Psychodynamic Psychotherapy for the Treatment of Substance Use Disorders

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Abstract

An understanding of addiction to drugs and alcohol and their treatment is reviewed from a modern-day psychodynamic perspective drawing on ego/self-psychology and object relations and attachment theory. The author places emphasis on addictions as a self-regulation disorder. Deficits in regulating emotions, self-esteem, relationship, and self-care interact variably and cause individuals so affected to relieve their pain and suffering associated with these deficits with addictive substances and to become addicted to them. The author considers addictive drugs to be appealing not so much as pleasure producing but rather as agents that create and foster comfort and contact for individuals who are discomforted and disconnected. Alcohol and drugs relieve and/or change states of anhedonia, dysphoria, and unbearable painful emotional states. Individuals so affected discover that depending on the particular emotional pain with which they suffer, they discover a preference for a particular class of drugs. The action of each class of drugs is linked to how individuals discover these specific effects in relation to the suffering associated with their self-regulation problems.

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Appreciating these vulnerabilities and in contrast to outmoded psychoanalytic modes of detachment, passivity, and more strictly interpretive approaches, the author considers, from a contemporary perspective, important therapeutic elements and attitudes necessary to address the vulnerabilities such as being more interactive and to incorporate attitudes of kindness, support, empathy, respect, patience, and instruction in order to build and maintain a strong therapeutic alliance.

49.1 Introduction

Psychodynamic psychotherapy rests on the principle that important psychological factors are at the root of addictive behaviors and that these factors can be identified, targeted, and modified in the treatment relationship and thus eliminate or make less likely a reliance on addictive substances. We have reviewed elsewhere (Dodes and Khantzian 2005) early psychoanalytic formulations that, with a few exceptions, emphasized the use of addictive drugs as a regressive, pleasurable adaptation, whereas more contemporary formulations have placed emphasis on a progressive adaptation where addictive substances serve to cope with painful internal states and conditions and overwhelming external realities. Contemporary psychodynamic psychiatrists dating back to the 1960s and 1970s have reported on the nature of addictive vulnerability based on an appreciation of factors from structural, ego/self, and object relations perspectives. These perspectives underscore how disturbances and vulnerabilities in experiencing and processing emotions, sense of self/self-esteem, interpersonal relations, and behaviors are important if not essential factors for the development and maintenance of addiction to substance of abuse. Although there is empirical data supporting the efficacy of psychodynamic psychotherapy for a range of psychiatric disorders, including treatment of addictive disorders (Khantzian 2012; Dodes and Khantzian, in press; Shedler 2010), there is a rich clinical literature describing how an appreciation of the underlying dynamics of addictive behavior can be fathomed and targeted in individual and group therapy to help addicted individuals understand and modify these dynamics and overcome their addictive attachments and behaviors (Dodes and Khantzian, in press). Although individual psychotherapy is the primary focus here, this treatment modality should not or need not compete with complimentary or alternative treatments when psychodynamic findings indicate the need for additional or alternative treatment as will be discussed subsequently.

What is reviewed in this chapter derives mainly from clinical work with drug-dependent individuals. The chapter rests on the assumption that the case method and the treatment relationship (practice-based evidence) yields rich data that illuminates the nature of addictive disorders and provides keys to understand and treat patients who suffer with addictive illness. We will emphasize the more contemporary formulations that provide a basis to appreciate the vulnerabilities that underlie reliance on addictive substances and behaviors and how individual and group psychotherapy can ameliorate addictive suffering and modify addictive behavior.

49.2 Addiction as a Self-regulation Disorder

Addictive disorders are rooted in suffering – not pleasure-seeking or self-destructive motives as early psychodynamic formulations suggested. The suffering is mainly a consequence of addicted individual's inability to regulate their emotions, self-esteem, relationships, and behavior, especially their self-care (Khantzian 2012). From the earliest phases of infancy through early adult development, environmental influences around parenting, safety, comfort, traumatic abuse/neglect, and peer relationships are crucial in influencing self-regulation capacities, and significantly, experiences from earliest phases of development, for which there are no memories or symbolic representations, have some of the most profound influences (Gedo 1986; Khantzian 2003; Krystal 1988; Lichtenberg 1983). In this respect, these developmental factors weave their way through addictively prone individuals' ways of experiencing their emotions, sense of self, relationships, and behaviors to make addictions more likely. In what follows, I will elaborate on these self-regulation problems and how appreciation of the dynamics involved can guide effective individual and group therapeutic responses.

