

# Psychodynamic Approach to Addiction Treatment

## The Psychodynamic Approach to Addiction Treatment The Biopsychosocial Model Revisited

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### Introduction

A great many of the writings pertaining to the disease model of addiction (sometimes referred to as chemical dependency) invoke the theoretical framework developed by E. M. Jellinek from his survey of Alcoholics Anonymous members; lectures at the Yale Summer School of Alcohol Studies: July 1951 and July 1952; and lectures at the European Seminar on Alcoholism: Copenhagen, October 1951. A summary of all of these appears in "Phases of Alcohol Addiction" (*Quarterly Journal of Studies on Alcohol*, Vol. 13, No. 4, pp. 673-684, December 1952). Later theorists, clinicians, researchers, and program developers chose not to place much emphasis on Jellinek's ideas about the relationship between psychopathology, social pathology and drinking behaviors. They were quick to seize upon his early musings about the possible relationships between biomedical, physiological and genetic factors (the so-called "X factor") and alcoholism. However, we begin our present considerations by sharing with the reader several important quotations from the original "Phases of Alcohol Addiction" paper. In the section entitled "The Disease Conception of Alcohol Addiction" Jellinek wrote (emphasis added):

*... In both groups (alcohol addicts and habitual symptomatic excessive drinkers), the excessive drinking is symptomatic of underlying psychological or social pathology, but in one group after several years of excessive drinking "loss of control" over the alcohol intake occurs, while in the other group this phenomenon never develops. The group with the loss of control is designated as "alcohol addicts."*

*... There is no intention to deny that the nonaddictive alcoholic is a sick person; but his ailment is not the excessive drinking, but rather the psychological or social difficulties from which alcohol intoxication gives temporary surcease.*

*...The "loss of control" is a disease condition per se which results from a process that superimposes itself upon those abnormal psychological conditions of which excessive drinking is a symptom.*

*...Whether this superimposed process is of a psychopathological nature or whether some physical pathology is involved cannot be stated as yet with any degree of assurance, the claims of various investigators notwithstanding. Nor is it possible to go beyond conjecture concerning the question whether the "loss of control" originates in a predisposing factor (psychological or physical) or whether it is a factor acquired in the course of prolonged excessive drinking.*

... The "occasional symptomatic excessive drinker" tends to take care of the stresses and strains of living in socially accepted-i.e. "normal"-ways, and his drinking is most of the time within the cultural pattern. No psychological abnormality can be claimed for this type of drinker, although he does not represent a well-integrated personality.

It is quite clear that Jellinek postulated that those people we now call "problem drinkers" and "alcoholics" suffered from a variety of individual and social pathologies that interacted with less well-understood biochemical and genetics ways. In effect, Jellinek was the first to propose a true biopsychosocial model for understanding addictive behaviors involving alcohol consumption.

A great deal of attention was paid to the medical and biochemical aspects of Jellinek's theoretical musings regarding "alcohol addicts" by alcoholism counselors, Alcoholics Anonymous, and the National Council on Alcoholism. If alcoholism could be understood as primarily a medical disease then its victims could be considered medical patients, worthy of treatment rather than condemnation. They would be able to get a better deal in terms of treatment and insurance coverage. The idea of alcoholics as "crazy people" was to be avoided and discredited at all costs. Too many alcoholics, appearing psychotic while intoxicated, ended up on psychiatric wards that had no alcoholism-specific treatment protocols. For the patient suffering from alcohol dependence without premonitory or coexisting psychological disorders there were virtually no treatment models. This need created a fertile laboratory in which to create a humane and compassionate form of treatment for alcoholics. As pointed out by Spicer in his book, *The Minnesota Model* (Hazelden Foundation, 1993), the three priorities (core perspectives) in the evolution of compassionate care for alcoholics were:

- Treat people with chemical dependency
- Treat them with dignity
- Treat them as whole persons-body, mind and spirit

It is *not* a well-known fact that the original Hazelden program actually evolved from experimental programs in several psychiatric settings in the Midwest. It makes a great deal of sense to the authors of this paper that early sensible and humane treatment would be developed in a setting dedicated to the treatment of human suffering in which psychopathology was already being considered. Over the next several decades several important factors influenced the development of addiction treatment programs. Chief among these were:

- Organized psychiatry and psychology failed to offer treatment models that reflected some of the unique problems defining addictive behaviors. For example, the American Psychological Association did not create a Division of Addictions until the 1990's. The American Society of Addiction Medicine was not officially part of the American Medical Association, which is open to all branches of medicine, until the late 1980s. Addiction is still not a popular specialty within psychiatry.
- Psychiatrists, not trained in the treatment of alcoholism or drug addiction, have had a tendency to prescribe cross-addicting medications to already chemically dependent patients. They were not trained in medical school, internships or residencies to screen for chemical dependency problems in psychiatric patients.

- Addicted clients were not forthcoming about their addictions and manipulated mental health practitioners of all disciplines for food, clothing, shelter, money, and treatment, often feigning or "hyping" other mental disorders. Patients quickly learned buzzwords around suicidality, homicidality, and depression to gain admission to psychiatric settings when their addictions closed in on them while, at the same time, avoiding addiction treatment settings.
- Unless the patient was committed to abstinence, psychotherapy was often counterproductive and futile. However, unknown numbers of therapists persisted in encouraging their patients to reduce their drinking and/or drug taking as therapy continued. This practice was anathema to prevailing addiction treatment wisdom, which targeted interventions at the actual drinking, and/or drugging and led to the creation of interventions as a clinical specialty with total abstinence as the goal.
- Practitioners in the developing-and separate-alcoholism and drug abuse treatment fields wanted addictive behaviors considered as primary diagnoses, reimbursable by insurance companies, but rarely worked together toward this end. These same people found few sympathetic allies in the mental health fields who could lobby for changes in funding streams and insurance laws.
- While some chemically dependent patients sought out mental health settings, other alcoholics and drug addicts wanted to avoid the major social stigma associated with mental illness. Chemically dependent patients, free of co-existing mental illness, with intact jobs and family, tended to do well in rehabilitation programs if therapeutic leverage and support were applied by families and employers. However, an overemphasis on addictive behaviors and a lack of training in the diagnosis of co-existing mental disorders created a blind spot in the eyes of chemical dependency counselors to the underlying multiple problems of the treatment resistant, relapse-prone patient with Axis I and II diagnoses. Multidisciplinary treatment did not begin until the creation of Minnesota Model programs. With this model and the addition of mental health professionals to the staff mix, more serious pathology was detected and patients could be directed to other treatment resources.
- Multidisciplinary alcohol and drug programs were more accepting of mutual-help fellowships like Alcoholics Anonymous and Narcotics Anonymous, and indeed, modeled many of their program tools around AA concepts in particular. This marked the beginning for use of a "psychoeducational" teaching approach as opposed to the process-oriented, dynamic psychotherapy approach used within other chemical dependency treatment programs.
- The growing therapeutic community movement-Synanon, Daytop, Phoenix House, etc.-made extensive use of recovering people as treatment staff. Persons-in-recovery as treatment staff was an alien concept to mental health practitioners. Yet, the TC movement was slow to accept the value and importance of 12-step meetings as an adjunct to their approach, resulting in many "old-time" recovering addicts with significant drinking problems.
- In the 1970s, there was a breakthrough in receiving insurance reimbursement for treatment of addictive disorders-an agreement between Smithers Rehabilitation Program and Blue Cross/Blue Shield of New York designating the 28-day rehab benefit. Addictive behavior was now considered a **primary illness**, not necessarily a symptomatic expression of an underlying mental disorder. Axis II disorders were not considered

