cost of great anxiety and followed by an increase of obsessional activity, particularly of the more manifestly sexual ceremonials and defences. At this stage it was clear that the original strength of the addiction was due in part to the fact that the drugs were officially prescribed (i.e. benign substances). An increase in the paraldehyde habit then occurred. This developed to such an extent that a formal deprivation course became essential. The deprivation phase was accompanied by the usual hallucinatory manifestations. When these died down, two facts emerged ; that the patient had a slight paranoidal system in operation and that *the obsessional neurosis had for the time disappeared.* As the paranoidal system slowly vanished, the obsessional system returned in full swing. The paraldehyde deprivation was complete, but on occasions of acute anxiety the patient was allowed small doses of non-habit-forming

hypnotics. These she herself supplemented with doses of sal volatile. Of the various changes observed I will note here just one. The drugs had previously always been employed in a ceremonial way, not as a direct hypnotic. Now they were used less obsessionally as sedatives and more for their hypnotic effect, but the same drug was definitely regarded as a ' good ' or ' bad ' drug depending on whether the amount conformed to or exceeded the prescribed amount. The amount over the prescribed dose was a bad, evil, dangerous substance. The same differentiation applied to the person of the prescriber. Increases sanctioned by the physician who had regulated the deprivation were good ; those sanctioned in emergency by myself were dangerous. A pseudo-paranoid mechanism had made its appearance in the drug system. Incidentally the phase following deparaldehyding shewed an immediate transference alteration in which I became more dangerous ; first of all the lessened defence to sadistic phantasies increased reactions of anxiety during any absence, and in the sexual part of the obsessional phantasies I was made to play a more direct rôle.

Casting back to the open paranoid features that were manifested immediately after deprivation, it became clear that the mechanism was not purely paranoic. At first sight they had appeared to be pure delusions of reference, but that was not quite accurate. The jeering voices and hostile reproaches, or attacks, which were supposed to damage the patient and at the same time to remove something from her were linked on to a conspiracy system. For example, certain hostile individuals were conspiring to take away some good substance from a clergyman. There was however a hint that the patient herself might somehow be in the conspiracy—or at least that she was being used by others as a tool in order to effect their designs. But by dint of identifying herself with the clergyman she could restore the damage provided she took drugs. The clergyman was a not very effectively disguised mother-figure. This system of identification was on ordinary occasions concealed by the manifest homosexual content of the obsessions, e.g. active or passive contamination or destruction effected by the ' fantastic penis ' systems.

Here was a case that shewed historically a gradual crescendo of symptoms rising to a paranoid crisis, but including elements of reaction to every stage of development from primitive oral reaction down to infantile genital and adult genital anxiety systems. In the next place the most dramatic and permanent feature, the severe obsessional system, appeared in the rôle of a defence formation, guarding against

anxiety of a paranoid type. The homosexual system which had played an obvious part in the obsessional formation was still present in the early hallucinatory phase of deprivation, but gave place to [illegible] direct phantasies of incestuous attack by the father; this suddenly gave place to the delusions of persecution. The homosexual element thus showed its 'regressive' aspect in relation to the incest phantasies and its 'progressive' aspect in relation to paranoid fear of the mother. Moreover in the phase prior to actual deprivation the increase in drug-addiction corresponded directly with an increase in the destructive aspects of obsessional thinking and ceremonial; after the deprivation there was a more manifest connection between ceremonial habit and destructive impulse.

A similar compromise-mechanism could be detected in the Sherlock Holmes case I have mentioned. The castration elements appeared to be mostly concerned with later genital systems. The homosexual organization was kept under effective repression and there was no clinical sign of paranoid reaction; nor was there any notable paranoid reaction after deprivation. The melancholic element in the case was, however, extremely obvious. There was a constant recurrence of manifest depressed oral reactions, and phases of injection of massive doses of cocaine which were practically unsuccessful attempts at suicide. But even in the most acute stages the melancholic mechanisms were not actually pure. The drug habit represented sufficient of a projective system to prevent deeper regression. And after final deprivation it was maintained in the modified form of medicinal drugging for which justification had to be found in every possible source of organic disturbance. For example, a heavy meal would be taken in order to justify all sorts of alimentary medicine drinking. The reduction in projected sadistic charge allowed a substitution of mainly 'good' drugs for 'bad'. Nevertheless the good drugs, by upsetting the patient's internal economy, carried on the work of bad drugs, although in a milder degree. Even the 'injection' element was maintained for a time under the guise of vaccine therapy.

