Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Brief Interventions and Brief Therapies for Substance Abuse

Treatment Improvement Protocol (TIP) Series

34

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6 Brief Humanistic and Existential Therapies

Humanistic and existential psychotherapies use a wide range of approaches to case conceptualization, therapeutic goals, intervention strategies, and research methodologies. They are united by an emphasis on understanding human experience and a focus on the client rather than the symptom. Psychological problems (including substance abuse disorders) are viewed as the result of inhibited ability to make authentic, meaningful, and self-directed choices about how to live. Consequently, interventions are aimed at increasing client self-awareness and self-understanding.

Whereas the key words for humanistic therapy are *acceptance* and *growth*, the major themes of existential therapy are client *responsibility* and *freedom*. This chapter broadly defines some of the major concepts of these two therapeutic approaches and describes how they can be applied to brief therapy in the treatment of substance abuse disorders. A short case illustrates how each theory would approach the client's issues. Many of the characteristics of these therapies have been incorporated into other therapeutic approaches such as narrative therapy.

Humanistic and existential approaches share a belief that people have the capacity for self-awareness and choice. However, the two schools come to this belief through different theories. The humanistic perspective views human nature as basically good, with an inherent potential to maintain healthy, meaningful relationships and to make choices that are in the interest of oneself and others. The humanistic therapist focuses on helping people free themselves from disabling assumptions and attitudes so they can live fuller lives. The therapist emphasizes growth and self-actualization rather than curing diseases or alleviating disorders. This perspective targets present conscious processes rather than unconscious processes and past causes, but like the existential approach, it holds that people have an inherent capacity for responsible self-direction. For the humanistic therapist, not being one's true self is the source of problems. The therapeutic relationship serves as a vehicle or context in which the process of psychological growth is fostered. The humanistic therapist tries to create a therapeutic relationship that is warm and accepting and that trusts that the client's inner drive is to actualize in a healthy direction.

The existentialist, on the other hand, is more interested in helping the client find philosophical meaning in the face of anxiety by choosing to think and act authentically and responsibly. According to existential therapy, the central problems people face are embedded in anxiety over loneliness, isolation, despair, and, ultimately, death. Creativity, love, authenticity, and free will are recognized as

potential avenues toward transformation, enabling people to live meaningful lives in the face of uncertainty and suffering. Everyone suffers losses (e.g., friends die, relationships end), and these losses cause anxiety because they are reminders of human limitations and inevitable death. The existential therapist recognizes that human influence is shaped by biology, culture, and luck. Existential therapy assumes the belief that people's problems come from not exercising choice and judgment enough—or well enough—to forge meaning in their lives, and that each individual is responsible for making meaning out of life. Outside forces, however, may contribute to the individual's limited ability to exercise choice and live a meaningful life. For the existential therapist, life is much more of a confrontation with negative internal forces than it is for the humanistic therapist.

In general, brief therapy demands the rapid formation of a therapeutic alliance compared with long-term treatment modalities. These therapies address factors shaping substance abuse disorders, such as lack of meaning in one's life, fear of death or failure, alienation from others, and spiritual emptiness. Humanistic and existential therapies penetrate at a deeper level to issues related to substance abuse disorders, often serving as a catalyst for seeking alternatives to substances to fill the void the client is experiencing. The counselor's empathy and acceptance, as well as the insight gained by the client, contribute to the client's recovery by providing opportunities for her to make new existential choices, beginning with an informed decision to use or abstain from substances. These therapies can add for the client a dimension of self-respect, self-motivation, and self-growth that will better facilitate his treatment. Humanistic and existential therapeutic approaches may be particularly appropriate for short-term substance abuse treatment because they tend to facilitate therapeutic rapport, increase self-awareness, focus on potential inner resources, and establish the client as the person responsible for recovery. Thus, clients may be more likely to see beyond the limitations of short-term treatment and envision recovery as a lifelong process of working to reach their full potential.

Because these approaches attempt to address the underlying factors of substance abuse disorders, they may not always directly confront substance abuse itself. Given that the substance abuse is the primary presenting problem and should remain in the foreground, these therapies are most effectively used in conjunction with more traditional treatments for substance abuse disorders. However, many of the underlying principles that have been developed to support these therapies can be applied to almost any other kind of therapy to facilitate the client–therapist relationship.

Using Humanistic and Existential Therapies

Many aspects of humanistic and existential approaches (including empathy, encouragement of affect, reflective listening, and acceptance of the client's subjective experience) are useful in any type of brief therapy session, whether it involves psychodynamic, strategic, or cognitive–behavioral therapy. They help establish rapport and provide grounds for meaningful engagement with all aspects of the treatment process.

While the approaches discussed in this chapter encompass a wide variety of therapeutic interventions, they are united by an emphasis on *lived* experience, authentic (therapeutic) relationships, and recognition of the subjective nature of human experience. There is a focus on helping the client to understand the ways in which reality is influenced by past experience, present perceptions, and expectations for the future. Schor describes the process through

which our experiences assume meaning as *apperception* (Schor, 1998). Becoming aware of this process yields insight and facilitates the ability to choose new ways of being and acting.

For many clients, momentary circumstances and problems surrounding substance abuse may seem more pressing, and notions of integration, spirituality, and existential growth may be too remote from their immediate experience to be effective. In such instances, humanistic and existential approaches can help clients focus on the fact that they do, indeed, make decisions about substance abuse and are responsible for their own recovery.

Essential Skills

By their very nature, these models do not rely on a comprehensive set of techniques or procedures. Rather, the personal philosophy of the therapist must be congruent with the theoretical underpinnings associated with these approaches. The therapist must be willing and able to engage the client in a genuine and authentic fashion in order to help the client make meaningful change. Sensitivity to "teachable" or "therapeutic" moments is essential.

When To Use Brief Humanistic and Existential Therapies

These approaches can be useful at all stages of recovery in creating a foundation of respect for clients and mutual acceptance of the significance of their experiences. There are, however, some therapeutic moments that lend themselves more readily to one or more specific approaches. The details of the specific approaches are laid out later in this chapter. *Client-centered* therapy, for example, can be used immediately to establish rapport and to clarify issues throughout the session. *Existential* therapy may be used most effectively when a client is able to access emotional experiences or when obstacles must be overcome to facilitate a client's entry into or continuation of recovery (e.g., to get someone who insists on remaining helpless to accept responsibility). *Narrative* therapy may be used to help the client conceptualize treatment as an opportunity to assume authorship and begin a "new chapter" in life. *Gestalt* approaches can also be used throughout therapy to facilitate a genuine encounter with the therapist and the client's own experience. *Transpersonal* therapy can enhance spiritual development by focusing on the intangible aspects of human experience and awareness of unrealized spiritual capacity. These approaches increase self-awareness, which promotes self-esteem and allows for more client responsibility, thus giving the client a sense of control and the opportunity to make choices. All of these approaches can be used to support the goals of therapy for substance abuse disorders.

Duration of Therapy and Frequency of Sessions

Although many aspects of these approaches are found in other therapeutic orientations, concepts like empathy, meaning, and choice lie at the very heart of humanistic and existential therapies. They are particularly valuable for brief treatment of substance abuse disorders because they increase therapeutic rapport and enhance conscious experience and acceptance of responsibility. Episodic treatment could be designed within this framework, with the treatment plan focusing on the client's tasks and experience between sessions. Humanistic and existential therapies assume that much growth and change occur outside the meetings. When focused on broader problems, these therapies can be lifelong journeys of growth and transformation. At the same time, focusing on specific substance abuse issues can provide a framework for change and more discrete goals. These techniques will also work well in conjunction with other types of therapy.

Initial Session

The opening session is extremely important in brief therapy for building an alliance, developing therapeutic rapport, and creating a climate of mutual respect. Although the approaches discussed in this chapter have different ways of addressing the client's problems, the opening session should attempt the following:

- Start to develop the alliance
- Emphasize the client's freedom of choice and potential for meaningful change
- Articulate expectations and goals of therapy (how goals are to be reached)

Developing the alliance can be undertaken through reflective listening, demonstrating respect, honesty, and openness; eliciting trust and confidence; and applying other principles that emerge from these therapies. The therapist's authentic manner of encountering the client can set the tone for an honest, collaborative therapeutic relationship. Emphasizing freedom of choice and potential for meaningful change may be deepened by a focus on the current decision (however it has been reached) to participate in the opening session. Expectations and goals can be articulated through strategic questions or comments like, "What might be accomplished in treatment that would help you live better" or "You now face the choice of how to participate in your own substance abuse recovery."

Because of time constraints inherent in approaches to brief substance abuse treatment, the early phase of therapy is crucial. Unless the therapist succeeds in engaging the client during this early phase, the treatment is likely to be less effective. "Engaging" includes helping the client increase motivation for other aspects of substance abuse treatment such as group therapy. Moreover, the patterns of interaction established during the early phase tend to persist throughout therapy. The degree of motivation that the client feels after the first session is determined largely by the degree of significance experienced during the initial therapeutic encounter. A negative experience may keep a highly motivated client from coming back, whereas a positive experience may induce a poorly motivated client to recognize the potential for treatment to be helpful.

Compatibility of Humanistic And Existential Therapies and 12-Step Programs

Humanistic and existential approaches are consistent with many tenets of 12-Step programs. For example, existential and humanistic therapists would embrace the significance stressed by the "serenity prayer" to *accept* the things that cannot be changed, the *courage* to change what can be changed, and the *wisdom* to know the difference. However, some would argue against the degree to which Alcoholics Anonymous (AA) identifies the person's "disease" as a central character trait, or the way in which some might interpret the notion of "powerlessness." The principles of existentialism, free choice, and free will may appear incompatible with the 12-Step philosophy of acceptance and surrender. Yet, such surrender must result from conscious decisions on an individual's part. The AA concept of rigorous self-assessment—of accepting one's own personal limitations and continually choosing and rechoosing to act according to certain principles as a way of living life—are compatible with both existential and humanistic principles.