"serious" mental illnesses whose treatment could be underwritten by insurance companies and, later, by managed-care policy makers. Fragmenting symptoms as if they derived from separate illnesses led to a misuse of the concept of so called "dual diagnosis," flying in the face of Jellinek's original ideas and enabling patients to minimize the severity of their core ego deficits by splitting them into disparate and unconnected parts serving their delusions of denial and the maintenance of dependency.

- Prevailing cynicism among mental health professionals ordained that since addictive disorders involve chronic relapse, then patients were indeed hopeless. This cynicism was not only a result of frequent relapse by patients but also a projective identification on the part of the practitioners. When mental health professionals project such feelings, then relapse follows, which, in turn, is followed by more hopelessness. Organized medicine and psychology rarely made this a focus of clinical care. In particular, the emerging community mental health center movement of the 1960s and 1970s failed to respond to the needs of people with addictive disorders. Instead, this became the era of the "Minnesota Model" with many rehabilitation centers ("rehab") being established across the nation.
- The establishment of three separate fields: alcoholism, drug abuse and mental health, led to deep schisms that exist to this day. While some programs have become "multidisciplinary" in terms of staffing patterns, the internecine warfare has taken a terrible toll and obscured some of the critical clinical issues. One such strategic clinical issue is the question of how to best treat the core ego disturbances of many patients currently being treated in clinical settings in all three fields.
- The newly emerging field of "dual diagnosis" treatment is not clearly defined and deserves a closer analysis. Remember the old cliché: "There is very little new under the sun." Different nosological concepts are being applied to modern day diagnoses that often have more to do with payment protocols than clinical protocols. Zeitgeist-the prevailing popular theory of the day-rarely stands the test of time. This raises an important issue: is psychopathology among addicts on the increase, or did sociopolitical and philosophical biases prevent patients from being accurately diagnosed all along? Many suspect that the so-called dual diagnosis patient has been the model patient all along.

It has been the authors' clinical experience that good treatment for addictive disorders requires the accumulated wisdom of the three fields. At times, less than collegial relations between competing disciplines, fields and belief systems have been manifested. One favorite phrase used in the chemically dependency field has been: "The heart has a mind, that the brain does not comprehend." This kind of reasoning is used to defend the "folk wisdom" and beliefs of such groups as Alcoholics Anonymous. The entire dialogue regarding the spiritual side of life and recovery has tended to act as a giant sinkhole and created a chasm between mental health and addiction professionals. Counselors and clinicians as well as managed care companies are hungry for new models that are truly comprehensive in scope and cost effective. The medical side of current treatments only relates to detoxification and the medical complications of addiction. The majority of counseling efforts is psychological (individual, group and family), psychoeducational and spiritual in nature. Where and how the art and science of such tools should be applied is the leading edge question facing the three fields. The biopsychosocial model of addictive disease is emerging as the most comprehensive and holistic body of theory and practice. An explication of the important role played by psychodynamic factors will further

advance our understanding of the biopsychosocial model. Our purpose here is to explore the most neglected aspects of that model—the psychological and social components.

One should be wary of models that tease apart the "bio," "psycho," and "social" aspects of addiction to the exclusion of the other parts. This is strategically important for avoiding buying into the patient's delusional system that protects their personal responsibility for change. For example, the media has tended to oversell the biological basis of alcoholism as holding hope for a "cure." The latest "magic bullet" is Serotonin. Low levels of Serotonin are being held to account for a variety of mental illnesses, aggressive behavior, alcoholism, and impulsive behavior in general. Already chemical cures such as Prozac are being announced. Excellent research with animal models has already demonstrated that Serotonin levels are influenced by environmental and behavioral factors. An interactive-biopsychosocial-model is far more likely to be supported, in the long run, than an exclusively biomedical one. Psychotropic medications, properly applied, are helpful with symptoms of Axis I disorders (e.g., depression, mania, anxiety). Outcome studies support a medication **and** therapy approach to treatment. Personality disorders (Axis II) have proven highly resistant to medication-only approaches. This makes perfect sense since Axis II formulations tend to obscure the organic connection between core pathology and both the addiction and Axis I symptoms. Understanding the patient's experience should be the priority rather than matching symptom clusters to disorder diagnoses. Behavior is in the service of the ego and existentially defies simplistic diagnostic descriptors. This is another reason why the importance of spirituality in recovery has eluded the scientific approach.

All interested parties are aware that the most frequent outcome of treatment is relapse. Although patients are held responsible, in fact, for their own behavior, the public perceives such behaviors as a failure of the treatment environment. Therefore, grasping the psychodynamic aspects of addiction and its treatment can only work to advance the knowledge and technology of effective treatments. This is particularly essential when one considers the treatment resistant, relapse-prone patient with Axis I and II disorders. Such patients have come to represent a significant subset of addicted Americans. We think Jellinek was definitely on the right track. We think it clinically productive to view relapse as regression; that is, regression in the service of the ego, albeit an underdeveloped ego. The goal of treatment then becomes understanding the core ego deficits and addressing them before the patient gets to the act of actual substance ingestion. Relapse behavior, therefore, is a natural phenomenon when understood in terms of developmental deficits. Quality clinical care can be provided by training addiction counselors in the psychodynamic model, providing them with excellent clinical supervision, and having all staff share the creation of counseling based on psychodynamic formulations.

### **A Psychodynamic Model of Addiction**

A number of prominent addiction theorists and clinicians have pointed out the need to intervene at the behavioral level of the actual dangerous and debilitating use of alcohol and other drugs. This line of reasoning led to the development of intervention strategies to confront the active drinking and drugging and bring people into treatment with dispatch.