Reviewing the paraldehyde case briefly, it could be said that, in spite of the obvious importance of later infantile genital systems (the model Œdipus nucleus), the drug element attached to the obsessional neurosis related to a more primitive Œdipus conflict occurring at the age of 2, and coinciding with the birth of the rival sister. It was an attempt to deal with sadistic charges only slightly more tolerable than those dealt with by purely paranoid mechanisms. It came into action

because the later and more developed Œdipus relations (inverted and positive) still maintained a high sadistic charge. No adult derivative from these later systems could be permitted to act as a reassuring system of relations, hence every ordinary fluctuation in libido or aggressive tendency laid the patient at the mercy of an older anxiety system.

While therefore I agree with the tendency of recent attempts to compare drug-addiction with melancholia and obsessional neurosis, I feel that the emphasis laid on the model Œdipus phase and on early constitutional factors has obscured not only an equally close relation to paranoia, but the possibility of establishing a *specific* mechanism for drug-addiction. This specific reaction represents a *transition* between the more primitive psychotic phase and the later psychoneurotic phase of development. I should have said a *number* of specific mechanisms, because I do not believe in any rigid layering of early psychotic phases. I imagine that different types of drug-addiction represent variations in the amount of original erotogenic sources of libido (and consequently different fusions of sadism) : hence that they represent variations not only in the structure of the primitive ego, but in the type of mechanism employed to control excitation. When Simmel claims that drug-addiction is closely connected with both obsessional neurosis and melancholia,[20] I have no objection to offer, except that this applies only to some cases and that it neglects the relation of other cases to paranoia. But in spite of many correspondences of mechanism I cannot confirm his view that the state belongs essentially to the obsessional group, acquiring a melancholic character as a result of regression. Nor do I agree with his general statement that in the first stages the addiction represents a pleasure-toned obsessional state. This description, in my opinion, applies with more accuracy to the medicinal and food idiosyncrasies seen in neurotic-character cases, and particularly to various social habits of normal individuals, e.g. food indulgences and dietetic systems, habits of bodily inunction and inhalation, routine medicinal habit, fresh-air apostledom, and so forth.

A word here about the question of specific phantasies in drug-addiction. In my experience the main phantasy of drug-addictions represents a condensation of two primary systems, one in which the child attacks (later restores) organs in the mother's body, and one in

[20] See note [16], p. 304.

which the mother attacks (later restores) organs in the child's body. These phantasies are also represented in masturbation systems and are still present in later, genital object-relations. In this paper I have not stressed the question of specific phantasies: first, because the condensation I have described seems to be universal, and secondly because I am more concerned for the moment with defining the function of drug-addiction. It is always possible that the main element in any psychopathological state is not so much the actual unconscious phantasy-system as the degree of localization or mastery of anxiety achieved. In any case we cannot estimate the significance of such stereotyped phantasies until we know what organ-substance is represented by the drug.

Provisional Conclusions

(1) Drug-addiction implies fixation to a transitional Œdipus system —a system lying between the more primitive Œdipus nuclei that produce paranoid (or melancholic) anxieties and the Œdipus nucleus that is responsible for later obsessional reactions.

(2) Its defensive function is to control sadistic charges, which, though less violent than those associated with paranoia, are more severe than the sadistic charges met with in obsessional formations. (An alternative formulation would be that the libidinal components found in drug-addiction are stronger and contain more genital elements than those associated with the psychoses, but weaker than those associated with the transference neuroses.)

(3) Drug-addiction acts as a protection against psychotic reaction in states of regression.

(4) Unconscious homosexual phantasy-systems are not a direct etiological factor, but represent a restitutive or defensive system; on account of their stronger libidinal cathexis (both narcissistic and genital), homosexual systems act as a protection against anxieties of the addiction type. Hence the close association of homosexual interests with drug-addiction implies either the persistence of a defensive system or the ruins of a defensive system.