49.2.1 Disordered Emotions

Contemporary psychodynamic views have placed heavy emphasis on how addictively prone individuals suffer in the extreme with their emotions. Affect life at one extreme is perplexing, elusive, cut off, or absent, and at the other extreme feelings are overwhelming and unbearable. Terms such as alexithymia, disaffected, anhedonia, non-feeling states, etc., have been adopted to capture how feelings are not available, elusive, and disconnected, thus causing individuals so effected to feel empty, cut off, and unable to use their emotions to guide their reactions and behavior (Krystal 1988; McDougall 1984; Krystal and Raskin 1970). Krystal and Raskin (1970) appreciated some of the bases of these deficits when they described how feeling life has a normal developmental line (and potential for arrest or regression secondary to trauma or neglect) and how at the outset of life feelings are undifferentiated (i.e., anxiety cannot be distinguished from depression), that feelings are somatized, and without words (alexithymic). Addictively prone individuals at the other extreme suffer because feelings are intense, overwhelming, and unbearable. In this respect, more recent psychoanalytic investigators stressed defects in affect and drive defense and deficits in psychological structure to explain how substance-dependent individuals adopt addictive drugs to make intolerable feelings more bearable, especially those involving rage and aggression (Khantzian 1978; Weider and Kaplan 1969; Wurmser 1974).

These same investigators have elaborated on how addictive drugs can stimulate and enliven individuals who are cut off or feel vacuous or help to contain disorganizing and intense emotions when such affect is threatening or overwhelming. In these reports, the activating properties of stimulants and the releasing effects of low to moderate doses of depressants are described as correctives for individuals

experiencing their feelings as cut off or vacuous (Khantzian 1975, 1985, 1997). Weider and Kaplan (1969) coined the term "drug of choice," elaborating on how individuals self-select addictive drugs as a "prosthetic" to cope with overwhelming adolescent anxiety. The works of Wurmser (1974) and Khantzian (1985) emphasized the calming or muting action of opiates or obliterating doses of alcohol, especially for feelings of rage and aggression. What should be emphasized here is that these reports better focused on and appreciated how addictive drugs were used not for pleasure or self-destructive motives as early psychoanalytic studies stressed, but more precisely to selectively alleviate or make more tolerable affects that were confusing, unbearable, or intolerable.

More recently, Khantzian (2012) has considered some of the more subtle psychodynamics of addictive behavior that are insufficiently considered, namely, why so much of addictive behavior unfortunately continues to be linked to pleasure seeking (especially by neuroscientists) and how and why seeking relief from addictive drugs most usually produces more suffering than it relieves, and yet addicted individuals persist in the use of their drugs. In the former instance, especially those who are alexithymic and confused about their feelings, addicted individuals wittingly and unwittingly substitute the suffering which they perpetuate and control with use for the suffering they do not understand or control. The operative changes from simply relieving suffering, for one of control where they better understand and control it. In the second case, Khantzian (2012) has speculated, based on clinical observations, that addicted individuals often suffer with pervasive anhedonia and that the often magical relief they first experience with their drug of choice is experienced as euphoric, which is interpreted as pleasure, when in fact it is the result of relief of the anhedonia.

49.2.2 Disordered Relations with Self and Others

Dating back to the seminal contributions of self-psychologist Heinz Kohut (1971, 1977), recent formulations have underscored the faulty and troubled ways addictively inclined individuals suffer with troubled inner states of discomfort about self. Inner states of cohesion and well-being are lacking and lead to periodic and/or chronic feelings of helplessness, fragmentation, impoverishment, shame, and a low sense of self-worth; as a consequence, feelings of rage and defensive postures of omnipotence and bravado often result to mask underlying feelings of emptiness and inadequacy (Khantzian 2012). Dodes (1996, 2002) has emphasized how feelings of helplessness and compensatory narcissistic rage are major factors leading to drug use and relapse. On this basis, he formulated that addictions are a compulsive disorder and thus subject to traditional psychodynamic psychotherapy. Along similar lines, Director (2005) focused on feelings of powerlessness, unimportance, and compensatory reactions of omnipotence to explain recurrent relapse to addictive drugs in her work with two addicted women.

The importance of these perspectives is that clinicians must be sensitive and fine-tune to the troubled sense of self and painful lack of self-regard drug-dependent

individuals struggle with and to be appreciative of how the off-putting defensive characteristics can be understood as necessary postures to avoid narcissistic collapse. Furthermore, these findings indicate the significance of appreciating how such dynamics basically interweave with the compulsion to self-medicate the emotional pain such dynamics engender.

Troubled sense of self and self-esteem issues powerfully interact with relational difficulties for substance-dependent individuals. The early psychoanalytic literature linked addictions to pathological or problematic dependency. In contrast, contemporary psychodynamic views underscore problems of interpersonal isolation and counterdependence (Khantzian 2012). Although drug-dependent individuals suffer from enduring troubled, disrupted, and often traumatizing histories, experiencing or expressing their needs for connection and comfort with others that they so desperately need cannot be dared or accepted. As a consequence, feeling lonely, cut off, and alienated becomes a tragic way of life. Psychodynamic explorations of these attachment problems, more often infantile in origin, reveal how such adaptation is powerfully connected to addictive use of substance to deal with the associated distress and the pain perpetuating defenses of self-sufficiency, disavowal of need, and counterdependence (Flores 2004; Khantzian 2012; Walant 2002; Weegmann 2004).