Research Orientation

The predominant research strategy or methodology in social science is rooted in the natural science or rational–empirical perspective. Such approaches generally attempt to identify and demonstrate causal relationships by isolating specific variables while controlling for other variables such as personal differences

among therapists as well as clients. For example, variations in behavior or outcomes are often quantified, measured, and subjected to statistical procedures in order to isolate the researcher from the data and ensure objectivity. Such strategies are particularly useful for investigating observable phenomena like behavior. Traditional approaches to understanding human experience and meaning, however, have been criticized as an insufficient means to understanding the *lived* reality of human experience. Von Eckartsberg noted, "Science aims for an ideal world of dependent and independent variables in their causal interconnectedness quite abstracted and removed from personal experience of the everyday life-world" (Von Eckartsberg, 1983, p. 199). Similarly, Blewett argued, "The importance of human experience relative to behavior is beyond question for experience extends beyond behavior just as feeling extends beyond the concepts of language" (Blewett, 1969, p. 22). Thus, traditional methodological approaches seem ill-suited for understanding the meaning of human experience and the process by which self-understanding manifests itself in the context of a therapeutic relationship.

A humanistic science or qualitative approach, which has its roots in phenomenology, is claimed to be more appropriate for the complexities and nuances of understanding human experience (Giorgi, 1985). The personal and unique construction of meaning, the importance of such subtleties as "the relationship" and the "fit" in therapy, and shifts in internal states of consciousness can be quantified and measured only in the broadest of terms. A more subtle science is required to describe humans and the therapeutic process.

Rather than prediction, control, and replication of results, a humanistic science approach emphasizes understanding and description. Instead of statistical analysis of quantifiable data, it emphasizes narrative descriptions of experience. Qualitative understanding values uniqueness and diversity—the "little stories" (Lyotard, 1984)—as much as generalizability or grander explanations. Generally, this approach assumes that objectivity, such as is presumed in rational empirical methods, is illusory. For the qualitative researcher and the therapist, the goals are the same: openness to the other, active participation, and awareness of one's own subjectivity, rather than illusory objectivity. Intersubjective dialog provides a means of comparing subjective experiences in order to find commonality and divergence as well as to avoid researcher bias.

Because humanistic and existential therapies emphasize psychological process and the therapeutic relationship, alternative research strategies may be required in order to understand the necessary and sufficient conditions for therapeutic change. For example, Carl Rogers "presented a challenge to psychology to design new models of scientific investigation capable of dealing with the inner, subjective experience of the person" (Corey, 1991, p. 218). Some 50 years ago, he pioneered the use of verbatim transcripts of counseling sessions and employed audio and video taping of sessions long before such procedures became standard practice in research and supervision.

The Humanistic Approach to Therapy

Humanistic psychology, often referred to as the "third force" besides behaviorism and psychoanalysis, is concerned with human potential and the individual's unique personal experience. Humanistic psychologists generally do not deny the importance of many principles of behaviorism and psychoanalysis. They value the awareness of antecedents to behavior as well as the importance of childhood experiences and unconscious psychological processes.

Humanistic psychologists would argue, however, that humans are more than the collection of behaviors or objects of unconscious forces. Therefore, humanistic psychology often is described as holistic in the sense that it tends to be inclusive and accepting of various theoretical traditions and therapeutic practices. The emphasis for many humanistic therapists is the primacy of establishing a therapeutic relationship that is collaborative, accepting, authentic, and honors the unique world in which the client lives. The humanistic approach is also holistic in that it assumes an interrelatedness between the client's psychological, biological, social, and spiritual dimensions. Humanistic psychology assumes that people have an innate capacity toward self-understanding and psychological health.

Some of the key proponents of this approach include Abraham Maslow, who popularized the concept of "self-actualization," Carl Rogers, who formulated person-centered therapy, and Fritz Perls, whose Gestalt therapy focused on the wholeness of an individual's experience at any given moment. Some of the essential characteristics of humanistic therapy are

- *Empathic understanding* of the client's frame of reference and subjective experience
- *Respect* for the client's cultural values and freedom to exercise choice
- *Exploration of problems* through an authentic and collaborative approach to helping the client develop insight, courage, and responsibility
- *Exploration of goals and expectations,* including articulation of what the client wants to accomplish and hopes to gain from treatment
- *Clarification of the helping role* by defining the therapist's role but respecting the self determination of the client
- *Assessment and enhancement of client motivation* both collaboratively and authentically
- *Negotiation of a contract* by formally or informally asking, "Where do we go from here?"
- *Demonstration of authenticity* by setting a tone of genuine, authentic encounter

These characteristics may prove useful at all stages of substance abuse treatment. For example, emphasizing the choice of seeking help as a sign of courage can occur immediately; placing responsibility and wisdom with the client may follow. Respect, empathy, and authenticity must remain throughout the therapeutic relationship. Placing wisdom with the client may be useful in later stages of treatment, but a client who is currently using or recently stopped (within the last 30 days) may not be able to make reasonable judgments about his well-being or future.

Each therapy type discussed below is distinguished from the others by how it would respond to the case study presented in Figure 6-1.

Client-Centered Therapy

Carl Rogers' client-centered therapy assumes that the client holds the keys to recovery but notes that the therapist must offer a relationship in which the client can openly discover and test his own reality, with genuine understanding and acceptance from the therapist. Therapists must create three conditions that help clients change:

1. Unconditional positive regard
2. A warm, positive, and accepting attitude that includes no evaluation or moral judgment
3. Accurate empathy, whereby the therapist conveys an accurate understanding of the client's world through skilled, active listening

According to Carson, the client-centered therapist believes that

Figure 6-1

A Case Study

This case study will be referred to throughout this chapter. It will provide an example to which each type of humanistic or existential therapy will be applied.

Sandra is a 38-year-old African-American woman who has abused a number of substances, including cocaine, heroine, alcohol, and marijuana over the past 15 years. She left high school and was a prostitute for 5 years. Later she found a job as a sales clerk at a home furnishings store. Sandra had two children in her early twenties, a daughter who is now 15, and a son, aged 18. Because of her substance abuse problems, they live with other relatives who agreed to raise them. Sandra has been in treatment repeatedly and has remained substance free for the last 5 years, with several minor relapses. She has been married for 2 years, to Steve, a carpenter; he is substance free and supports her attempts to stay away from substances.

Last month she became symptomatic with AIDS. She has been HIV-positive for 5 years but had not developed any illnesses related to the disease. Sandra has practiced safe sex with her husband who knew of her HIV status. Recently, after learning from the physician at her clinic about her HIV symptoms, she began to "shoot up," which led her back into treatment. Out of fear, she came to the treatment center and asked to see a counselor at the clinic one day after work. She is worried about her marriage and that her husband will be devastated by this news. She is afraid she is no longer strong enough to stay away from drugs since discovering the onset of AIDS. She is also concerned about her children and her job. Uncertain of how she will keep on living, she is also terrified of dying.

- Each individual exists in a private world of experience in which the individual is the center.
- The most basic striving of an individual is toward the maintenance, enhancement, and actualization of the self.
- An individual reacts to situations in terms of the way he perceives them, in ways consistent with his self-concept and view of the world.
- An individual's inner tendencies are toward health and wholeness; under normal conditions, a person behaves in rational and constructive ways and chooses pathways toward personal growth and self-actualization (Carson, 1992).

A client-centered therapist focuses on the client's self-actualizing core and the positive forces of the client (i.e., the skills the client has used in the past to deal with certain problems). The client should also understand the unconditional nature of the therapist's acceptance. This type of therapy aims not to interpret the client's unconscious motivation or conflicts but to reflect what the client feels, to overcome resistance through consistent acceptance, and to help replace negative attitudes with positive ones.

Rogers' techniques are particularly useful for the therapist who is trying to address a substance-abusing client's denial and motivate her for further treatment. For example, the techniques of motivational interviewing draw heavily on Rogerian principles (see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT, 1999c], for more information on motivational interviewing).

Response to the case study

A client-centered therapist would engage in reflective listening, accepting the client and her past, and clarifying her current situation and feelings. As Sandra developed trust in the therapist, he would begin to emphasize her

positive characteristics and her potential to make meaningful choices to become the person she wants to (and can) become. Another goal of therapy would be to help her develop sufficient insight so that she can make choices that reflect more closely the values and principles to which she aspires. For example, she may want to tell her husband about her symptoms and try to strengthen her marriage.

If Sandra began to feel guilt about her past as a prostitute, the therapist would demonstrate appreciation of her struggle to accept that aspect of herself, highlighting the fact that she did eventually choose to leave it. He may note that she did the best she could at that time and underscore her current commitment to choose a better life. Sandra would be supported and accepted, not criticized. She would be encouraged to express her fear of death and the effect this fear has on her. This might be the first time in her life that someone has been unconditionally accepting of her or focused on her strengths rather than her failings. She apparently has the ability to solve problems, which is reflected by her return to therapy and her insight about needing help. By being understood and accepted, her self-esteem and sense of hope would increase and her shame would decrease. She would feel supported in making critical choices in her life and more confident to resume her recovery.

Narrative Therapy

Narrative therapy emerges from social constructivism, which assumes that events in life are inherently ambiguous, and the ways in which people construct meaning are largely influenced by family, culture, and society. Narrative therapy assumes that people's lives, including their relationships, are shaped by language and the knowledge and meaning contained in the stories they hear and tell about their lives. Recent approaches to understanding psychological growth have emphasized using storytelling and mythology to enhance self-awareness (see Campbell, 1968; Feinstein and Krippner, 1997; Middelkoop, 1989).