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The next step is to consider what relation exists between drug-addiction and neurotic habits or social usages, in particular habits and customs belonging to an 'ingestion' group. Most processes of incorporation, e.g. the processes of eating and reading, are subject to modifications of a more or less pathological stamp. These habits must

be correlated with the usual drug-addictions. We must know, for example, why noxious drugs are chosen in certain addictions in preference to less harmful or harmless substances and whether the fixations and defensive systems are identical. Why does an individual swallow, inhale or inject cocaine instead of smoking cigarettes or sucking chlorodyne lozenges or eating ice-cream or drinking almond emulsions or taking nutrient enemata or rubbing in lanoline ointment or chewing bus tickets ?

The answer originally given by psycho-analysis was perfectly simple. Study of clinical data confirmed what was already apparent to the student of mythology and anthropology. The drug represented the phallus or semen of the father (God) and the breast—nipple—milk of the mother (Goddess). Less obvious at first—possibly because less attention was paid to this aspect—was the fact the drugs represented other bodily substances of an excretory nature, urine, fæces, etc. Soon it was held that all bodily ' ejecta '—breath, sweat, spit, urine, fæces, blood, semen, milk, could be represented by the drug. It was nevertheless believed that the phallic (seminal) symbolism was the most important, and that, through this link, drug-addiction could be traced to the genital Œdipus situation. The other elements were regarded as contributions to genital interest from earlier erotogenic zones (oral, anal, etc.) ; or simply as disguised displacements of genital interest. The inverted (homosexual) Œdipus aspect was thought to account for the predominance in some cases of anal symbolism.

More careful clinical investigation showed that this apparently water-tight system was inadequate. It had always been known that under conditions of suggestive *rapport*, a comparatively inert substance (injections of salt water, tablets of aspirin, chewing-gum, etc.) could function as a drug-substitute. True, in many cases it was felt to be inadequate but it would tide over phases of deprivation. A more striking observation was to follow.

There is now no doubt that the pharmacotoxic effects of drugs do not play such a specific part in dangerous drug-addictions as is supposed in extra-psychological circles. In certain addiction-cases where a harmless substitute was established (in one case sugar was used in this way), I have observed the same slavish compulsion attach itself to the substitute. And deprivation of the substitute loosened massive charges of anxiety. On the other hand, during the analysis of psychoneurotics and of neurotic (or psychotic) character abnormalities, I have discovered idiosyncrasies which had the same subjective sense of

compulsion and aroused the same anxiety on deprivation as standard drug-habits. These are sometimes connected with food, e.g. a compulsion to eat stewed meat with a highly seasoned ketchup added to the gravy. Compulsive habits of 'taking medicine' are even more common. I recall in this connection an addiction to white purgative emulsions, attempts to abandon which invariably induced severe anxiety. In another case the 'addiction' was to hot water. Moreover in actual drug-deprivations it is well known that the last and most diluted drop of an addiction substance is as significant to the addict as the last and most trivial ceremonial is to a severe case of obsessional neurosis. It is true that in many cases of neurotic idiosyncrasy, the formation is not a massive one and the emotional reactions are spread over a number of apparently insignificant occasions; but they exert a striking cumulative effect. In one recent case, consuming steak-pie, beer, and reading a newspaper shared equally in an 'ingestion' compulsion, by means of which an intolerable state of boredom and depression was periodically relieved. The evidence in other directions is overwhelming. For every contamination-phobia, there is a corresponding compulsion, either social, fetichistic or 'perverted'. For every cleansing ceremonial there is a corresponding ingestion habit. This fact escapes attention owing to the number of compromise-formations. When a washing maniac must use 'scented' soap or an ointment reeking of antiseptic, or when the fresh-air addict with a 'fog' phobia insists on living in a pinewood, the mixture of phobia and 'counter-addiction' usually escapes notice.

The substitution of psychic 'substances' for concrete is not difficult to demonstrate. The activity of reading is perhaps the simplest example and it is clear that systems of 'good' and 'bad' reading have some resemblances to addictions. In the paraldehyde case I have described the only guilt-free ceremonial was as follows: having drawn the blinds in a particular room the patient removed all objects from the pockets which were then filled with biscuits; she then sat exactly opposite the centre of the fireplace with legs apart and feet raised and proceeded to read 'good' books, at the same time munching biscuits. Here again compromise-formations abound: e.g. compulsive reading of 'elevating' or 'good' books, particularly theosophical literature, during the process of defæcation. Perhaps the most interesting group is that where psycho-neurotic processes and psycho-therapeutic activities function as 'drugs.' It is easy to observe that obsessional psychic constructions and the affects accompanying