It became an addiction treatment axiom that psychotherapy and psychoanalysis in particular were **not** the treatment of choice. It was often stated that "uncovering" therapies created such intense anxiety that the patient had to drink or drug to deal with it. Alcoholics Anonymous, in respecting the fragility of early recovery, suggested that members make as few life changes as possible in the first year (e.g., no new relationships). Interestingly, classical psychoanalytic treatment likewise discourages major life change in the first year of analysis. Experience has shown how frustrating and countertherapeutic such tools are while the patient continues to drink and/or drug. This experience led to an out-of-hand rejection of the use of psychotherapy in almost all addiction treatment settings. A few wise therapists realized that once a patient developed solid recovery tools, they could safely probe more deeply into the patient's psyche. For these patients, a phased type of approach has been useful. For many other patients, the uncovering therapy and acquisition of recovery skills needs to happen **simultaneously**. These patients require a treatment plan that understands the underlying issues that inhibit recovery. They need to understand the secondary gains represented by the addictive behaviors.

Rather than discount a psychotherapeutic approach, it is the therapy consulting room as a treatment setting that needs to be faulted. For the patient with serious character pathology (also referred to as personality disorders) who became dependent on substances, the therapy office is of little use. Although some chemically dependent people were getting well using more traditional psychotherapeutic modalities (sometimes combined with 12-Step involvement), these persons tended to have more intact egos and more intact lifestyles. However, since research has shown the co-morbidity of addiction and mental illness to be not less than 50%, office practice is not the setting of choice for most addicted patients. It is imperative that such a psychotherapy approach be placed in the proper setting with an appropriately trained staff in order for it to work. Failure to "uncover" the psychic pain and maladaptive patterns of thinking, feeling and behaving that are at a person's psychological core leaves him or her vulnerable to repeated relapse and a failure to achieve improved self-care. It is the major reason for relapse, treatment failures and premature departure from treatment (patients leaving "Against Medical Advice"). Let us consider some of what we already know about such patients.

### **1. Core Psychological Vulnerabilities - Ego Deficits**

Addicts and alcoholics with Axis I (clinical syndromes such as mood disorders and anxiety disorders) and Axis II (personality disorders) diagnoses exhibit ego disturbances that, at their core, appear in several dimensions of human behavior. It is essential to note that these developmental lags or deficits predate the addictive behavior, interact with it, and re-emerge full-force in abstinence. Treatment professionals have noted that many addicted patients have both Axis I and II disorders. The primary emphasis in psychiatric hospitalization is symptom relief for Axis I disorders. Many psychodynamically oriented practitioners believe that it is actually the character pathology (Axis II disorders) that is the cause of Axis I type symptoms. Psychic distortions, missing psychic structures, developmental disruptions, and emotional pain are often the precursors of addiction and mental illness, as the underdeveloped ego seeks recreation of its original dependent state.

The first such ego deficit is the addict/alcoholic's inability to experience, label, process, and manage his or her emotional life. Such persons often experience the extremes of psychic numbing and emotional flooding. Overwhelmed by an inner emptiness and rush of powerful external affects, they retreat from a hostile external world and a chaotic inner world into drug-induced states. As Dr. Ed Khantzian at Harvard and others have pointed out, one's drug of choice is neither random nor accidental. Drugs are selected for their differential ability to numb, excite, calm, energize, sedate, sexualize, narcotize, and induce both ecstatic and fantasy states. In these alternative psychic states, the addict finds momentary surcease from the straight world. Cannabis is so popular because of its ability to open psychic portals to a wide assortment of such effects, as it is, pharmacologically, both a sedative and a stimulant.

Second are profound dependency needs, usually acted out in powerful interpersonal dramas. The addict/alcoholic lies and manipulates the people around him/her in a desperate attempt to be taken care of by others. The addict lacks his/her nurturing "psychic supplies" and self-soothing psychological structures, and keeps trying to incorporate these supplies from the outer world, be it love or drugs. Without realizing it, they are recreating ancient family of origin psychodramas wherever they go. The addict can only incorporate another person as an "object" rather than as a "subject." In this state they exhibit extreme narcissism and grandiosity. They transfer blame and responsibility to others. Addicts develop a delusional system about the outside world, and are so good at manipulating, they can selfishly foster a false sense of responsibility in others for their personal good and welfare. Loved ones pay bail money, lawyer fees, credit card debt, money owed to drug dealers, and all manner of things in a misguided attempt to protect the addict from the consequences of their own behavior. In this "dependent position," encapsulated within oneself, unable to experience genuine contact with others, experiencing rescue again and again, the addict is not free to experience his or her own competencies and fails to thrive in the adult world, having been continuously accommodated, rather than internalizing accommodation.

By avoiding personal responsibility for their own actions, addicts and alcoholics exhibit the third area of psychological vulnerability: a failure to take proper care of themselves. By getting high and drinking they demonstrate the core unconscious fantasy of the addict, **THE FANTASY OF LIFE WITHOUT CONSEQUENCES**. Failing at self-care, they manipulate others to take care of them or rescue them. They appear childlike. Even when they can articulate better ways to do things, they seem unable to carry them out. They are assigned a dependent role in the family. However, the patient is rarely consciously aware of his or her excessive dependency needs. Dr. Sheldon Zimberg postulates that childhood rejection, overprotection, or premature responsibility leads to an unconscious need for nurturance that cannot be met in reality, which leads to feelings of abandonment, creating heightened states of anxiety. The disease of addiction perverts and/or distorts an otherwise healthy parental process of defending, protecting, and providing for one's child into a pathological process of enabling and rescuing. Many therapists in the field of addiction have experienced the frustration of trying to form a therapeutic alliance with a family that is not yet prepared to give up this dysfunctional familial pattern. Conversely, when the family does form such an alliance with treatment staff, improvements in the patient's self-care become possible. This is the only way, at times, to break through the defenses surrounding the core fantasy (life without consequences). Increasing numbers of treatment professionals have come to regard the confrontation of this core fantasy as the main work of effective addiction and psychotherapeutic treatment. Escape routes need to be cut off, and former rescuers need to

abandon useless strategies of the past. When the addict has no human alternative but to face reality, he can learn to take better care of himself (initially in supportive settings) and internalize competency rather than utilizing narcissistic "entitlement."