Parker and Horton argue that "Studies in a variety of disciplines…have suggested that all cognition is inherently metaphorical" and note "the vital role that symbolism plays in perception" (Parker and Horton, 1996, p. 83). The authors offer the "perspective that the universe is made up of stories rather than atoms" and suggest, "Myth and ritual are vehicles through which the value-impregnated beliefs and ideas that we live by, and for, are preserved and transmitted" (p. 82). From this perspective, narratives reveal a deeper truth about the meanings of our experience than a factual account of the events themselves. As Feinstein and Krippner note, "Personal mythologies give meaning to the past, understanding to the present, and direction to the future" (Feinstein and Krippner, 1997, p. 138).

When people tell and retell their life stories (with the help of a therapist), the stories evolve into increasingly meaningful and healing constructions. As narrative therapists listen to the stories clients tell, they assist them by identifying alternative ways of understanding events in their lives. Thus, they help clients to assume authorship of their lives in order to rewrite their stories by breaking patterns and developing new solutions. Narrative therapy helps clients resolve their problems by

- Helping them become aware of how events in their lives have assumed significance
- Allowing them to distance themselves from impoverishing stories by giving new meaning to their past
- Helping them to see the problem of substance abuse as a separate, influential entity rather than an inseparable part of who they are (note the discrepancy between this and the AA member's statement, "My name is Jane, and I am an alcoholic")

- Collaboratively identifying exceptions to self-defeating patterns
- Encouraging them to challenge destructive cultural influences they have internalized
- Challenging clients to rewrite their own lives according to alternative and preferred scripts

Narrative therapy can be a powerful approach for engaging clients in describing their lives and providing them with opportunities to gain insight into their life stories and to change those "scripts" they find lacking. Storytelling is a way of articulating a subjective, experiential truth, and it is important for the therapist *and* client to become aware of the significance of the story being told and its potential therapeutic value.

Narrative approaches to psychological healing have been used across various cultures for thousands of years (Katz, 1993), but they have often been overlooked by mainstream mental health professionals. Contemporary approaches to narrative therapy recognize the importance of understanding how human experience becomes meaningful. A person's life is influenced by the narratives he constructs, which are in turn influenced by the narratives of those around him. Thus, therapy is viewed as a collaborative attempt to increase clients' awareness of the ways in which events in their lives become significant. In effect, the therapist says, "Let's be curious about your story together."

The narrative approach often involves posing questions in a way that situates the problem as an external influence. "When the problem is externalized, it's as if the person can peek out from behind it" (Nichols and Schwartz, 1998, p. 412). In substance abuse treatment, for example, a client might be asked, "How has substance abuse influenced your life?" or "Have there been times when you did not allow addiction to take over?" Such questions can help identify positive aspects and potential resources occurring in people's narratives that can be enhanced, as well as deficits that must be overcome.

In an effort to be understood, clients sometimes tell a story as a way of educating the therapist to their culture or lifestyle. Therefore, it is essential for the therapist to appreciate the unique influences (positive and negative) of the client's specific cultural experiences and identity. Often these stories do not constitute sharing in its usual meaning. When listening to them, one may sense that these stories have been told repeatedly over the years. It is through this sense of storytelling—as oral history—that we reveal our values, expectations, hopes, and fears. For the therapist, a story provides insight into the clients' responses, their need to act on the responses, and their desire to be heard or understood. A story can become a way for a client to become both participant and observer in order to find new solutions or break down barriers.

Response to the case study

The therapist may initially ask Sandra to describe some of the important transitional moments in her life. These may include examples of loss of innocence occurring early in her life, her experience of school, circumstances and influences surrounding prostitution and drug use, the experience of being supported by her husband, and internal resources that enabled her to enter treatment and maintain sobriety. The therapist would ask questions about expectations she felt from family, society, and herself. She may be asked questions like, "How did addiction interfere with your attempts to be a good mother" or "How has fear contributed to your recent relapse and feelings of hopelessness?" Positive aspects of her story and exceptions to destructive aspects of her narrative could be identified by asking questions like, "Were there times that you didn't allow addiction to make choices for you?" and "How has your ability to accept love and support from your husband helped you?"

The focus of therapeutic dialog could then shift toward developing alternatives to hopeless aspects of personal and cultural expectations. It would be helpful to remind her that recent advances in medical treatments mean that AIDS may not be the death sentence it was once thought to be. Other important questions can help her to begin to create an alternative story: "As you begin to understand the positive and negative influences in your life, what qualities must you possess in order to remain sober and develop better relationships with your husband and children?" She may need help replacing these stories with more positive narratives about herself. As Sandra talks about the people and events in her life, such as her childhood and her children, she can discover some of her feelings, as well as the personal meaning in her story. She can experience a great deal of healing through the therapist's feedback and questions that uncover the desires and emotions beneath her story. A continued focus on identifying, practicing, or even imagining changes in her story can begin the process of developing new ways of living.

Transpersonal Therapy

Transpersonal psychology emerged as a "fourth force" in psychology in the late 1960s and has strong roots in humanistic and existential psychologies, Jungian analysis, the East–West dialog, and ancient wisdom traditions. Transpersonal therapy may be thought of as a bridge between psychological and spiritual practice.

A transpersonal approach emphasizes development of the individual beyond, but including, the ego. It acknowledges the human spiritual quest and recognizes the human striving for unity, ultimate truth, and profound freedom. It cultivates intuitive ways of knowing that complement rational and sensory modes. This approach also recognizes the potential for growth inherent in "peak" experiences and other shifts in consciousness. Although grounded in psychological theory, transpersonal practitioners also tend to incorporate perspectives from ancient wisdom traditions.

The practice of transpersonal therapy is defined more by its orientation and scope rather than by a particular set of techniques or methods (Boorstein, 1980). Wittine suggests five postulates for a transpersonal psychotherapy (Wittine, 1989):

1. Transpersonal psychotherapy is an approach to healing and growth that recognizes the centrality of the self in the therapeutic process.
2. Transpersonal psychotherapy values wholeness of being and self-realization on all levels of the spectrum of identity (i.e., egoic, existential, transpersonal).
3. Transpersonal psychotherapy is a process of awakening from a limited personal identity to expanded universal knowledge of self.
4. Transpersonal psychotherapy makes use of the healing restorative nature of subjective awareness and intuition in the process of awakening.
5. In transpersonal psychotherapy, the therapeutic relationship is a vehicle for the process of awakening in both client and therapist.

Integrating insights and practices in everyday life is the goal of every therapy. Bringing the transpersonal dimension to the forefront may involve the following:

- Exploration of "inner voices" including those of a higher self that provides guidance for growth of the individual (Rowan, 1993)
- Refinement of intuition or nonrational knowing
- Practice of creativity in "formal" (art) or informal (personal relationships) encounters

- Meditation
- Loving service
- Cultivation of mindfulness
- Use of dreams and imagery

These techniques may be taught and supported explicitly in the therapy session. At times, a therapist may directly cultivate shifts in consciousness (e.g., through meditation [Weil, 1972], or imaginal work [Johnson, 1987]), providing immediate insight and inspiration that may not be available through more conventional means (Hart, 1998). This may provide clients with a skill they can practice on their own; initiating such activity represents a potential for brief intervention.

Transpersonal therapy recognizes the need for basic psychological development to be integrated with spiritual growth (Nelson, 1994). Without such integration there is danger of "spiritual bypassing," where issues of basic psychological functioning are avoided in the name of spiritual development. In other words, the basic psychological work should be undertaken first.

Substance abuse disorders may be seen broadly as an attempt to fill a spiritual void. They may also be understood as a means for the ego to defend itself against a natural drive for growth. If growth were to occur, the ego might find its dominance relinquished. Addiction, like spirituality, also raises questions of surrender (May, 1991): for example, to what and to whom do we surrender? In a culture and a psychology that are dominated by issues of rational ego control, what is the role of constructive surrender (regularly described in spiritual traditions)? How does constructive surrender become destructive and distorted in substance dependency? In addition, substance abuse may be understood as a means for shifting out of a normal waking state of consciousness. This may be an attempt to fulfill an innate drive (Weil, 1972) for nonrational consciousness.

Response to the case study

As the existentialists remind us, there is nothing like death to rivet our attention. A glimpse of death—for example, seeing the aftermath of a serious car crash—reminds the witness of how valuable life is, bringing up other issues as well. Sandra is now confronted with death due to AIDS. This opportunity to face death and life squarely provides a chance to reconsider and reprioritize her life. In fact, it could be argued that the best catalyst to brief therapy may be a death sentence precisely because it has the potential to wake up an individual. In many respects, helping the client wake from habitual, mechanical routines that are often based on ego protection and move toward an appreciation that the individual is not bound to or defined by a limited ego, is the goal of transpersonal therapy. This can be seen as a transformation of identity.

Many inspiring instances of people facing death, including death through AIDS, have shown that emergent spirituality can change the quality and direction of existence very quickly. For treatment, the basic sharing of these experiences with a group of others in a similar predicament often quickly moves the client beyond isolation and a sense of self-separateness to connect intimately with others who understand her situation. This community may not only bring comfort and support but also a deep sense of communion with humanity. In this instance, breaking through the shell of isolation may enable Sandra to begin to make new connections with her family and with herself. A sense of interconnection, a central postulate and experience in the wisdom traditions, may replace her perceived isolation.

Sandra may use this opportunity of facing possible death to begin to encounter and let go of such feelings as guilt, shame, disappointment, and anger that have kept her life less satisfying than it could be. Accessing the imaginal through art or dreams, for example, can provide

a clear and symbolic expression of unresolved issues. The use of rituals or rites-of-passage inspired by the wisdom traditions can provide some catalyst for shifting her consciousness through forgiveness and release.

The therapist may engage in a wide variety of methods (e.g., imagery, art, or dream work, meditation, rituals), but the heart of the work is in the simple and humane spirituality that is embodied by the therapist's loving presence along with the therapist's openness to explore the full range of human experience directly. For Sandra, this experience may be seen as an opportunity for practicing love and forgiveness, moving out from behind rigid self-separateness, facing fears, and transforming her self-definition.