melancholia are felt and described in terms of ' substance '. The obsessional feels that if his neurosis were cured he would be left with a ' hole ' or ' gap ' in his mind, and the depressed case very frequently expresses the state of endopsychic conflict and affect in terms of ' weights ' and ' masses ' in his ' inside '. I have recently studied a case in which a very definite drug-addiction was suddenly and spontaneously abandoned in favour of an obsessional neurosis. The patient then reacted to the idea of cure of the neurosis precisely as a drug-addict reacts to the idea of abstinence. She ' must have ' the neurosis ; she ' could not give it up ', and so forth. The change was not due solely to an alteration in methods of defence ; the obsessional psychic construction with its accompanying affect provided a suitable drug ' substance '. The immediate stimulus to substitution was the establishment of friendly relations with a mothering type of male admirer. A similar valuation of psychotherapeutic activities was suggested by Janet [21] in the case of hypnosis : he pointed out that the stage of somnambulic passion is comparable to the craving of a morphine addict. Ernest Jones,[22] commenting on this observation, linked it up to similar manifestations exhibited in alcoholism. And it is common psycho-analytic experience that patients react to interpretations as if they were either hostile foreign bodies or friendly substances. In short, there is every reason to think (*a*) that given suitable psychic conditions *any* substance can function as a ' drug ', (*b*) that ' psychic substances ' can function as replacements for ideas of concrete substances, (*c*) that both types of substance can be subdivided into good or bad, innocent or guilty, beneficent or malignant, restorative or destructive.

It is difficult to resist the conclusion that, however varied may be the contributions to drug-addiction from erotogenic sources, one special interest is represented by all drug-substances, viz. repressed aggressive or sadistic interest. Admittedly it is hard to isolate this interest and therefore to claim that drug-addiction is solely and simply a reaction to sadism. Quite apart from the indisputable importance of libidinal components in drug-symbolisms, there are certain attributes of drugs which represent a combination of libidinal and aggressive components. Thus it is clear that the good and bad elements in some

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[21] Janet : *Névroses et idées fixes*, 1898, p. 429.

[22] Ernest Jones : ' The Action of Suggestion in Psychotherapy ', *Papers on Psycho-analysis*, 3rd Edition, 1923.

addictions depend on the impregnating and abortifacient powers unconsciously attributed to the drug. Nevertheless it might be inquired whether by accentuating the sadistic element we could establish a specific factor operative in the ' noxious ' as compared with socially ' benign ' addictions.

The first step in this investigation is to compare the actual properties of ' noxious ' with those of ' benign ' drugs. It is evident that noxious drugs possess certain injurious and destructive properties. And although many non-noxious foods, if eaten regardless of consequences, produce equally disintegrating effects (as in the case of a patient who refuses to follow a prescribed diet), the distinction appears to have some general validity. This would suggest that in the choice of a noxious habit the element of sadism is decisive. The drug would then be a substance (part-object) 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 situation would represent a transition between the menacing externalized sadism of a paranoid system and the actual internalized sadism of a melancholic system. The addiction would represent a peculiar compound of psychic danger and reassurance. Doubtless the melancholic (internalized) aspects would be increased by an attempt to deal with the externalized menace (drugs) by swallowing, and the fact that drugs actually exist ' outside ' (in chemists' shops) would encourage a move towards abstinence during the dangers of the exacerbated melancholic phase.

The second group of properties of noxious drugs presents a more difficult problem. These substances have the capacity to produce effects that are usually described in a compromise terminology, partly psychological, partly physiological. They are called stimulants, depressants, hypnotics, narcotics, anælgesics, sedatives, intoxicants, etc., and various sensory and psychic disturbances are described in the same terminology. Clinical experience of melancholia, hypochondria and conversion-hysteria warns us, however, that this semi-physiological approach is not only inadequate but misleading ; that subjective sensory and affective experiences cannot be understood apart from the existence of conflict between psychic institutions. For example, in one of my cases, the effect of strong doses of a hypnotic was to produce a ' tottery ' feeling as if the legs were ' cut off '. Incidentally, the hypnotic was rarely taken at the most appropriate time, i.e. at bedtime. As a rule it was swallowed just before the patient was about to go for a walk. A few associations connected the idea