Repeated failure at self-care, coupled with an addictive lifestyle, launches the fourth psychology vulnerability: serious deficits in self-concept. Patients develop self-loathing and then compensate with narcissistic entitlement and reactive grandiosity. Unresponsive to demands to be productive employees or students, they develop a syndrome of social and vocational failures. They often experience repeated social rejection and feel profoundly alienated from the mainstream of society. This vicious cycle leads to greater despair, more self-hatred and progression into ever more dangerous enterprises. They experience further regression in the service of the ego and they revert to infantile gratification modes like drinking and drugging. Overtly, patients reveal underlying vulnerability by **denial** of the very things they need (e.g.; "I don't need anyone!"). This is a reactive form of grandiosity, which leads to more social failure with its accompanying anxiety, depression, anger and guilt. The addict must learn to acknowledge and challenge the childlike dependency and emerge into adulthood by taking on the *adult* tasks of sobriety and recovery. When this is done, the pride that comes with genuine accomplishment can raise esteem and lead to more enduring positive changes in self-concept. Resolving repeated developmental crises leads to a sense of maturity, improved self-care, and a marked improvement in internalizing object relations. The core ego deficits listed above evolve into a *mélange* of maladaptive behaviors by the addict. Included among these maladaptive behaviors are:

- Profound narcissism. They are self-centered and self-absorbed and extremely sensitive to narcissistic injury.
- Extreme grandiosity. Mostly image-addicts "front" strength but are actually weak.
- Manipulation and lying. Con games, stealing, cheating- the whole gamut.
- Impulsiveness. Like lightning they move from impulse to action, bypassing the weighing of possible consequences to self or others.
- Extreme risk taking. Crime, overdose, HIV infection, etc.
- Externalizing of blame. Its always someone else's fault, never their own ("blame shifting").
- Isolation. They retreat into a world filled with secrets, shame and guilt.
- Passivity. At times, they collapse into inaction, awaiting rescue by others.

## **2. The Defensive Structure of Addicts and Alcoholics**

Surrounding and protecting both the core psychic vulnerabilities and the addictive behavior are any number of psychological defense mechanisms. Defense of the ego against a hostile and difficult external world and a suffering internal world is a psychological necessity. However, when defensive structures keep patients trapped inside their own developmental deficits, growth cannot occur. Addiction can become a functionally autonomous process-take on a life of its own. This idea is integral to formulating an effective treatment plan. Families do not cause nor can they hope to "cure" addiction in their loved one. Neither can treatment staff. The familial contribution to later addictive disease is the failure to allow their children to complete necessary developmental tasks. But, both staff and families can play vital roles in the recovery process. A



recognition that the work must be done, in fact, by the addict is crucial to understanding addiction as a biopsychosocial disease. It may take a village to nurture that process, but there is no alternative to the patient working through these defensive structures and owning the process! Since each person's human psychology is uniquely his or her own, the individual must lay claim to that fact and go through the struggles of personal growth. Dr. Sheldon Koop reminds us that the greatest battles are those fought within oneself. The work is not easy and later we will explore some issues about treatment philosophy and structure that bear directly on this. Addicts and alcoholics have the same ego defenses as all other people. However, Dr. John Wallace and others have helped us to understand some of the "preferred" defenses of addicted patients. We list several below:

- **DENIAL** is considered the most primitive of the defenses and operates on a preconscious as well as conscious level. In the service of addictive disease, denial has been observed to reach psychotic proportions. Denial is closely allied with, but differs from, outright lying and distortions of truth such as minimizing consequences. In the defense of denial the addict actually believes his or her distortions are essentially correct and that it is we who are experiencing faulty perceptions. Many of you have experienced the frustration of trying to "educate" someone who is actively in denial. Denial in the service of the ego coupled with a clinging to addictive behaviors is difficult to overcome. Psychoeducational approaches often fail. More direct assaults are usually required to break through this defense. Facts do not change deeply ingrained attitudes that exist to protect fragile psychic structures. Getting someone to "admit" to their chemical dependency does not mean they can also shed other defenses, which are more deeply entrenched, predate the addiction-often by many years-and are by operational definition, not in conscious awareness. Psychodynamically-oriented treatment is needed to address these archaic ego defenses.
- **RATIONALIZATION**. Active addiction can be defined as immediate gratification followed by delayed negative consequences. A great aid in avoiding contemplation of the many negative consequences brought on by addictive behavior is the ability of the patient to seemingly rationalize just about anything. One of the necessary therapeutic goals of recovery is for the patient to stop making *sober* rationalizations and to learn to deal with life "on life's terms."
- **PROJECTION**. There are two forms of projection: disowning and assimilative. In disowning projection, the person attributes unwanted and unacceptable aspects of self to others. With assimilative projection, the person assumes that others are very much like oneself and perceives them as such. This can work with positive as well as negative identification. For example, a person can walk into his or her first AA meetings and say, (a) "I'm not like these people" (disowning) as opposed to (b) "I'm home- they are just like me" (assimilation). The same thing happens in rehabilitation centers, psychiatric hospitals, and outpatient settings. The process of identification is very closely aligned with projection as a defense.
- **CONFLICT MINIMIZATION AND AVOIDANCE**. When people have ingested alcohol and other drugs they often seek out conflict and confrontation. In a sober state, most chemically dependent people shun interpersonal conflict, as they do not handle it well as a rule. Their issues with profound conflict. Very often these patients can be extremely passive in group treatment settings. Until the advent of crack cocaine, addicts were not

known for committing crimes against people, preferring more anonymous crimes against property.

- **ALL-OR-NONE THINKING.** Chemically dependent people tend to see the world and themselves in black and white, not tolerating shades of gray (uncertainty). They tend to have rigid rules for making decisions, appear inflexible and overly simplistic. This explains why many do well in settings with lots of rules (rehab, hospitals, etc.) and not as well in less structured (outpatient) settings. It also helps us understand one reason why the simple-sounding slogans of AA ("One day at a time, keep it simple, easy does it", etc.) are so appealing. Life may be chaotic when patients are using, but they prefer "dance steps" in recovery.
- **SELF-CENTERED SELECTIVE ATTENTION.** Addicted patients view the world from a very singular point of view-namely, theirs! As Dr. Wallace points out "...They tend to be obsessed with self, to perceive the happenings around them largely as they impinge on self. They attend selectively to information relevant to self, ignore other information, that is discrepant with their views of themselves, and distort other information that does not fit their preferred self-image." They can be extremely resistant to feedback and lack empathy for others.
- **OBSESSIVE FOCUSING.** Many workers have observed how patients tend to be obsessed not only with their drug of choice but also with work, money, success, sex, etc. They exhibit a sense of dynamic tension often with accompanying intense anxiety. Interestingly, newly sober people tend to be "obsessed" with recovery. However, while this may seem desirable, the core ego deficits that drive these obsessions must be uncovered and faced in order for long-term recovery, personal growth and adjustment to a healthy ego state. A simple redirection of energies seems to work best when the patient is in a highly structured and supportive setting. A return to sobriety in the real world requires a reduction of this obsession-based anxiety state.
- **PREFERENCE FOR NON-ANALYTIC MODES OF THINKING AND PERCEIVING.** Patients are often swayed more by emotional than rational appeals. They need to "feel" the people who treat them. They respond to inspirational, charismatic and spiritual leadership more than dispassionate logical types. Addicts in their narcissistic entitlement expect unconditional love at all times. They have failed to move from the primary narcissism of the child to a healthier, socially adaptable secondary narcissism. This has a great deal to do with developmental deficits regarding getting basic emotional needs met, time and again, in childhood. For most addicts, these needs were met to the detriment of their ability to be self-reliant. Many times patients have found ways to tell treatment staff, "Before you tell us how much you know, tell us how much you care!" It is not surprising, therefore, to find that addicted patients have found the traditional distant, objective stance of the mental health clinician to be aloof and uncaring. This particular defense points to some of the difficulties in applying psychoeducational and cognitive-behavioral treatments that lack a psychodynamic component.