Considering how these problems with sense of self, self-worth, and relational difficulties cause drug-dependent individuals so much pain and difficulty in tolerating distress and interactions with others, it should not be surprising the action of addictive drugs provide temporary relief and "solutions" to their intrapsychic and interpersonal pain and difficulties. Stimulants can counter states of helplessness, enfeeblement, and deflation in narcissistically injured individuals as well as provide a psychic boost for deflated self-esteem, or opiates can contain or offset the dysphoria that comes with disorganizing rage and make connections to others less threatening (Dodes 1996; Khantzian 1997, 2012). Low to moderate doses of alcohol can help shamefully restricted individuals, briefly, and therefore tolerably, to breakthrough and connect with others (Krystal and Raskin 1970).

These examples offer support for the recurrent clinical observation of why and how addictive substances become so compelling in individuals who suffer with an injured sense of self, poor self-esteem, and problematic interpersonal relations.

49.2.3 Disordered Self-care

Khantzian (2012) and Khantzian and Mack (1983) have described a fundamental ego function involved in life and in addictive vulnerability, namely, a capacity for self-care.[1] Self-care functions ensure safety, well-being, and survivability. They are underdeveloped or deficient in substance-dependent individuals. Early in his career, Khantzian (2012) cites his experience working with intravenous heroin users in

[1]The following sections on self-care and treatment are based in part on a recent report by Khantzian (2012).

a methadone program wherein he describes his powerful subjective reaction to the idea of injecting oneself with illicit drugs; he realized that his reaction of repugnance to that idea was one of countertransference (modern theorists would call it an "intersubjective" response, namely, patients getting the therapist to feel something that the patient is unaware or incapable of). Tactfully sharing his recoil and discomfort with the many patients he was evaluating consistently and monotonously elicited reactions of little or no emotions or concerns of alarm about crossing the so-called needle barrier. Subsequently, working with abstinent drug- or alcohol-dependent patients in psychotherapy, Khantzian was struck by how such lack of worry or thought persisted when no longer addicted. He observed these deficiencies to be involved in interpersonal and physical mishaps, slipups around management of important matters of unpaid premiums, lapsed licenses, and preventable medical and dental problems. It is in this context that he began to conclude that a major contributing factor to the development of addictions involved deficits in a capacity for self-care. Namely, addictively prone individuals think and feel differently about potential and real situations of harm and danger. Anxiety, fear, worry, and apprehension are deficient or absent and fail to guide such individuals in risky or self-harmful situations. There is a failure to draw cause/consequence relationship in the face of risk. Where anticipatory shame and guilt might guide when self-care capacities are better developed, in addictively prone people shame and guilt come after the fact (e.g., "I felt stupid and bad when I did that" [rather than] "I will feel stupid and bad if I do that"). It is the combination of self-care deficits interacting with the pain and suffering involved in self-regulation difficulties that makes vulnerable individuals more likely to develop addictive disorders.

49.3 Implications for Psychodynamic Psychotherapy

Treating clinicians need to constantly appreciate the underlying dynamics and vulnerabilities that govern addictive behavior. Considering the difficulties addicted individuals have with regulating their emotions, sense of self/self-esteem, relationships, and self-care, therapists need to think about therapeutic elements and attitudes that would best attune and respond to the suffering and dysfunction with which patients struggle. Old psychoanalytic approaches of passivity, therapeutic detachment, and strictly interpretive methods, therefore, would not be the order of the day. In fact, such approaches could perpetuate the confusion, shame, alienation, and disconnect with which addicted patients suffer. Thus, a contemporary psychotherapist needs to be more interactive (balance talking and listening) and incorporate attitudes of kindness, support, empathy, respect, patience, and instruction in the service of building and maintaining a strong treatment alliance. These elements are essential in order to deal with and overcome the problems with inaccessible or intense emotions, shame, broken self-esteem/relationships, and poor self-care (Khantzian 2012). Confrontation should be avoided and used only rarely such as concerns about safety but done in a way that preserves self-esteem.

The psychodynamic findings that have been outlined previously are considered in what follows, not only in reference to individual psychotherapy but also as they apply to considering other treatments, especially psychodynamic group therapy, as they can enhance individual therapy or be considered as alternatives when there are psychodynamic indications to do so.