with weakness in the mother's legs. At this time the patient's mother was unable to get about owing to a debilitating illness. So the patient not only carried out a form of self-punishment, but repeated the crime of cutting off the mother's legs. In this case drug-taking was frequently followed by a feeling of 'sanity' in the upper parts of the body. This system was illuminated by the discovery that, during obsessional preoccupation with the idea of possessing a penis, one of the ways of ridding herself of this dangerous organ was to imagine it stowed away in one or other of the lower limbs. Evidently not only the legs but the concealed penis was destroyed by taking the drug. The same patient was clear that the compulsion to take a 'dose' frequently coincided with worry over the mental images of some person. She felt they were 'in her head', and that the drug could 'kill them inside her'. It could also 'dull' (kill) the intensity of certain obsessional 'pictures' (organs, persons). Here again there was admittedly a masochistic element: when she was stupified, 'little enemies' could steal a march on her, a system which had more obvious representation in conscious rape and pregnancy phantasies.

In this type of case the relief following drug-taking depends to a large extent on the exploitation of sadism to cure sadism, although undoubtedly there is a strong factor of masochistic gratification. In other cases where the immediate effect of the drug appears to be entirely alleviating and gratifying and where no secondary deterioration is apparent, punishment and masochistic aspects are gratified in the abstinence period. This is in keeping with the views of Simmel [23] and many others, viz. that abstinence phases are essential parts of an organized addiction. On the whole the evidence seems to suggest that the narcotic and noxious properties of certain drugs put them in a clinical class by themselves, in so far as they are excellently adapted to the purposes of sadistic expression. The necessary formula appears to be that the individual's own hate impulses, together with identifications with objects towards whom he is ambivalent, constitute a dangerous psychic state. This state is symbolized as an internal concrete substance. The drug is then in the last resort an external counter-substance which cures by destruction. In this sense drug-addiction might be considered an improvement on paranoia: the

[23] See note [16], p. 304.

paranoidal element is limited to the drug-substance which is then used as a therapeutic agent to deal with intrapsychic conflict of a melancholic pattern. In the sense of *localizing* paranoid anxiety and enabling external adaptation to proceed, this may be one of the specific functions of drug-addiction.

On the other hand, there are some considerations which suggest that we should not push this view to extremes. In the first place we find that patients at different times regard the same drug as ' good ' as well as ' bad '. Secondly, obsessional neurotics without any manifest addiction tendencies are prone to use food images in cleansing ' as well as in ' contamination ' systems. ' An apple a day keeps the doctor away '. Moreover, some drug-addicts exhibit a distinctly obsessional tendency in their dosage and timing of noxious drugs (e.g. taking them when their thoughts are ' bad '), thereby suggesting more friendly exploitation of the drug-system. Again, in some noxious addictions the sedative and restorative effects are a prominent feature. On the other hand, in a great majority of ' benign ' addictions, the restorative and life-giving properties of the substance are clearly manifest. Finally, however important unconscious paranoid and melancholic factors in drug-addiction may be, the clinical fact remains that throughout the greater part of many severe addictions there are no manifest symptoms of this kind. Even allowing for disturbances occurring under the influence of drugs (e.g. intoxication), and for impairment of psychic function during comparative abstinence (e.g. retrograde amnesia), the patient's reality sense is not grossly and obviously distorted. Moreover, as I have indicated, some drug addictions shew an actual refractoriness to paranoid regression. To these clinical views may be added the theoretical consideration that a purely paranoid basis to drug-addiction would suggest a worse prognosis than is actually justified by statistics of permanent abstinence.

Analytic support for the benign aspect of drug-substances is based almost entirely on three groups of observation : (*a*) the close connection between drug-substances and erotogenic interests, (*b*) the exploitation of later and more predominantly genital libidinal development as a reassurance against earlier more sadistic phases, (*c*) the existence of ' cancellation ' and ' restitution ' mechanisms.