### **3. Understanding Addictive Disease as Secondary Gain**

Thus far, we have developed the idea that addiction is driven, in part, by a search for release from psychic pain in a world perceived by the addict as hostile and unsatisfying, and as

reenactment of unresolved ego deficit psychodramas. In order to understand the psychodynamic model of addiction treatment, it is essential to grasp the concept of **secondary gain**. Secondary gains are the secondary advantages accruing from addictive illness, such as gratification of dependency yearning or attention seeking. Patients who have histories of trauma—a large segment of addicts—often use their addiction as an unconscious means of seeking out love and protective security. When they are not actively engaged in soothing their wounded psyches with alcohol and other drugs, they are attention seeking and extremely needy of family, friends, and treatment staff. However, if you were to ask them, they would deny such needs. Staff often perceives this as the prelude to relapse, sensing they are being manipulated toward that end. When one stops to consider the psychodynamics of secondary gain, the behavior takes on a deeper and more important meaning.

Let us consider some reasons why we need to place such strong emphasis on secondary gain. Secondary gain keeps the repetition compulsion of the addiction itself alive: "Why should I stop using? My game is working!" Unaware of the core ego deficits that underlie the addiction and continually inhibit recovery, the patient is resistant to messages about the dangers of addiction and associated risk taking behaviors. Such patients are highly resistant to psychoeducational and cognitive behavioral forms of treatment. Insight alone does not change attitudes or behavior. For the young addict, other forms of secondary gain exist in profound dependency issues. These patients refuse to individuate and separate from their parents and later in life, their spouses. In short, the addiction represents a refusal to grow up and assume independent adult responsibilities. In these families there is often **tertiary gain**. Tertiary gains are benefits to someone other than the patient such as family members, friends, caregivers, etc. It is not sufficient to educate such persons only about addictive disease. They also need to look at their own personal histories and motives for reacting to the addict the way that they do. In fact, some of their unconscious motives have nothing to do with the addict. Rather, they reflect their own personal needs for power, control, comfort, and the like. Clinicians can reflect for a moment on all that treatment resistance they have encountered in their work with addicts and their families. Viewing this resistance with secondary and tertiary gains in mind helps us to understand why it is so powerful, and gives us a different way to try and work with it. The new approach lies with helping people to look more deeply into themselves, viewing addiction as reflective of other human needs and dynamics, and creating treatment plans that are based on psychodynamic formulations.

#### **4. The Creation of New Residential Treatment Settings**

A review of the above makes it easier to understand why it has been extremely problematic to conduct effective treatment of addiction in traditional psychotherapy settings. The transference and counter-transference issues alone are daunting! The patient's transference includes intense ambivalence toward treatment, the testing of limits, denial, and grandiosity. The therapist's counter-transference includes intense feelings of frustration and anger, and a threat to a need for omnipotence. The early founders of the therapeutic community movement understood this and created long-term inpatient "intentional" communities such as Synanon, Daytop, and Phoenix House. In these counter-culture, extended family, tribal-type settings, transference was defused throughout a larger communal body and rigid rules of behavior made life more certain and

predictable. Street-wise addicts, whether raised in poverty or middle-class families, enmeshed in the criminal justice system found refuge and safe haven in such programs. Fully 75% of such TC clients are referred by the courts. Such programs use confrontation therapy to strip away the outer core of the character pathology so that the more vulnerable core is exposed and rehabilitated. Outcome research has shown residents who complete such programs-ranging in length from 12-18 months-do well, even years later.

Employed, middle-class patients, not caught up in street-crime, found life too harsh in such settings and tended to gravitate to Minnesota model rehabilitation centers. Those with intact families, jobs, and who were relatively free of mental disorders tended to do well after rehab if they followed their aftercare plans. In these settings, the patient's problematic behaviors were viewed as stemming almost exclusively from the progression of their addictive disease. Dr. Daniel Anderson, President Emeritus and Director of Hazelden for 25 years, explains who does well in such settings:

*"Few people really like drunks or drug addicts, anyway. But there are different ways of interpreting that pathological behavior. And see, that's what we do in the Minnesota Model. We see a bunch of crazy behavior, but the interpretation, the spin we put on it, is that the crazy behavior is part of an addiction. If we can deal with the addiction, we can modify a lot of that behavior. For the vast majority of addicted people, when they sober up and find a way to stay sober, they change their values and become human beings again. They start using the ethical codes that they should."*

But the treatment resistant, relapse prone patient, with Axis I and II disorders, was unable to thrive outside such a setting and often got himself in trouble while inpatient at rehabs. Others slipped by with a good "act as if" (being the masters of manipulation and deception that they are). Such patients remain unchanged by a "psychoeducational approach." Even when they tend to respond well to this type of treatment, lengths of stay have been reduced and the work is aborted prematurely. These patients require much more intense clinical care over a substantially longer period of time. They actually shy away from clinicians who demonstrate a positive counter-transference or otherwise attempt to manipulate and sabotage such relationships. Such patients usually find ways to avoid confrontation therapy as well as psychodynamically oriented treatment, preferring instead to be rescued by others. They move easily between "addictive careers" and "rehabilitative careers," precipitating crisis after crisis, usually dropping out of treatment prematurely on repeated occasions. As a field, our failure to articulate the clinical pathology of the patient has led to a shortening in lengths of stay in Minnesota Model programs. For similar reasons, lengths of stay in psychiatric hospitals, even those on so-called dual diagnosis units, also dwindled, and patients found themselves bouncing in and out of such institutions, usually during the many crises that define their "addictive careers." In this instance, staff trained in psychotherapy, does not have adequate time to practice their art. Also few psychiatric staffs are very sophisticated in dealing with addicted patients, who usually are demanding, manipulative of staff., and superficially compliant.

Outpatient programs experienced all the problems noted above. Patient attendance is inconsistent, dropout rates are high, relapse is prevalent, and families are often difficult to engage in treatment. Repeated failure in outpatient settings often spins off more inpatient

referrals. A cycle of movement between different types of modalities with frequent failure leads to high rates of staff burnout. As case loads increase, despair tends to grip the staff, and currently, we find the entire field in disarray. New models are clearly needed.

Psychiatric settings, therapeutic communities and Minnesota Model programs have all made substantial contributions to our knowledge of treatment effectiveness. After several decades, we have become more sensitive to matching patients to programs. But treatment technology must be advanced further. We conclude our examination of the psychodynamics aspects of the biopsychosocial model with the rationale for a relatively new approach to treatment of the treatment-resistant, relapse prone patient with Axis I and/or II disorders. We describe the basic elements of this form of treatment below.