Gestalt Therapy

Gestalt theory holds that the analysis of parts can never provide an understanding of the whole. In a therapeutic setting, this approach opposes the notion that human beings can be understood entirely through a rational, mechanistic, scientific process. The proponents of Gestalt therapy insist that the experiential world of a client can be understood only through that individual's direct experience and description. Gestalt therapists seek to help their clients gain awareness of themselves and the world. Discomfort arises from leaving elements and experiences of the psyche incomplete—primarily past relationships and intrapsychic conflicts that are unresolved, which Perls calls "unfinished business" (Perls, 1969). According to Gestalt theory

- The organism should be seen as a whole (physical behavior is an important component, as is a client's mental and emotional life).
- Being in the "here and now" (i.e., being aware of present experience) is of primary importance.
- How is more important than why (i.e., causes are not as important as results).
- The individual's inner experience is central.

For Gestalt therapists the "power is in the present" (Polster and Polster, 1973). This means that the "now" is the only place where awareness, responsibility, and change can occur. Therefore, the process of therapy is to help the client make contact with the present moment.

Rather than seeking detailed intellectual analysis, the Gestalt therapist looks to create a "safe emergency" in the therapeutic encounter. Perls' invocation to "lose your mind and come to your senses" implies that a feeling-level, "here and now" experience is the optimal condition for therapeutic work. This may be accomplished in a fairly short amount of time by explicitly asking clients to pay attention (e.g., "What are you aware of now? How does your fear feel to you?"). The therapist may point out how the client could be avoiding the present moment through inauthentic "games" or ways of relating such as "talking about" feelings rather than experiencing them directly. Clients may be asked to exaggerate certain expressions (e.g., pounding a fist) or role-play certain internal dialogs (e.g., through an empty chair technique). These may all serve the goal of helping clients move into the immediacy of their experience rather than remaining distant from it through intellectualization or substance abuse.

The term *contact* in Gestalt refers to meeting oneself and what is other than oneself. Without appropriate contact and contact boundaries there is no real meeting of the world. Instead, one remains either engulfed by the world on one hand or, on the other hand, distant from the world and people.

Substance abuse interrupts the flow of what Perls called "organismic self-regulation." The result is that individuals do not achieve satisfaction of their needs and can remain unaware of what their needs are. The substance

abuser may distort or thwart the natural cycle at any of the following points:

- Experiencing the need
- Mobilization of energy
- Contact
- Satisfaction
- Withdrawal
- Rest

Treatment involves bringing awareness to each of these dimensions and the client's strategies of avoidance.

Substance abuse may also be understood as "introjection" in which the client attempts to "swallow whole" or "drink in" his environment without contact and discrimination. This type of client bypasses and blocks other experiences that might enable contact and the development of discrimination. Perls maintains that such a client seeks immediate confluence without preparatory contact. This pattern of interaction extends to other relationships (besides the substance) as well.

In order for this work to proceed, the therapist must maintain a fine-tuned, present-moment immediacy, even serving as a "resonance chamber" (Polster and Polster, 1973) for the client's experience. They, too, must be able to make and sustain contact with the client and with their own reactions.

Response to the case study

The Gestalt therapist begins with Sandra's current experience of the world, starting with awareness and attention. The therapist may simply help her become aware of basic sights, sounds, somatic reactions, feelings, and thoughts as well as what her attention drifts to. The immediate contact between therapist and client is a component of the "now" where these sensations are explored directly. The therapist might notice and ask about her style of eye contact, or her fidgeting body, or stream of thoughts (e.g., "What is it like to make eye contact now? What is the sensation in your body at this moment?").

Sandra may also identify certain issues such as substance abuse, relationship difficulties, and the threat of death from AIDS that seem to dominate her life. The therapist might invite her to name and explore the sensation that the thought of death, for example, brings; perhaps this involves a sense of a void, or feeling cold and dark, or a feeling of engulfment. She then may be asked to become these sensations—for example, the therapist may ask her to be "the void" and encourage her to speak as if she were that void. This may then open possibilities for a dialog with the void through acting out the opposite polarity: separateness and choice. This might involve using an empty chair technique in which the client would literally move into the chair of the "void," speak as if she were that, and then move into an opposite chair and respond in a dialog. A therapist could also explore her introjection through questions such as, "How is this void different or the same as from the feeling of alcohol or in relationships with your children or husband?" She might also use this same technique to dialog with family members, or certain aspects of herself.

Sandra seems to have a great deal of "unfinished business" that involves unexpressed feelings (e.g., anger, longing, hurt). Experimentation with these sensations may begin to free her to express and meet these feelings more directly. All of this work encourages Sandra's experimentation with new ways of relating both during and outside of the session in order to move into the "here and now" and work toward the resolution of "unfinished business."

The Existential Approach To Therapy

The existential approach to therapy emphasizes the following six propositions:

1. All persons have the capacity for self-awareness.
2. As free beings, everyone must accept the responsibility that comes with freedom.
3. Each person has a unique identity that can only be known through relationships with others.
4. Each person must continually recreate himself. The meaning of life and of existence is never fixed; rather, it constantly changes.
5. Anxiety is part of the human condition.
6. Death is a basic human condition that gives significance to life.

The core question addressed in existential therapy is "How do I exist?" in the face of uncertainty, conflict, or death. An individual achieves authenticity through courage and is thus able to define and discover his own meaning in the present and the future. There are important choices to be made (e.g., to have true freedom and to take responsibility for one's life, one must face uncertainty and give up a false sense of security).

A core characteristic of the existential view is that an individual is a "being in the world" who has biological, social, and psychological needs. Being in the world involves the physical world, the world of relationships with others, and one's own relationship to self (May and Yalom, 1995, p. 265). The "authentic" individual values symbolization, imagination, and judgment and is able to use these tools to continually create personal meaning.

Existential therapy focuses on specific concerns rooted in the individual's existence. The contemporary existential psychotherapist, Irvin Yalom, identifies these concerns as *death, isolation, freedom,* and *emptiness.* Existential therapy focuses on the anxiety that occurs when a client confronts the conflict inherent in life. The role of the therapist is to help the client focus on personal responsibility for making decisions, and the therapist may integrate some humanistic approaches and techniques. Yalom, for example, perceives the therapist as a "fellow traveler" through life, and he uses empathy and support to elicit insight and choices. He strongly believes that because people exist in the presence of others, the relational context of group therapy is an effective approach (Yalom, 1980).

Preliminary observations and research indicate individuals with low levels of perceived meaning in life may be prone to substance abuse as a coping mechanism. Frankl first observed this possibility among inpatient drug abusers in Germany during the 1930s (Frankl, 1959). Nicholson and colleagues found inpatient drug abusers had significantly lower levels of meaning in life when compared to a group of matched, nonabusing control subjects (Nicholson et al., 1994). Shedler and Block performed a longitudinal study and found that lower levels of perceived life meaning among young children preceded substance abuse patterns in adolescence (Shedler and Block, 1990).

In the context of treating substance abuse disorders, the existential therapist often serves as a coach helping the client confront the anxiety that tempts him to abuse substances. The client is then focused on taking responsibility and making his own choices to remain substance free. If he chooses to avoid the anxiety through substances, he cannot move forward to find truth and authenticity. The challenge for the existential therapist is to help the client make personal decisions about how to live, drawing upon creativity and love, instead of letting outside events determine behavior.

Time and Existential Therapy

Although existential therapy may not have been designed for practice in a time-limited fashion, its underlying principles relating to the client's struggle for meaning in the face of death can be applied to a time-limited setting. Brief therapy

(no matter what the modality) must be concerned with the "here and now." Both existential and brief therapies are also concerned with the limitations of time. Hoyt suggests that in brief therapy time should always be an issue for discussion, and the therapist should make a point of reminding the client of his use of time and the time scheduled for terminating therapy (Hoyt, 1995).

Mann's model of time-limited psychotherapy (Mann, 1973; Mann and Goldman, 1994), although based in part on psychodynamic theory, also uses an existential approach to the primacy of time. In Mann's approach, the time limitation of brief therapy is emphasized to help the client confront issues of separateness and isolation. This facilitates the client's becoming engaged in and responsible for the process of recovery.

Response to the case study

An existential therapist may help Sandra understand that her diagnosis of AIDS forces her to confront the possibility of death and, consequently, face the responsibilities thrust upon her by life. The therapist could accomplish this by helping her understand that her life (like everyone else's) is finite. Therefore, she is challenged to forge meaning from her life and make difficult decisions about her relationships and ways of dealing (or *not* dealing) with choices about substance abuse. The focus in her therapy would be on choosing the life she wants to live. The therapist would assist her in dealing constructively with anxiety so that she can find meaning in the rest of her life. This could be accomplished by engaging her in the struggle to assume authorship of her choices. She may be encouraged to "play out" scenarios of choices she faces and acknowledge the accompanying fears and anxieties. She might be asked, "What keeps you from sharing your fears with your husband, and accepting the possibility of his support?" or "Imagine yourself expressing your love for your children and regret for the mistakes you have made." Thus, the therapist would help her understand that making difficult choices in the face of death is actually a way to find integrity, wholeness, and meaning.

The teachings of the existential therapist, Yalom, can be a useful resource in dealing with issues related to death, since he has worked with terminally ill cancer patients for many years, helping them to use their crisis and their danger as an opportunity for change (Yalom, 1998). Yalom explains that although death is a primary source of anxiety for a client, incorporating death into life can enrich life and allow one to live more purposefully.

7 Brief Psychodynamic Therapy

Psychodynamic therapy focuses on unconscious processes as they are manifested in the client's present behavior. The goals of psychodynamic therapy are client self-awareness and understanding of the influence of the past on present behavior. In its brief form, a psychodynamic approach enables the client to examine unresolved conflicts and symptoms that arise from past dysfunctional relationships and manifest themselves in the need and desire to abuse substances.