There is no need to recall the extensive evidence in support of a symbolic relation between drugs and erotogenic interests. The symbolism in many cases requires no interpretation. And there is a

good deal to be said for Radó's conception of ' meta-erotism ',[24] in the sense of a system of drug-excitation which short-circuits the zonal components of infantile sexuality. I am unable, however, to confirm his assumption of a decisive ' alimentary orgasm ' based on alimentary erotism. That alimentary erotism is an important factor in most cases I have no doubt. It is in my experience most obvious in addictions of the chlorodyne type (new B.P.). But in still other addictions, e.g. chloroform, ether, etc., it is obvious that nasal and respiratory erotism is picked out. Again, in certain cases of alcoholism it is clear, not only from the symbolism but from actual reports of the patient, that urinary erotism is picked out in preference to the alimentary element. In one instance the first mouthful of white wine, whisky, sherry or beer produced immediate erotic sensations in the bladder which were then referred to the tip of the penis. In any case, whether the important mechanism is ' short-circuiting ' or a process of direct selection, the guilt or anxiety system involved is not simply a reaction to excitation of one zone. In the alcohol-instance just mentioned, although urinary erotism was obviously the important factor, it was important because the ego-object relations as a whole were expressed in urinary-sadistic terms. Thus wine was a dangerous poison : it could only be cured by taking in more wine ; it was an impregnating substance ; it was an abortifacient, etc. And ultimately it was a loving and curative substance.[25]

This brings us to the second point, viz. exploitation of later and more genital elements as a reassurance against earlier anxieties of menacing external substances. This aspect of drug-addiction has been emphasized by Simmel and later by Schmideberg. The closer the identification with a comparatively friendly ' semen-penis-child ' system the more compulsive the benign aspects of addiction. The friendliness is of course only comparative, because in the stage of infantile genital interest a sadistic component is still important, and can be measured by the amount of castration-anxiety.

The third point is also concerned with reassurance. It involves the

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[24] See note [15], p. 304.

[25] Although there is general agreement as to the importance of oral, excretory and genital interests in the etiology of drug-addiction, we are not yet entitled to make any final pronouncement on their relative importance. No deep analyses of ' respiratory (inhalation) addictions ' have yet been published, and until this has been done an open-minded attitude seems indicated.

idea that a good substance can either neutralize a bad substance or can make good any injury caused by an existing bad substance. These mechanisms have now been shewn to play a large part in obsessional neuroses [26] and in many apparently normal activities, e.g. sublimations.[27, 28] So far as my experience goes it is difficult to exclude these factors in drug-addiction. The main difficulty is that, owing to the confused state of identifications of self with object, what appears to be a pure object-restitution is condensed on a system of restitution of the self by the object.

An interesting aspect of this problem of benign elements in addiction is presented by the companion problem of fetichism. The relation between fetichism and some forms of drug-addiction, particularly alcoholism, is well known. But the negative aspects of fetichism have had less attention paid to them, for the reason that they are usually regarded as obsessional phobias of the contamination type. I have observed on several occasions that, after a more than usually anxious phase of abstinence, a type of obsessional phobia makes its appearance which is of this negative fetichistic type. Also that after a more spontaneous abstinence phase the return of the addiction seemed to be delayed by a more positive fetichistic interest, with or without genital masturbation. In the case of the positive fetichistic activities, a feature of the situation was that the interest also obtained narcissistic representation. In one case excitement over the idea of stockings of others could be expressed also by a lesser degree of excitement over the individual's own stockings and shoes. On the other hand, in the phobia system, fears which had originally been attached to contamination ideas concerning the clothes of others later took the form of acute anxiety concerning the destructive powers of the patient's own clothes. Two types of fear-localization could be detected: fear in which the organ-interest was displaced from the genital-abdominal area to stockings and legs, collar and neck, etc., and secondly, fear attached to clothing having close contact with the genital and abdominal area, underclothes, corsets, etc. The amount of anxiety provoked seemed to depend on whether an early paranoidal system or a later genital

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[26] Freud: *Hemmung, Symptom und Angst*, Wien.

[27] Sharpe: 'Certain Aspects of Sublimation and Delusion', this JOURNAL, 1930, XI, 12.

[28] Klein: 'Early Anxiety-Situations reflected in a work of Art', this JOURNAL, 1929, X, 436.

system of phantasy predominated. Fear lest part of the patient's knickers should 'get into' gluteal or genital folds, and effect some disastrous change, varied in intensity in accordance with the 'goodness' or 'badness' of the drugs taken. If the drugs were bad, the 'getting in' of clothing had no more anxiety than one might expect to accompany a masochistic genital phantasy. When, however, the drugs were reduced or good, the underclothing fear was almost paranoidal in intensity.