## **5. Psychodynamic Treatment of Addiction**

We have indicated that a paradigm shift is needed. For many patients, addictive behaviors are the natural consequence of core ego vulnerabilities and accompanying developmental deficits. For many years, clinicians have quoted the research of Dr. George Valiant (*The Natural History of Alcoholism*). A closer examination of the original data has revealed that the emphasis on psychopathology and deviant behavior as *outcomes* of alcoholism is not supported. Rather this same data, and that of many other studies, have shown that they are more often the *antecedents*, sometimes by decades, of the addictive behavior. A more balanced view is that these elements interact in ways that are not entirely understood. Most of us working in the field have come to realize how many of our addicted patients, for example, are the victims of verbal, physical and sexual abuse years before addiction occurs. These are clearly antecedents rather than outcomes of addiction. However, that is not to say that the addictive lifestyle does not cause a worsening of pathology. For example, not only can depression lead to chemical dependency, but chemical dependency and its sequelae can lead to depression. Certainly, when patients are intoxicated they can appear to be quite delusional, manic, depressed, etc. When coming off certain substances, patients may also evidence a variety of symptoms that appear as mental illness. But psychopathology that persists beyond acute and post-acute withdrawal is more often a pre-existing condition. The most important methodologies in establishing these facts are the taking of complete biopsychosocial histories from patients and direct behavioral observation of the patient. It is essential that this history is corroborated by family, significant others, etc. *Again, it is essential that his history is corroborated.* Such a history includes the following information:

- Social history
- Medical history
- Educational history
- Sexual history
- Vocational history
- Family history
- Substance use history
- Criminal history

The core unconscious fantasy that drives addiction is LIFE WITHOUT CONSEQUENCES and the many defense mechanisms explored above protect and surround both the addiction and the core ego deficits. For many other patients, addiction is also the outcome of poverty, racism, sexism, classism, homophobia, the lucrative drug trade, social pressure, and growing cynicism in society regarding the good life. All of these feed into negative self-identification for our patients. The psychosocial issues must be addressed for treatment to be effective. However, we will only consider those patients who are considered higher functioning; that is, despite their psychological and social pathology, they still have families who care, an education, and some degree of work experience. They have not allowed themselves to become homeless or welfare recipients. The emphasis is on patients with personality disorders who may also suffer from mood disorders, anxiety disorders, learning disabilities, and milder forms of psychotic disorders: in short, patients with the potential for growth when familial, vocational, educational, and peer pressure is brought to bear. The approach we describe below has been shown to work with treatment resistant, relapse prone patients.

**A. REMOVAL FROM RELAPSE ENVIRONMENT.** Patients with multiple relapse histories almost always return to the people, places and things that support their addiction and their dependent personality structure. Old drinking and drugging buddies, family traps, vocational pressures, and relapse triggers await them upon every return from the hospital or the rehab. The whole idea of a "premature" return to such an environment is fraught with relapse triggers. Patients, who are temporarily moved ("geographic cure") to isolated settings (apart from adult responsibilities), are like accidents waiting for a place to happen. The two main reasons for treatment away from familiar places is (1) to interrupt the cycle of addiction, and (2) to participate in a different form of treatment, one that will address both the addiction and the underlying psychic structures (both internal and external missing psychic structures). The removal from the relapse environment can happen when certain things are put in place *before* treatment begins. Families, employers, probation officers, lawyers, and judges are all the forces that are impinging on the life of the patient, and there needs to be an understanding that things must be different this time: escape routes must be cut off, enabling stopped, and "rescuing" must be averted. Remember that the patient has been ducking responsibilities and manipulating all the systems. He or she relies on that old dynamic when the inevitable crises of treatment arise. The more that can be put in place to forestall the repetition compulsion of past failures and aborted treatments the better. This is often referred to as "therapeutic leverage."

**B. COOPERATION OF FAMILY/SIGNIFICANT OTHERS.** Rather than telling families how dysfunctional they are, it is best to educate and support them toward new and different ways to deal with their chemically dependent loved one. Chronically relapsing patients' families and friends need emotional support and factual information in order to buy into using different strategies. Staff must gently but firmly guide them in reviewing the past futility of behaviors that did not help. However, keep secondary and tertiary gains in mind. In order for family members to free themselves from old tactics that support enabling and rescuing, they need to look into themselves. Their own personal histories contain the information needed to make change. How were they raised? What are their issues with their own parents? What personal motives drive their behavior other than those directly related to the actions of the addict? Very importantly,

what is it in their own personal histories that prevent them from practicing "tough love" with the addict? Such parents often attempt to defend their behavior by stating, "I love my child!" Staff needs to point out that parents who *do* practice tough love also love their children. A statement of love does not explain why parents stay stuck in old behaviors after repeated treatment failures and relapses. We need to look at what things have been internalized by them and drive their behavior. They often require their own psychotherapy to aid them in this process. However, they can act therapeutically with some gentle prodding, a pointing out of the futility of past efforts, emotional support, and some help in exploring their own dynamics. These people must be invited to join with treatment staff so that together a united effort can support and confront the patient back to health and balance.

It is useful to consider having a skilled and sensitive staff member whose sole responsibility is to act as family advocate. Such a person is dedicated to meeting the needs of families and friends who own past efforts have been painfully frustrating and who often, inappropriately, feel responsible for their loved one's addiction. They need to learn that addiction is a functionally autonomous process. It belongs to the chemically dependent person and has a life of its own. Families neither cause nor cure addiction. However, they can be powerful allies in fostering recovery. It is an essential part of the clinical mission to draw these families into treatment planning and execution. Patients often seek ways to sabotage treatment and split treatments staff and families. They know exactly which family buttons to push to effect predictable behaviors. Escape routes, rescue maneuvers, and manipulation can be greatly foreshortened when patients must go through staff to communicate with families. Staff and families need to manage patient-precipitated crises together. All of this works much more smoothly when families are able to look into themselves as individuals and see how their personal psychology influences their interactions with others. Enabling is now understood to reveal more about parental needs and inhibitions than the needs of the addict. On the other hand, the patients must stop taking their families' inventories and learn to focus on their own, and on how they have become co-conspirators and reenactors. Here, patients learn the depths of their repetition compulsion. They must be able to work through dysfunctional defenses and become aware of how all pervasive their core ego disturbed transference is (in AA parlance how cunning, baffling and powerful their addictive disease has become).