Several different approaches to brief psychodynamic psychotherapy have evolved from psychoanalytic theory and have been clinically applied to a wide range of psychological disorders. A growing body of research supports the efficacy of these approaches (Crits-Christoph, 1992; Messer and Warren, 1995).

Short-term psychodynamic therapies can contribute to the armamentarium of treatments for substance abuse disorders. Brief psychodynamic therapies probably have the best chance to be effective when they are integrated into a relatively comprehensive substance abuse treatment program that includes drug-focused interventions such as regular urinalysis, drug counseling, and, for opioid-dependents, methadone maintenance pharmacotherapy. Brief psychodynamic therapies are perhaps more helpful after abstinence is well established. They may be more beneficial for clients with no greater than moderate severity of substance abuse. It is also important that the psychodynamic therapist know about the pharmacology of abused drugs, the subculture of substance abuse, and 12-Step programs.

Psychodynamic therapy is the oldest of the modern therapies. As such, it is based in a highly developed and multifaceted theory of human development and interaction. This chapter demonstrates how rich it is for adaptation and further evolution by contemporary therapists for specific purposes. The material presented in this chapter provides a quick glance at the usefulness and the complex nature of this type of therapy.

Background

The theory supporting psychodynamic therapy originated in and is informed by psychoanalytic theory. There are four major schools of psychoanalytic theory, each of which has influenced psychodynamic therapy. The four schools are: Freudian, Ego Psychology, Object Relations, and Self Psychology.

Freudian psychology is based on the theories first formulated by Sigmund Freud in the early part of this century and is sometimes referred to as the drive or structural model. The essence of Freud's theory is that sexual and aggressive energies originating in the *id* (or unconscious) are modulated by the *ego*, which is a set of functions that moderates between the id and external reality. Defense mechanisms are

constructions of the ego that operate to minimize pain and to maintain psychic equilibrium. The *superego*, formed during latency (between age 5 and puberty), operates to control id drives through guilt (Messer and Warren, 1995).

Ego Psychology derives from Freudian psychology. Its proponents focus their work on enhancing and maintaining ego function in accordance with the demands of reality. Ego Psychology stresses the individual's capacity for defense, adaptation, and reality testing (Pine, 1990).

Object Relations psychology was first articulated by several British analysts, among them Melanie Klein, W.R.D. Fairbairn, D.W. Winnicott, and Harry Guntrip. According to this theory, human beings are always shaped in relation to the significant others surrounding them. Our struggles and goals in life focus on maintaining relations with others, while at the same time differentiating ourselves from others. The internal representations of self and others acquired in childhood are later played out in adult relations. Individuals repeat old object relationships in an effort to master them and become freed from them (Messer and Warren, 1995).

Self Psychology was founded by Heinz Kohut, M.D., in Chicago during the 1950s. Kohut observed that the self refers to a person's perception of his experience of his self, including the presence or lack of a sense of self-esteem. The self is perceived in relation to the establishment of boundaries and the differentiations of self from others (or the lack of boundaries and differentiations). "The explanatory power of the new psychology of the self is nowhere as evident as with regard to…the addictions" (Blaine and Julius, 1977, p. vii). Kohut postulated that persons suffering from substance abuse disorders also suffer from a weakness in the core of their personalities—a defect in the formation of the "self." Substances appear to the user to be capable of curing the central defect in the self.

> [T]he ingestion of the drug provides him with the self-esteem which he does not possess. Through the incorporation of the drug, he supplies for himself the feeling of being accepted and thus of being self-confident; or he creates the experience of being merged with the source of power that gives him the feeling of being strong and worthwhile (Blaine and Julius, 1977, pp. vii–viii).

Each of the four schools of psychoanalytic theory presents discrete theories of personality formation, psychopathology formation, and change; techniques by which to conduct therapy; and indications and contraindications for therapy. Psychodynamic therapy is distinguished from psychoanalysis in several particulars, including the fact that psychodynamic therapy need not include all analytic techniques and is not conducted by psychoanalytically trained analysts. Psychodynamic therapy is also conducted over a shorter period of time and with less frequency than psychoanalysis.

Several of the brief forms of psychodynamic therapy are considered less appropriate for use with persons with substance abuse disorders, partly because their altered perceptions make it difficult to achieve insight and problem resolution. However, many psychodynamic therapists work with substance-abusing clients, in conjunction with traditional drug and alcohol treatment programs or as the sole therapist for clients with coexisting disorders, using forms of brief psychodynamic therapy described in more detail below.

Introduction to Brief Psychodynamic Therapy

The healing and change process envisioned in long-term psychodynamic therapy typically requires at least 2 years of sessions. This is because the goal of therapy is often to change an

aspect of one's identity or personality or to integrate key developmental learning missed while the client was stuck at an earlier stage of emotional development.

Practitioners of brief psychodynamic therapy believe that some changes can happen through a more rapid process or that an initial short intervention will start an ongoing process of change that does not need the constant involvement of the therapist. A central concept in brief therapy is that there should be one major focus for the therapy rather than the more traditional psychoanalytic practice of allowing the client to associate freely and discuss unconnected issues (Malan, 1976). In brief therapy, the central focus is developed during the initial evaluation process, occurring during the first session or two. This focus must be agreed on by the client and therapist. The central focus singles out the most important issues and thus creates a structure and identifies a goal for the treatment. In brief therapy, the therapist is expected to be fairly active in keeping the session focused on the main issue. Having a clear focus makes it possible to do interpretive work in a relatively short time because the therapist only addresses the circumscribed problem area. When using brief psychodynamic approaches to therapy for the treatment of substance abuse disorders, the central focus will always be the substance abuse in association with the core conflict. Further, the substance abuse and the core conflict will always be conceptualized within an interpersonal framework.

The number of sessions varies from one approach to another, but brief psychodynamic therapy is typically considered to be no more than 25 sessions (Bauer and Kobos, 1987). Crits-Christoph and Barber included models allowing up to 40 sessions in their review of short-term dynamic psychotherapies because of the divergence in the scope of treatment and the types of goals addressed (Crits-Christoph and Barber, 1991). For example, some brief psychodynamic models focus mainly on symptom reduction (Horowitz, 1991), while others target the resolution of the Oedipal conflict (Davanloo, as interpreted by Laikin et al., 1991). The length of therapy is usually related to the ambitiousness of the therapy goals. Most therapists are flexible in terms of the number of sessions they recommend for clinical practice. Often the number of sessions depends on a client's characteristics, goals, and the issues deemed central by the therapist.

Psychodynamic Psychotherapy for Substance Abuse

Supportive-expressive (SE) psychotherapy (Luborsky, 1984) is one brief psychodynamic approach that has been adapted for use with people with substance abuse disorders. It has been modified for use with opiate dependence in conjunction with methadone maintenance treatment (Luborsky et al., 1977) and for cocaine use disorders (Mark and Faude, 1995; Mark and Luborsky, 1992). There have been many studies of the use of SE therapy for substance abuse disorders, resulting in a significant body of empirical data on its effectiveness in treating these problems (see below).

Mark and Faude asserted that although their therapeutic approach was devised specifically for cocaine-dependent clients, these people often have multiple dependencies, and this approach can be used to treat a variety of substance abuse disorders. However, clients should be reasonably stable in terms of their substance abuse before beginning this type of therapy (Mark and Faude, 1995).

Mark and Faude theorized that substances of abuse substitute a "chemical reaction" in place of experiences and that these chemically induced experiences can block the impact of

other external events. The person with a substance abuse disorder will therefore have a "tremendously impoverished and impaired capacity to experience," and traditional psychotherapy might have to be augmented with techniques that focus on increasing a client's ability to experience (Mark and Faude, 1995, p. 297).

Effective SE therapy depends on appropriate use of what is termed the *core conflictual relationship theme* (CCRT), a concept first introduced by Lester Luborsky. According to Luborsky, a CCRT is at the center of a person's problems. The CCRT develops from early childhood experiences, but the client is unaware of it and how it developed. It is assumed that the client will have better control over behavior if he knows more about what he is doing on an unconscious level. This knowledge is acquired by better understanding of childhood experiences (Bohart and Todd, 1988). The CCRT develops out of a *core response from others* (RO), which represents a person's predominant expectations or experiences of others' internal and external reactions to herself, and a *core response of the self* (RS), which refers to a more or less coherent combination of somatic experiences, affects, actions, cognitive style, self-esteem, and self-representations.

Most people with substance abuse disorders have particularly negative expectations of others' attitudes toward them (that is, the RO), although it remains unclear which came first—this response or the substance abuse disorder. Either way, the two become mutually reinforcing. Following are examples of statements that reflect the core RO of a person with a substance abuse disorder:

- "Everybody hates me."
- "I am just being used."
- "People laugh at me."
- "No one understands how I feel."
- "Everybody wants me to be something I'm not."
- "They're just waiting for me to make a fool of myself."

For many people with substance abuse disorders, alcohol or drug use is a way of self-medicating against feelings of low self-worth and low self-esteem that reflect the client's RS. A negative RO reinforces a negative RS and can lead to the deceptive and manipulative behavior that is sometimes observed in this population. The client's RS is based on the individual's somatic experiences, actions, and perceived needs. Following are examples of statements that could reflect a client's core RS:

- "I'm so stupid and gullible."
- "I can't do anything right."
- "If I didn't use drugs, I would lose my mind."
- "I can't help myself."
- "I'm not a very nice or honest person."

A third component of CCRT is a person's *wish*; it reflects what the client yearns for, wishes for, or desires. The client's "wish" is largely based on individual personality style. Those with substance abuse disorders often have a wish to continue using the substance without having to endure the consequences. Put another way, they would like to be accepted (or loved or appreciated) as they are, without having to give up the pleasure they get from their use (Levenson et al., 1997). Many people who have substance abuse disorders have much invested in denying that they really have a problem, in portraying themselves as helpless victims, and in disclaiming their role in the behavior that has brought them into treatment.