Space does not permit more detailed investigation of this subject here. But perhaps two rough formulations are permissible: (1) that in the transition between paranoidal systems and a normal reaction to reality, drug-addiction (and later on fetichism) represent not only continuations of the anxiety system within a contracted range, but the beginnings of an expanding reassurance system. The reassurance is due to contributions from later libidinal stages in infancy which contain a decreasing amount of sadism. (2) That clothing in general is, after food, the next line of defence in overcoming paranoidal reactions to reality. It appears reasonable to suppose that the first paranoid systems of the child attach themselves to food, that these anxieties are modified not only by the appearance of less sadistic impulse but by a determined effort at displacement of anxiety. In this displacement clothes play their part. When subsequently displacement leads to reactions to the clothes of external objects, the foundation of the classical fetish is laid. So that when anxiety is excessive the result is either a typical sexual fetish or the negative form, viz. a contamination phobia. I would suggest that the association of fetichism and alcoholism implies a combined effort to establish friendly relations with external dangerous objects which, at an earlier stage, were thought of as existing within the patient's body, e.g. the sadistic penis of the father which the child has stolen from the mother. *A propos*, the most successful exploitation of a fetichistic principle is to be seen in the mild forms which accompany or merge with the foreplesure of adult genital primacy.

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To sum up the position of noxious drug-habits as compared with benign habits: there appears to be no question that noxious addictions represent the reaction to a more acute state of anxiety; that the destructive properties of drugs lend themselves to symbolic and actual expression of sadism, nevertheless that the restitutive and neutralizing effect even of noxious drugs cannot be excluded. In the

benign addictions the substance still represents a vehicle of sadism, but the sadism is less heavily charged, and connected with less archaic phantasies. Hence anxiety both as to the state of the body and the dangers of the external world is reduced. Reality has taken on a more friendly aspect, consequently non-injurious foods or their substitutes can function in these milder addictions. With regard to the corporeal element represented by the drug, I have already indicated that we are not in a position to speak with finality on this subject. One or two modifications of earlier ideas are, however, already justifiable. The obvious emphasis laid by drug-addicts on phallic elements must be to some extent discounted. And although in the past I have stressed importance of oral elements, I have come to realize that particularly in the case of noxious drugs, these are sometimes emphasized for defensive purposes. Admittedly in the melancholic types oral elements are the most important, but, taking the average run of noxious addiction, I have the impression that the drug symbolizes excretory substances which in turn represent a primitive and almost uncontrollable form of excretory sadism.

In this paper I have so far deliberately avoided using the term 'super-ego'. My main aim is to draw attention to the significance of drug-addiction as representing a compromise between projective and introjective processes. And owing to lack of agreement as to early phases of super-ego formation it is advisable to keep to these more general terms. Nevertheless I feel convinced that when Radó says guilt-processes do not play a specific part in drug-addiction, he has in mind the guilt associated with the late Œdipus phase of super-ego formation. Theoretically speaking, however, a super-ego formation can be presumed as soon as an introjective process is sufficiently organized to attach to itself energy which would otherwise strive for more direct discharge on objects. And the whole point about drug-addiction is that it represents a phase of development when primitive part-objects are introjected and absorb psychic energy, but before projection of a massive type has been finally abandoned. It has always been difficult to conceive how the *physiological* effects of alcohol could have a specific effect on *psychic* institutions, e.g. the super-ego. The answer is now apparent: the drug has no more *direct* effect on guilt than a stunning blow on the head. The effect is produced by virtue of a psychological and mainly symbolic manœuvre, to which the physiological action of drugs adds an element of realism. The physiological action of drugs is exploited by the addict because it saves

some expenditure of psychic energy. The same system is seen to operate in the psychoses and neuroses. The remissions of melancholia observed during intercurrent organic illness represent a saving of melancholic energies ; and a conversion-hysteric obviously makes the most of any casual organic disturbance, thereby reducing the labour of symptom-formation.