Remembering how cut off addicted patients can be with their thoughts and feelings, therapists can help significantly with these dysfunctions by actively drawing out, identifying, and labeling feelings that begin to surface or seem evident to the therapist. When patients protest they do not know what they are feeling, treating clinicians should avoid concluding it is resistance or denial but rather use such interactions to invite and support the patient to consider the challenge of exploring, discovering, and understanding their feelings and emotions. Allen, Fonagy and Bateman (2008) have coined the term *mentalization* to emphasize one of the most basic aspects of psychotherapeutic work in general, but the concept preeminently applies to work with addicted patients, namely, to persistently focus on helping patients to access feelings, put them into words, and sustain them. Beyond individual therapy, the narrative and storytelling traditions that occur in group therapy and 12-step meetings are often very beneficial in helping patients to develop a capacity to recognize, express, and practice their own thoughts and feelings.

For those patients who struggle with and self-medicate intense and threatening emotions, particularly anger and rage, considerations and efforts should be made to help them contain and moderate the feelings that can feel so dangerous to self and others. It is worth noting how the positive treatment relationship and the therapist's concern for the safety of the patient is in and of itself a containing influence. For those whose rage and violent feeling derive from trauma and neglect, it is crucial to acknowledge and validate the legitimacy of such reactions and help them to understand how and why they have resorted to addictive drugs to contend with such intense emotions. Carefully timed and gentle explorations of the experiences that engender such emotions can gradually diminish or resolve such intense affect. In this context, judicious use of legitimate psychotropic medications targeting these affects can significantly attenuate the intensity to make the working through of these affects in psychotherapy more doable.

The support and empathy exhibited by the therapist in response to drug patients' pervasive sense of shame and broken self-esteem (predisposing and consequential) are a vital element in engaging and retaining such patients in psychotherapy. Such an approach helps in gaining inroads on the confusing and elusive ways in which the sense of self and others is experienced by substance users. Openings are created to focus on and help identify and resolve feelings of powerlessness, defensive rage, and reactions of omnipotence that are experienced and often surface in treatment. Patience, support, and kindness remain of paramount importance and allow for opportunities to therapeutically address and help the patient and the therapist, understand, and better work out problems with off-putting characteristics. These characteristics are more often reactive and defensive secondary to feelings of helplessness as well as feelings of unimportance (Dodes 1996; Director 2005).

And for those who are seemingly void of emotions and disengaged, the therapist may draw on their own energy and liveliness to help activate and enliven patients who are so affected. Again, group therapy experiences often can be invaluable in this respect in instilling and validating a better sense of self/self-esteem.

The issue of low self-esteem of substance abusers is related to their tendency to be avoidant of relationships and interpersonally isolated. They feel undeserving of the care and connection to others. Remaining interactive, engaging, and empathic are important elements in responding to patients' fear of and ambivalence about relationship. Impassivity and detached interpretations can be counter-therapeutic and devastating. Tactful focus on the ambivalence can materially stimulate possibilities of beneficial connections to others. It is in this respect that the connections stimulated by individual and group therapy are extraordinarily helpful in addressing and ameliorating the attachment difficulties and sense of alienation with which substance-dependent individuals struggle.

The thoughtless and unfeeling behaviors of substance-dependent patients that are characteristic of self-care deficits become manifest in the treatment relationship by the alarm stirred in the therapist by patients' risky or dangerous behaviors. Such reactions and interactions can alert the therapist and patient to how such deficits are major factors for patients to use and relapse to additive behaviors. The therapist should be unhesitant in using their reactions of alarm and concern that patients stir to identify the lack of such reaction in the patient. Constant attention to patients' poor self-care can help to instill a growing awareness of how their self-care deficits continuously leave those so affected continuously in harm's way, especially those involved with the harm and dangers associated with addictive substances. Long-term therapy often helps in getting at and understanding the developmental and environmental roots of these deficits, but a here-and-now, active, instructive approach is essential in order to stimulate and better develop a better capacity to recognize, anticipate, and avoid self-harm, particularly related to addictive substances. Finally, "We need to help patients use self-respect, feelings of apprehension/worry, relationships with others, and thoughtfulness as a guide for safe behavior and self-preservation" (Khantzian 2012, p. 278).

49.4 Conclusion

Contemporary psychoanalytic understanding of addictive disorders has generated and documented observable, developmental, structural, ego/self, and object relations disturbances that predispose to and maintain addictive behaviors and attachments. These findings provide a basis to identify the ways in which these disturbances affect feelings, self-esteem, relationships, and self-care. They provide a basis to guide therapists in targeting these problems psychotherapeutically. Impassive and strictly interpretive approaches are contraindicated if not damaging. Modern psychotherapeutic treatments employ more interactive, supportive, and empathic attitudes and techniques to help patients and therapist to focus on vulnerabilities and dysfunction that perpetuate addictive suffering and pain. This contemporary

perspective provides understanding, hope, and more effective means to overcome the compelling, self-defeating, and tragic causes and consequences of addictive disorders.

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