Once therapy has been initiated, the therapist and client can work together to put the client's goals into the CCRT framework and explore the meaning, function, and consequence of her substance abuse, looking in particular at how the RO and RS have contributed to the problem. The CCRT framework also can be used to identify potential obstacles in the recovery

process as the therapist and client explore the client's anticipated responses from others and from herself and discuss how these perceptions will change when she stops abusing substances.

The CCRT concept also can help clients deal with relapse, which is regarded by virtually all experts in the field as an integral and natural part of recovery. Relapse offers the client and the SE therapist the opportunity to examine how the RO and RS can serve as triggers and to devise strategies to avoid these triggers in the future. Finally, SE therapy is conducive to client participation in a self-help group such as Alcoholics Anonymous, or it can be used as a mechanism to examine a client's unwillingness to participate in these groups.

Stella and Christopher: A Case Study

The case study in this section came from the NIDA Collaborative Cocaine Study (Mark and Faude, 1997; adapted with permission). SE is the therapeutic approach used.

While dependent and impulsive, Stella, a 28-year-old cocaine-dependent woman, would be seen under many circumstances as warm and open. She appears to be the kind of person who wears her heart on her sleeve, but it is a big heart nonetheless, capable of caring for others with loyalty and compassion. In addition, she has a tenacity of spirit; despite a horrific personal history she completed her training as a medical technician and has worked in that capacity for much of the last 4 years. Her therapist, Christopher, is a well-trained psychodynamically oriented therapist. He is an intelligent, serious, and measured person, whose well-meaning nature comes through under most circumstances despite his natural reserve.

Stella has a history of polysubstance abuse, including the abuse of prescription drugs, both anxiolytics and opioids. She worked as a medical technician until she injured her back 3 months ago. At the beginning of treatment, she told Christopher that she was going to request medication from her physician for her back pain. After her eighth session, with her reluctant agreement, Christopher informed the physician that she was in treatment for cocaine dependence. Christopher asked the physician to find a medication other than diazepam (Valium) for Stella's back pain.

Stella began the 19th session complaining that ever since the physician found out she was a drug user, he has treated her differently. "He thinks I'm a scumbag drug addict," she said. Christopher acted uncharacteristically: he offered some advice. He suggested that Stella consider telling her physician how she feels about his treatment. The intervention strikingly altered the mood and productivity of the session. After a brief expression of sympathy for her position, he focused on her extreme distress over the physician's treatment. He attempted to explain the intensity of her reaction in terms of projection: that she responded so strongly because of her negative view of herself.

Matters got worse as the session continued. Stella related a second negative incident when she described her treatment by the physician in a group therapy session. The group therapist responded, "Well, you manipulate doctors!" Stella had been furious.

Christopher encouraged her to say more. Stella became frustrated at Christopher's lack of understanding and explained that again, she felt she was being treated like a "scumbag," this time by the group therapist. Christopher suggested that Stella might tell both the physician and the group therapist how she felt. The tension in the session disappeared, and Stella remarked that she has always had trouble sticking up for herself.

In supervision, Christopher realized immediately that he was indirectly letting Stella know that he understood and agreed with her.

Diagnostically speaking, Stella has a borderline personality disorder as defined by the *Diagnostic and Statistical Manual of Mental Disorders,* 4th Edition [DSM-IV] (American Psychiatric Association, 1994). When she was between 6 and 8 years old, Stella's maternal grandfather sexually abused her. Her parents divorced when she was 10, and she lived with her mother, who was often drunk and physically abusive. Stella said she was closer to her father, whom she described as gentle. He appeared to others as weak and ineffectual.

At age 15, Stella ran off with a boyfriend who was also her pimp. After 2 weeks she returned home, was unable to leave her mother, and was diagnosed as having agoraphobia, for which she took chlordiazepoxide (Librium). Two years later she ran away with another man, a particularly sadistic pimp. For 5 years she was too terrified to leave him. It was during this period that she started using cocaine.

The cocaine both "disclaims action" and affirms her "badness." Her cocaine use enabled her to avoid examining why she stayed with her boyfriend and simultaneously affirmed her badness. So, she deserves her fate. She would use the cocaine to clear her painful feelings and feel "strong and independent," then "feel like a big baby for having to use the drugs." She thought of herself as a "big baby," for returning to her mother at age 15 and for being unable to leave her current boyfriend. Her reactions to cocaine are typical; a brief surge or a "high," followed by a crash. However, these typical reactions also fit her core theme: she wants to be loved and cared for but believes she will be thwarted and exploited by others because of this wish. Her response then is to use drugs, which makes her feel strong and independent for a brief time and also makes her see herself as deserving of being thwarted and exploited, which has happened repeatedly in interpersonal contexts in her life.

Stella's drug use became a part of the therapy in two ways. In the first session, Stella told Christopher that she had taken chlordiazepoxide for several days before their appointment, to relieve her anxiety. She pointed out that it had been prescribed by a doctor. Presumably, Christopher would have known the results of her drug screen, which was part of the program. She thus confessed before being confronted by drug screen results. Her claim that the prescription was legitimate facilitated her denial that she has anything to be concerned about.

Second, Stella announced her intention to ask her physician for diazepam, a commonly abused medication. By contacting her physician, Christopher replayed a common scenario in her life: she signals that someone should take control or care for her, then resents it when they do, feeling that she is being treated like a "scumbag drug addict." She can create the largely illusory sense of being cared for when someone treats her as a helpless incompetent. Was this how Christopher was treating her when he called her physician?

When Christopher suggested that she tell the physician and the group therapist how she felt about the way they had treated her, his words may have given advice, but his communication actually conveyed agreement with Stella's position that she had been unfairly treated.

Stella experienced Christopher's agreement and support through his intervention. However, what could have made this a more powerful therapeutic interaction would have been either for Christopher to directly acknowledge his misgivings about having taken charge and contacted the physician or to explore how Stella came to hear his initial obliqueness as giving her what she wanted—his care and support.

Research on the Efficacy of Supportive-Expressive Therapy

It is only since the 1980s that psychosocial components of the treatment of substance abuse disorders have become the subject of scientific investigation. Most research on the efficacy of psychotherapy for the treatment of substance abuse disorders has concluded that it can be an effective treatment modality (Woody et al., 1994). Comparisons among specific models of therapy have become the focus of much interest.

As mentioned above, SE psychotherapy has been modified for use with methadone-maintained opiate dependents and for cocaine dependents. In SE therapy, the client is helped to identify and talk about core relationship patterns and how they relate to substance abuse. One study compared SE therapy and cognitive–behavioral therapy with standard drug counseling for opiate dependents in a methadone maintenance program. Clients were offered once-weekly therapy for 6 months. Adding professional psychotherapies (either SE or cognitive–behavioral) to drug counseling benefited clients with higher levels of psychopathology more than using drug counseling alone. However, drug counseling alone was helpful for clients with lower levels of psychopathology (Woody et al., 1983). Another study involving three methadone programs was also positive regarding the efficacy of SE therapy (Woody et al., 1995). In this study, clients receiving SE therapy required less methadone than those who received only standard substance abuse counseling, and after 6 months of treatment these clients maintained their gains or showed continuing improvement. Gains tended to dissipate in those who received drug counseling only (Woody et al., 1995).

One study compared SE psychotherapy with structural family therapy for the treatment of cocaine dependence (Kang et al., 1991; Kleinman et al., 1990). Both types of therapy were offered once a week. The researchers found that once-weekly therapy, of either type, was not associated with significant progress. Dropout rates were high, and overall abstinence in both groups did not appear to differ from that expected from spontaneous remission. The main conclusions were that the lack of treatment effects may have resulted because these treatments did not offer enough frequency and intensity of contact to be effective for cocaine-dependent people in the initial stages of recovery. This study had at least two flaws, however. One was that the therapists were not well-trained in SE therapy; therefore, it is questionable whether or not the treatment they provided was actually SE therapy. The other was that the therapy was provided in a municipal office building where courts and social services were administered, thus this setting lacked many features of traditional substance abuse treatment settings.

More recently, a large multisite study of 487 persons receiving treatment compared SE therapy with cognitive therapy and drug counseling for cocaine dependence (Crits-Christoph et al., 1997). Each of the three conditions included, in addition to the individual treatment, a substance abuse counseling group. A fourth condition received group counseling without additional individual therapy. This study was a theoretical descendant of the methadone studies mentioned earlier. It was hypothesized that SE and cognitive therapy might be more effective than individual drug counseling for clients with higher levels of psychiatric severity. The results showed that each type of treatment was associated with significantly reduced cocaine use. However, for this population of outpatient cocaine-dependent clients, drug counseling was more successful at reducing substance use than SE or cognitive therapy (Crits-Christoph et al., 1999). One implication of this finding is that drug-focused interventions are perhaps the

optimal approach for providing treatment for substance abuse disorders (Strean, 1994).

What this means for practitioners of psychodynamically oriented treatments is that in addition to providing the more dynamic interventions, it is important to also incorporate direct, drug-focused interventions. This can be accomplished by one therapist combining both models or, in a comprehensive treatment program for substance users, one therapist providing dynamic therapy and an alcohol and drug counselor providing direct, drug-focused counseling. It can be argued that this is why SE therapy was so helpful in the methadone studies. In those studies, psychodynamic therapy was well integrated into a comprehensive methadone maintenance program. In other words, in addition to the dynamic therapy, clients received substance abuse disorder counseling along with methadone (Woody et al, 1998).

One study conducted a small, controlled trial comparing SE therapy to a brief (one-session) intervention for marijuana dependence. The SE approach was adapted for use in treatment of cannabis dependence (Grenyer et al., 1995) and was offered once a week for 16 weeks. Results showed that both interventions were helpful but SE therapy produced significantly larger reductions in cannabis use, depression, and anxiety, and increases in psychological health (Grenyer et al., 1996). The authors concluded that SE therapy could be an effective treatment for cannabis dependence.