I do not underrate what the physiologist would call the selective action of drugs on or through the nervous system. On the other hand, I maintain that the phenomena of *psychic* inhibition (or relief from inhibition) accompanying drug-addiction cannot be explained along purely *physiological* lines. My view is that the addict *exploits* the ' action ' of the drug in terms of an infantile system of thinking. In the earliest stages endopsychic appreciation of instinctual stimuli corresponds closely to sensory experience of disturbances in the bodily organs, or, more generally, of disturbing substances in the body. The same is true of the earliest experiences of the operation of primitive psychic institutions (e.g. super-ego conflict leading to frustration). So that when an infant psychically incorporates objects (or important organs of objects) and when a primitive form of guilt ensues, this guilt can be dealt with, as it were, along physiological lines. From this point of view the significance of addiction can be described as follows. By ' cutting off ' the body (i.e. sensory perceptions) the drug appears to have obliterated instinctual tension or frustration : it can also kill, cure, punish or indulge not only psychic ' objects ' in the body but the body as ' self '. By ' cutting off ' the external world, the drug can obliterate not only actual instinctual stimuli from without but stimuli due to projected instinct. By the same obliteration it can kill or punish external objects with or without projected characteristics : it can also rescue them by keeping them at a distance. This ' double action ' accounts for the extreme sense of compulsion associated with addiction. It is specially marked in cases where both ' self ' and ' introjected objects ' are felt to be bad and dangerous, and the only chance of preserving a good self lies in isolating it in the external world in the form of a good object.

In conclusion, we must inquire what bearing the foregoing discussion of addiction has on the tendencies of psycho-analytic research and in particular on terminological usage. I can imagine that recent emphasis laid on ' sadistic ' factors might give rise to a temporary undervaluation of libidinal factors, or to a degree of misuse of terms. The phrase ' oral-sadistic fixation ', for example, is just as inadequate as its

fellow, ' oral libidinal fixation ', or ' narcissistic fixation '. And its use might foster the tendency to think of a hypothetical ' pure sadistic ' (aggressive) fixation. Without entering into the actual definition of sadism as a pure culture of instinct or a primary fusion, it may be repeated that the ' complexion ' of sadism is contributed mainly by its libidinal fusion, whether primary or secondary. As Freud has said on the more general subject of life and death instincts, ' we are driven to the conclusion that the death instincts are by their nature mute and that the clamour of life proceeds for the most part from Eros '.[29] And in drug-addiction particularly it can be observed that although positive libidinal constructions are used as a cover for and reassurances against earlier more sadistically-charged situations, this very fact gives rise to a compulsive emphasis on libidinal components which is indistinguishable from a fixation effect. In short, there is a great deal to be said for the retention of the term ' ambivalence ' in etiological essays, provided due emphasis is laid on the primitive and rudimentary nature of the objects towards which the ambivalence is directed, and provided a series of characteristic expressions of ambivalence can be isolated. And, incidentally, Abraham's term ' preambivalent ' for the first oral phase before dentition is not the happiest way of describing a phase during which the tensions of sadism are very acute.

Any tendency to talk loosely of sadism as the chief etiological factor without an essential correction for libidinal modification would introduce or emphasize a quantitative element in etiology. Indeed, Schmideberg [30] has made the suggestion that the differences between various psycho-pathological states are due to quantitative differences in the amount of anxiety. This use of the term anxiety does not seem altogether satisfactory: it neglects the function of anxiety as a ' signalling ' system and leaves unexplained constitutional and individual factors (instinctual fixations) causing ' anxiety intolerance '. Indeed, it is difficult to think of an absolute measure of sadistic quantities which would not be complicated by libidinal factors. The difficulty might perhaps be overcome if we could establish characteristic differences between guilt-mechanisms at different stages of development. And it would be still easier if we could combine a characteristic guilt-mechanism with the factor of ' localization '. In the case of drug-addictions, although the introjective mechanisms are not very markedly

[29] See note [5], p. 302.

[30] See note [18], p. 305.

localized (e.g. the phantasy-effects of swallowing the drug are not limited to one phantasied system of internal organs), the projective systems are definitely circumscribed (i.e. concentrated on drug substances). For this reason the latent paranoid aspects of drug-addiction are more prominent etiological factors than the (introjective) guilt-systems alone. Even so we should still be compelled to introduce libidinal factors in order to account for the comparatively stable organization and resilience of some psychoses and neuroses. Admittedly, boundaries between psychopathological states are not very clearly defined and can be temporarily or permanently effaced in any flood of regression. On the other hand, experience of drug-addiction suggests that there are more of these boundaries than we are in the habit of thinking and that they shew a remarkable capacity to reassert function after grave regressional injury.