**C. CONSTANT BEHAVIOR FEEDBACK.** If patients are to learn from their experiences, there must be consequences for both positive and negative behavior. A cardinal rule in dealing with addicts is not to believe what they say and to judge them based on their actual behavior. It is not reasonable to presume trust at the beginning; it must be demonstrated and earned. Consistent follow-through on promises made and kept is the only realistic criteria for the instilling of trust. Continuous feedback among and between patients and staff is essential. Since patients are notorious for attempts to split people, a free flow of information is essential for preventing this splitting. Staff must be on the lookout for negative contracts and secrets kept between patients. The value of honesty is fostered at every turn. Both feedback and consequences need to be immediate. For example, when a patient calls in sick as an excuse for missing group, the entire group can pile in the van, go to the patient's residence, and hold group in the residence. Peers-in-treatment need to become responsible for confronting one another's negative behavior. The street

ethic of not "ratting someone out" must be turned into responsible concern and honesty. Feedback between staff and patients' families is equally essential. For example, if staff hears that a patient has been making unauthorized phone calls to family, they need to call the family and confront the situation. The feedback needs to recognize not only the behavior itself but also the dynamic psychological forces that drive it. Feedback is part of a solid treatment plan that emphasizes process over content. Why does the patient act and speak as he or she does? This is the essence of psychodynamically oriented treatment. In this way, we help the patient to connect thoughts, feelings and actions. This repairs the patient's internal split within his or her character structure and builds genuine integrity and object-relations that hold into the future.

**D. SELF-CARE AND ADULT RESPONSIBILITIES.** Patients need to be given adult expectations and responsibilities. Living with several roommates, managing a budget, and learning to pool resources (e.g., to buy and prepare food) gives patients a chance to learn self-sufficiency. With some initial guidance by staff, they are asked to live within their means, cooperate with others, get to places on time, and participate actively in communal living—these are all part of the treatment experience. Feedback, help, and confrontation of negative attitudes and behavior help to shape more adult behavior over time. Patients are also expected to get involved with daily 12-Step meetings and seek a sponsor. This gives patients a chance to form new kinds of sober relationships and a place to express some of their feelings outside the treatment setting proper. It is also a place to learn to practice the principles of sobriety and adult behavior. Positive transference and counter-transference with sponsors fosters more emotional growth.

**E. COUNSELING.** The essence of the counseling experience in this model is the *psychodynamic formulation*. Patient behavior is not taken at face value. The meaning of a behavior is only taken, in part, from the manifest content of the action or spoken word. Since behavior is driven by both conscious and unconscious motives, needs, fantasies and desires, the fuller meaning can only be construed by seeking a dynamic explanation and interpretation (including both manifest and latent content). Verbal, nonverbal and symbolic behaviors all contain clues to the patient's inner psyche. Spoken words and actions, body language (image, gesture, facial expression, etc.) and the symbolism of body and other personal adornments (clothing, jewelry, hairstyle, possessions, car, etc.) all contain important clues. It is vitally important to place current behavior in a historical context. The biopsychosocial history mentioned above contains important facts and clues. For example, it is quite common in the first days of treatment for patients to complain about the environment. They cannot resist acting out the repetition compulsion driven by the core ego deficits. It is important to ask the patient, "Is it you or is it us?" They will initially state that it is "us." Ask them for permission to call their 8th grade teacher, their first boss, and their old boy/girl friends. Can we expect these people to describe the problem as residing within the patient? Most patients when confronted in this manner are quick to acknowledge that, indeed, it is not our setting, but their personality structure that is truly at issue. When the patient reenacts the psychic drama that drives the addiction, it is crucial to look for the dynamics involved. We expect the patient's transference to us to be



ambivalent, to test limits, and to be filled with denial and grandiosity. This uncooperative stance by the patient can be troubling to staff and evokes powerful counter-transference. Such negative reactions as intense feelings of frustration and anger, and threats to the counselor's need for omnipotence are common. However, positive counter-transference is an asset to matching counselors and patients. There is a great deal to be gained by allowing counselors who have enthusiasm and optimism for a patient to have that person put on their case load. Quality clinical supervision will be vigilant to signs of over-identification.

Therefore, as complete an understanding as possible of the patient's developmental history, psychological conflicts, interpersonal relationships, self-concept, and affect management is helpful in dealing with transference and counter-transference. It also enables staff to know what interventions are appropriate to address both the manifest and latent content of the patient's actions. In this way, it becomes possible to emphasize process over content. By so doing, staff prevents themselves from being drawn into the same traps that ensnare the family and friends of the addict (tertiary gain). It gives staff the opportunity to instruct the patient about addiction as secondary gain and realize that they are actually responding to developmental issues that predate the addiction. This is how the counseling effort goes underneath the key reenactments driven by the core ego deficits (and only symbolically represented by the addictive behaviors). What behaviors is the patient trying to evoke in staff that they have been successful in drawing out of others in their past? This questioning is at the heart of the psychodynamic formulation and reveals the presence of the core ego deficits. Patients can, through both subtle manipulation and outrageous acting out, attempt to get staff to join in the ancient drama of being rescued and care-taken. Other reenactments may be about a past sado-masochistic relationship that results in failure to make use of treatment. Our job is to help them move away from this by setting treatment goals that intentionally disrupt these old patterns and establish more mature and self-nurturing behaviors. This will not be easy as the patient is used to having his or her way. Psychodynamic treatment works when staff can tolerate reenactments that reveal the true nature of the patient's inner self through their outer behavior. Staff, now armed with a clearer idea of latent psychic content as well as manifest behavior, can help the patient move away from reenacting core conflicts. Instead, patients initiate enactment of a healthy resolution of unresolved developmental tasks. The essence of this approach is a balance between rule enforcement and a playing-out of the drama that lasts long enough to lead to change.

The type of treatment being described here is designed to take place over a period of months rather than weeks. Each patient requires a primary counselor/therapist as well as a primary group. As patients move through different phases of treatment, it is essential that they remain with their primary counselor and group. By using group, as well as individual counseling, transference is diffused and used as a therapeutic tool. Counselors are role models of honesty, integrity, consistency, directness and openness. Patients may participate in specialty counseling as well (e.g., sexual and domestic violence trauma recovery). Patients are encouraged to work on issues, which represent past failures, self-concept, emotional flooding or numbness, and relationship problems. Material from the past as well as behavioral feedback on current attitudes and behavior are the agenda for counseling. Counselors need to be available for crisis intervention and brief counseling sessions as needed. The main task of the counseling enterprise is patient awareness of the difference between acting out emotional distress and working it through. The concept of "working through" is the most enduring of all psychodynamic

counseling concepts. Generally speaking, counselors working with this population must communicate the following to the patients:

- Caring and responsible concern
- Willingness to experience emotional pain no matter how horrible past traumas may have been. They let patients know that their experiences or their feelings will not overwhelm them.
- Expectation of openness and honesty which is reciprocal (mutual respect)
- Willingness to teach coping skills
- Optimism about the future
- Immediate confrontation of negative attitudes and behavior
- The alliance formed with the family (what is confidential and what is not)
- Nature of communications with other agencies (patients cannot use treatment to hide from the consequences of past behaviors)
- Patients will not be permitted to hurt themselves, their peers or their counselor
- That information is shared by staff about all patients (in order to help with everyone's treatment)
- They can count on the counselor in a crisis, but will not be rescued from the consequences of their own behavior. They will not be coddled or treated like children.
- Attempts at manipulation will be immediately confronted.
- Persistent refusal to engage in treatment will result in discharge.