Clients Most Suitable for Psychodynamic Therapy

Brief psychodynamic therapy is more appropriate for some types of clients with substance abuse disorders than others. For some, psychodynamic therapy is best undertaken when they are well along in recovery and receptive to a higher level of self-knowledge.

Although there is some disagreement in the details, this type of brief therapy is generally thought more suitable for the following types of clients:

- Those who have coexisting psychopathology with their substance abuse disorder
- Those who do not need or who have completed inpatient hospitalization or detoxification
- Those whose recovery is stable
- Those who do not have organic brain damage or other limitations due to their mental capacity

Psychodynamic Concepts Useful in Substance Abuse Treatment

Psychodynamic theories endeavor to provide coherent explanations for intrapsychic and interpersonal workings. Because of the importance of this approach in the development of modern therapy, the techniques that stem from these theories are inevitably used in any type of psychotherapy, whether or not it is identified as "psychodynamic." For example, people who have worked with those who have substance abuse disorders are familiar with "denial," even if they are not aware that this process is one of the psychodynamic defense mechanisms. Counselors whose clients have an immediate and strong negative reaction to them often benefit from an understanding of the concept of "transference." It also is helpful for an alcohol and drug counselor who is left feeling hopeless and confused after a session to understand how "countertransference" could be at work. Therefore, counselors who treat clients with substance abuse disorders can benefit from understanding the basic concepts of general psychodynamic theory discussed in this section, even if they do not use a strictly psychodynamic intervention.

The Therapeutic Alliance

The alliance that develops between therapist and client is a very important factor in successful therapeutic outcomes (Luborsky, 1985). This is true regardless of the modality of therapy. The psychodynamic model has always viewed the therapist–client relationship as central and the vehicle through which change occurs. Of all the brief psychotherapies, psychodynamic approaches place the most emphasis on the therapeutic relationship and provide the most explicit and comprehensive explanations of how to use this relationship effectively. Luborsky and colleagues are among those who have documented the profound effect that the therapist–client relationship has on the success of treatment, however brief (Luborsky et al., 1985).

The psychodynamic model offers a systematic explanation of how the therapeutic relationship works and guidelines for how to use it for positive change and growth. In all psychodynamic therapies, the first goal is to establish a "therapeutic alliance" between therapist and client. In most cases, the development of a therapeutic alliance is partially a process of the passage of time. The more severe the client's disorder, the more time it will take. The capabilities of the therapist to be honest and empathic and of the client to be trusting are also factors. A therapeutic alliance requires intimate self-disclosure on the part of the client and an empathic and appropriate response on the part of the therapist. However, in brief psychodynamic therapy this alliance must be established as soon as possible, and therapists conducting this sort of therapy must be able to establish a trusting relationship with their clients in a short time.

One study of the therapeutic alliance and its relationship to alcoholism treatment found that for alcoholic outpatients, ratings of the therapeutic alliance by the patient or therapist were significant predictors of treatment participation and of drinking behavior during treatment and at 12-month followup, though the amount of variance explained was small (Connors et al., 1997). Among cocaine-dependent patients, another study found that patients' ratings of the therapeutic alliance predicted the level of current drug use at 1 month but not at 6 months (Barber et al., 1999). The alliance at 1 month, however, predicted improvement in depressive symptoms at 6 months. These findings suggest that the therapeutic alliance exerts a moderate but significant influence on outcome in the treatment of substance abuse disorders. The specific outcomes measured vary from study to study but include length of participation in treatment, reduction in drug use, and reduction in depressive symptoms.

Developmental Level

Psychodynamic theory emphasizes that the client's level of functioning should determine the nature of any intervention. In Freudian psychoanalytic theory, substance abuse is considered a symptom associated with the oral or most primitive stage of development and represents an attempt to establish a need-gratifying symbiotic state (Leeds and Morgenstern, 1996). Analytic theorists within the Object Relations school hold that substances stand in for the functions usually attributed to the primary maternal (or care-giving) object. As a result, the substance abuser relates to the substance based on the disturbed pattern of relating that he experienced with the maternal object (Krystal, 1977). This would be considered a variant of borderline psychopathology, which is viewed as a fairly severe disturbance of ego functioning and object relations. It is for this reason that substance-abusing clients were and perhaps still are often considered unsuitable for psychoanalysis and also unsuitable for many of the short-term analytic models that involve a

very focused and active uncovering of the unconscious.

Contemporary analytic theorists who concern themselves with substance abuse disorders typically do not focus on the idea that addiction is linked to a developmentally primitive level of ego functioning, although they may endorse it. One reason is that this idea leads to a rather pessimistic belief regarding the outcome of analytic treatments for substance abuse disorders. Another reason is that it does not contribute helpful information to the therapeutic approach, and it can impede the development of an empathic and respectful therapeutic alliance. Furthermore, there is increasing empirical evidence for the idea that severe substance abuse is largely driven by biobehavioral forces and that individual psychological factors are of lesser importance (Babor, 1991). Although analytic theories have tended to ignore this (Leeds and Morgenstern, 1996), it has become increasingly a part of the knowledge base in understanding substance abuse disorders.

Insight

Another critical underlying concept of psychodynamic theory—and one that can be of great benefit to all therapists—is the concept of insight. Psychodynamic approaches regard insight as a particular kind of self-realization or self-knowledge, especially regarding the connections of experiences and conflicts in the past with present perceptions and behavior and the recognition of feelings or motivations that have been repressed. Insight can come through a sudden flash of understanding or from gradual acquisition of self-knowledge. So, for example, a client who feels depressed and angry and subsequently drinks comes to realize that his feelings toward his father are stimulated by an emotionally abusive supervisor at work. This type of realization gives the client new options. These options include learning to separate his reactions to the supervisor from his feelings about his father, working through his feelings about his father (of which he may not have been previously aware), actively choosing alternative behaviors to drinking when he feels bad (e.g., attending a 12-Step meeting), and accepting greater responsibility for his feelings and behaviors.

A broader definition of insight, also promoted by brief psychodynamic therapies, is simply any realization about oneself, one's inner workings, or one's behavior. For example, a client who says, "the only emotion I really feel is anger," has opened the door to understanding the effect others have on her, and vice versa. She can then begin to develop alternative behaviors to those that previously followed automatically from her anger (such as drinking), as well as to understand why her emotional repertoire is so limited.

Insight involves both thoughts and feelings. A purely intellectual exercise will not lead to behavior change. True insight involves a powerful emotional experience as well as a cognitive component and leads to a greater acceptance of responsibility for feelings and behavior. In treating substance abuse disorders, it is important to recognize that insight alone is often not sufficient to create change. Substances of abuse are powerful behavioral reinforcers and the therapist needs to help the client counter the strong compulsive desire for them. Thus, in addition to insight, it could be helpful to offer psychoeducation and make behavioral interventions, which might include encouraging attendance and participation in self-help programs and requiring regular testing by urinalysis and/or Breathalyzer™. Many therapists who conduct substance abuse treatment from a psychodynamic perspective are comfortable combining insight-oriented therapy with concrete, behavioral interventions.

Defense Mechanisms And Resistance

In psychoanalytic theory, defense mechanisms bolster the individual's ego or self. Under the pressure of the excessive anxiety produced by an individual's experience of his environment, the ego is forced to relieve the anxiety by defending itself. The measures it takes to do this are referred to as "defense mechanisms." All defense mechanisms have two characteristics in common: they deny, distort, or falsify reality, and they operate unconsciously. Some defense mechanisms are adaptive and support the mature functioning of the individual, while others are maladaptive and hinder the individual's growth. Generally the defenses hamper the process of exploration in therapy, and for this reason they are often confronted in the more expressive models of analytic therapy. However, in more supportive types of therapy, adaptive defenses are supported, and even the maladaptive defenses may not be confronted until the therapist has enabled the client to replace them with a more constructive means of coping.

In the treatment of substance abuse disorders, defenses are seen as a means of resisting change—changes that inevitably involve eliminating or at least reducing drug use. Mark and colleagues noted that two defenses frequently seen in those with substance abuse disorders are denial and grandiosity (Mark and Luborsky, 1992). Particularly with this group of clients, handling defenses can degenerate into an adversarial interaction, laden with accusations; for example, when a therapist admonishes the client by saying, "You are in denial" (Mark and Luborsky, 1992). They recommend avoiding ineffective adversarial interactions around the client's use of defenses by using the following strategies:

- Working with the client's perceptions of reality rather than arguing
- Asking questions
- Sidestepping rather than confronting defenses
- Demonstrating the denial defense while interacting with the client to show her how it works

Figure 7-1 defines the most common mechanisms clients use to defend themselves from painful feelings or to resist change.

Transference

Effective use of the therapeutic relationship depends on an understanding of transference. Transference is the process of transferring prominent characteristics of unresolved conflicted relationships with significant others onto the therapist. For example, a client whose relationship with his father is deeply conflicted may find himself reacting to the therapist as if he were the client's father. The opening session in psychodynamic therapy usually involves the assessment of transference so that it may be incorporated into the treatment strategy. Strean found that, "all patients—regardless of the setting in which they are being treated, of the therapeutic modality, or the therapist's skills and years of experience—will respond to interventions in terms of the transference" (Strean, 1994, p. 110).

An initial goal of brief psychodynamic therapy is to foster transference by building the therapeutic relationship. Only then can the therapist help the client begin to understand her reasons for abusing substances and to consider alternative, more positive behavior. A longer term goal—necessitated by the brevity of the process—is to increase the client's motivation and participation in other modalities of treatment for substance abuse disorders.

Etiology

Four contemporary analytic theorists have offered valuable psychodynamic perspectives on the etiology of substance abuse disorders.