Individual counseling should occur once or twice per week during the first month of treatment. Groups work best when they meet on a regular basis; two to three times per day in the first phase accelerates challenge and growth. Counselors should meet each morning as a group with the clinical director to review the previous day's events, and share information that supports or casts doubt on the psychodynamic formulation (treatment plan), and plan for the current day (which patients need special attention, problems to be solved, etc.). Counselors need to provide peer supervision for one another as well as meeting with their supervisor. The clinical work is very intense; the more cohesive and cooperative the staff is the better the treatment is. This helps with job satisfaction and avoids burnout. If counselors are responsible for the care of patients then the clinical supervisor is responsible for the care of the counseling staff. As Maimonedes admonished us, "If we give a person a fish they eat today. If we teach them how to fish, they eat every day." The clinical supervisor must be empathetic, a good listener, a good teacher, and willing to draw out the counselors deeply felt emotions that can interfere with their ability to do good clinical work. He or she must gently, but firmly, help the counselors work through their negative counter-transference and avoid the unconscious pursuit of tertiary gains. We want counselors to utilize positive transference to help patients overcome dependency traps and learn to be self-reliant. The patient should only be allowed to explore the past as it bears on reenactment in the present. This helps patients and staff use clinical counseling time in a productive manner. A sense of humor always helps. Clinical philosophy needs to be shared and understood among all staff. The staff must speak in one voice to patients. Rules and policies need to be clearly articulated. Recovery is the acceptance that one is responsible to the consequences he or she has earned. A patient's success with counseling and treatment is

dependent on their negotiating successfully through a series of crises. Counseling helps them to understand that only when they accept the consequences (both good and bad) of their own behavior, can they become adults. When one injures a limb, the physical therapist helps the patient by showing them how to place *stress* on the injured area with care and consideration of the weakness. The same applies to areas of psychic injury. The injury is healed by facing it and working through it. An essential part of the counseling experience is the setting of real boundaries and the consistent message that the patient must use his or her own developing skills to problem solve.

**F. SPIRITUAL RECOVERY.** In wartime, the first casualty is the truth. Both sides lie about troop strength, body counts, and the like. In the biopsychosocial disease of addiction, truth is also the first casualty. After years of relying on deception, lying, dishonesty, manipulation, and denial, the patient's value system is severely frayed. The placement of openness and honesty squarely in the middle of the counseling arena gives the patient a chance to repair this corrupted value system. The concepts of "right" and "wrong" behavior, the value judgments of "good" and "bad," and "appropriate" and "inappropriate" are vital parts of the boundaries set by counseling staff. The value of truth telling is strongly reinforced in groups and individual counseling settings. The creation of the Minnesota Model was an effort to get away from the moral condemnation heaped upon alcoholics in arbitrary and capricious ways. By asking the man and woman in recovery to return to a moral pathway is to ask no less than society ideally demands of all its citizens. Guilt (letting some one else down) and shame (letting one's self down) are vital to civilized society. Therefore, feelings of guilt and shame are not to be viewed as negative emotions. Instead, they are essential to personal growth and an orderly society. Some patients require shame reduction work while others require guilt induction work. A vital part of the therapeutic process is the admission of past behaviors for which one carries guilt and shame, and facing both the facts and the painful emotions associated with them. This is the **spiritual** part of recovery and is practiced by most addiction programs whether they make use of 12-Step recovery principles or not. Alcoholics Anonymous has made spirituality in the form of a "higher power" or "power greater than oneself" a central healing concept in the fellowship. The importance of restoring a value system as part of treatment cannot be overstated. Damaged self-concepts cannot be healed without it; criminality cannot be adequately addressed without it; fragmented and painful interpersonal relationships cannot be mended without it; and a respectful relationship between patient and counselor cannot exist without it. When a patient relapses-meaning actually picks up a drug or a drink-this will have been preceded by psychological and spiritual regression. However, growing numbers of patients are coming to treatment with extremely weak super ego structures and faulty guilt mechanisms. They express guilt, sometimes as a manipulation, only after they are caught doing something wrong. For this patient, an earlier developmental task of instilling a sense of morality and ethics must be repeated.

**G. 12-STEP FELLOWSHIP PROGRAMS.** Most of us have encountered patients who, after attending one AA meeting, describe with great enthusiasm how they felt right at home. This example of assimilative projection and all-or-none thinking helps us to understand the power of

12-Step fellowship programs. It is quite a unique experience to enter a room full of strangers and be welcomed there for the very same reason family and friends are hurt, angry, and rejecting—namely, one's addiction! Where else can patients experience unconditional acceptance and such a strong sense of immediate personal identification? In the 12-Step meetings and through sponsorship the patient experiences the world of adult responsibility and sees adults relying on each other without pathological dependencies. The interdependent relationship is neither co-dependent nor power-based. All members are peers, sponsors are guides, and the ideal of principles over personalities allows the patient to reinforce the skill he or she has learned in the treatment setting. The fellowship allows the patient to have relationships with people with long-term sobriety and the folk wisdom of AA teaches real world skills for living sober. In this setting, patients also can accelerate their spiritual growth and search for serenity. In the meetings, the patient can find in others their own missing psychic structures and internalize new "good enough" introjects and parental ego-ideals. Sponsors, home groups, commitment—all these wonderful AA tools—create the restoration of healthy ego ideals and interpersonal relationships.

### **Conclusion**

We have attempted to share with the reader some of the key concepts in the psychodynamics of addiction. By doing so we hope that you can more fully appreciate the idea of addiction as a truly biopsychosocial phenomenon, whose whole is different than the sum of its parts. We believe that the psychology of addiction has been sorely neglected and that it is time for the psychodynamic aspects of treatment to be given its rightful place in the field of addiction counseling. Good clinical treatment requires that addictive disease be understood in both a humanistic and psychologically sophisticated context. The time has come for the fields of alcoholism treatment, drug addiction treatment, and the treatment of mental illness to cooperate in fostering quality care for patients. We believe that a psychodynamic approach to addiction treatment presents a practical methodology for achievement of that goal. Addiction counselors can be trained and supervised in this model.

*The authors welcome the input of our readers. The state of the art can only be advanced if we treat it as a great quilt upon which many different threads and designs can be added. We have found the concepts and tools outlined above extremely helpful in engaging and helping the treatment-resistant, relapse-prone patient with Axis I and II disorders. We call upon all clinicians working with such patients to communicate their experiences with us, so that we can learn and grow together. Our patients deserve no less.*