Wurmser, a traditional drive theorist, suggests that those with substance abuse disorders suffer from overly harsh and destructive superegos that threaten to overwhelm the person with rage and fear. Abusing substances is an attempt to flee from such dangerous affects. These affects are the result of conflict between the ego and superego, brought about by the harshness of the superego. Given this understanding, Wurmser's main focus is the analysis of the superego. He believes that a moralistic stance toward the substance-abusing behavior is counterproductive and that substance abusers' problems consist of too much, rather than too little, superego. Wurmser recommends that the therapist provide a strong emotional presence and a warm, accepting, flexible attitude.

Figure 7-1
Defense Mechanisms

- *Denial*. Pretending that a threatening situation does not exist because the situation is too distressing to cope with. A child comes home, and no one is there. He says to himself, "They are here. I'll find them soon."
- *Displacement*. Feelings and thoughts directed toward one person or object are directed toward another person. For example, an employee has feelings of anger toward his boss but is unaware of these feelings because of his internal conflict over acknowledging them. Instead he becomes disproportionately angry at his wife over a minor problem at home.
- *Grandiosity*. Although not one of the originally identified analytic defenses, grandiosity is frequently employed by substance abusers (Mark and Luborsky, 1992). Grandiosity defends against unconscious low self-esteem by invoking self-deceptive, overly positive opinions about oneself. An example of grandiosity in a substance-abusing client is the client who insists that he can maintain control of drug use despite the fact that he was using an increasingly large amount of drugs with increasing frequency. This example can be seen as denial as well because denial involves denying or minimizing the consequences of the addiction. However, the grandiosity is evident in the user's unrealistic belief that he is in control of his drug use when it would seem that his use is compulsive and clearly out of control at this point.
- *Identification with the aggressor*. The activity of doing unto someone else what aroused anxiety when it was done to oneself. A child has a tonsillectomy. She then puts on a toy stethoscope and goes around pretending to take out the tonsils of her playmates.
- *Introjection*. The individual "takes inside" himself what is threatening. For example, a child feels strong anxiety about losing a parent's love when the latter admonishes her for not cleaning her room. To cope with the anxiety she tells herself, "You are a bad girl."
- *Isolation*. Painful ideas are separated from feelings associated with them. To face the full impact of sexual or aggressive thoughts and feelings, the ideas and affects are kept apart. For example, the thought of shouting obscenities in a church is kept separate from all the rage about being in church. Thus, in isolation the individual may have fleeting thoughts of an aggressive or sexual nature without any emotional accompaniment.
- *Projection*. This is the opposite of introjection; an intolerable idea or feeling is ascribed to someone else. For example, it could be hypothesized that because the late Senator Joseph McCarthy could not tolerate his own homosexual wishes, he spent much time compiling lists of men in the State Department who, according to McCarthy, were hiding their homosexuality.

Figure 7-1 (continued)

Defense Mechanisms

- *Reaction formation*. A painful idea or feeling is replaced by its opposite. A young girl, for example, who cannot tolerate her hateful feelings toward her new baby brother keeps saying, "I love my new brother!"
- *Regression*. A retreat to an earlier form of behavior and psychic organization because of anxiety in the present. For example, under the impact of anxiety stirred up by wishes to masturbate, a teenager returns to an earlier form of behavior and resumes sucking his thumb.
- *Repression*. An attempt to exclude from awareness feelings and thoughts that evoke anxiety. In repression, the feelings and thoughts may have been experienced consciously at one time, or the repressive work may have stopped ideas and feelings from ever reaching consciousness. For example, an individual may have consciously experienced hateful feelings toward a parent or sibling but, because of the anxiety evoked, blocked the feelings from awareness. Or to protect herself from feeling the unpleasantness and dread of hate and anger, a woman never allows any hostile thoughts or feelings to reach consciousness.
- *Undoing*. Trying to remove an offensive act, either by pretending it was not done or by atoning for it. For example, a boss hates an employee and wishes to fire him. Instead he promotes the employee, thereby diminishing in his mind what he thinks he has done.

Adapted from: Strean, 1994, pp. 13–15.

Khantzian theorizes that deficits, rather than conflicts, underlie the problems of those with substance abuse disorders. That is, weakness or inadequacies in the ego or self are at the root of the problem. Khantzian and colleagues developed Modified Dynamic Group Therapy (MDGT) to address these issues in a group therapy format, and this approach has some empirical support. Khantzian put forth the self-medication hypothesis, which essentially states that substance abusers will use substances in an attempt to medicate specific distressing psychiatric symptoms (Khantzian, 1985). It follows, then, that substance-dependent persons will express a strong preference for a particular drug of choice to medicate their particular set of symptoms. For example, those dependent on opioids are thought to be medicating intense anger and aggression that their egos are unable to contain. Cocaine-dependent people are believed to be seeking relief from intense depression or emotional lability (as in bipolar disorders) or attention deficit disorder. This continues to be a popular theory although most researchers and therapists now would say that this can offer only partial answers to the questions of how abusers develop drug preferences and what the meaning is of such preferences. It is important to consider the social and physical environmental context of substance abuse as well. That is, whatever drugs are most readily available in a person's community and what his peers and associates are using also have a strong influence on a user's drug preference.

Krystal offers two possible theories of the etiology of substance abuse disorders. One is based on an object-relations conceptualization. In this theory, the substance abuser experiences the substance as the primary maternal object. The substance abuser relates to the substance in the same maladaptive relationship patterns that she experienced developmentally with the mother. The second theory focuses on the substance abuser's disturbed affective functions, known as *alexithymia*. It is thought that

individuals with alexithymia do not recognize the cognitive aspects of feeling states. Instead, they experience an uncomfortable, global state of tension in response to all affective stimuli. Thus they seek to relieve this discomfort with substances.

McDougall views substance abuse as a psychosomatic disorder. It is a way of dealing with distress that involves externalizing and making physical what is essentially a psychological disturbance. Substance abuse then is the habitual use of an externalizing defense against painful or dangerous affects. McDougall suggests that these painful affects are the response to deep uncertainty about one's right to exist, one's right to a separate identity, and one's right to have control over one's body limits and behavior. The abuse of drugs is part of a "false self" that the individual creates to ward off these painful feelings.

Some critics have argued that a major limitation of those psychoanalytic theories is that they do not make allowances for the biological bases of substance abuse disorders (Babor, 1991). However, contemporary psychoanalytic theorists acknowledge that biology plays a role in behaviors related to substance abuse. But the unanswered question remains whether biological or psychological factors come first: Why does a person *start* using substances? Analytic concepts are useful here, in that they can be said to facilitate the resolution of problems that contribute to emotional distress and to help explore the connection among interpersonal patterns, emotions, and substance abuse.

Levenson and colleagues offer such a theory (Levenson et al., 1997). They describe a biopsychosocial conceptualization of substance abuse disorders that can, in part, be addressed by brief psychodynamic therapy. In this model, substance abuse disorders are particularly difficult to treat because, unlike other psychological disorders, there is a "primary urge" to abuse substances—an urge that can take precedence over every other aspect of life. Furthermore, the symptom (substance abuse) is often considered pleasurable by the client, in contrast to the symptoms of other psychological disorders (such as anxiety or depression). Thus, "[psychodynamic] therapy should be considered as part of an overall treatment plan that includes some kind of drug counseling and possibly other interventions as well, such as medications and family therapy" (Levenson et al., 1997, p. 125).

Integrating Psychodynamic Concepts Into Substance Abuse Treatment

Many of the concepts and principles used in psychodynamic therapy with clients who have substance abuse disorders are similar to those used with clients who have other psychiatric disorders. However, most therapists agree that people with substance abuse disorders comprise a special population—one that often requires more structure and a combined treatment approach if treatment is to be successful. To effectively treat these clients, it is important to combine skill in the provision of the model of therapy with knowledge of the general factors in the treatment of substance abuse disorders. These include knowledge of the pharmacology and the intoxication and withdrawal effects of drugs, familiarity with the subculture of substance abuse and with substance-dependent lifestyles, and knowledge of self-help programs. It also helps to feel comfortable working with substance abusers and for one's therapeutic style to express acceptance of and empathy for the client. In modifying SE psychotherapy for use with clients with substance abuse disorders, Luborsky and colleagues identified certain emphases that are particularly important (Luborsky et al., 1977, 1989). These emphases, listed below, are relevant for applying other

types of psychotherapy to substance-dependent clients as well.

- Much of the therapist's time and energy are required to introduce and engage the client in treatment.
- The treatment goals must be formulated early and kept in sight.
- The therapist must pay careful attention to developing a good therapeutic alliance and supporting the client.
- The therapist must stay abreast of the client's compliance with the overall treatment program (if the client is involved in a comprehensive treatment program). This includes such things as the client's attendance at all facets of the program, submission to regular urinalysis, and use of any drugs.
- If the client is receiving substitution therapy, such as methadone maintenance, attention should be given to the time of the client's daily dose and when, in relation to the dosing, the client feels therapy is best conducted.

Therapists whose orientations are not psychodynamic may still find these techniques and approaches useful. Therapists whose approaches are psychodynamic will be more successful if they also have a knowledge of the general factors in the treatment of substance abuse disorders and conduct psychotherapy in a way that complements the full range of services that clients with substance abuse disorders receive in a relatively comprehensive program.

Models of Brief Psychodynamic Therapy

Ten major approaches to short-term psychodynamic psychotherapy are briefly summarized in this section (for more detailed information, see Crits-Christoph and Barber, 1991). These approaches differ depending on the extent to which they use expressive or supportive techniques, focus on acute or chronic problems, have a goal of symptomatic change or personality change, and pay attention to intrapsychic or interpersonal dynamics.

Interpersonal psychotherapy is included because it is one of the important and better researched therapeutic approaches for treating substance abuse disorders. It is considered by some to be a psychodynamic model, but there are conflicting opinions on this. This list is not exhaustive; numerous other, perhaps less well known, approaches or modifications of these approaches are not mentioned. Many of these approaches have developed from clinical experience, and some are not well researched, if they are researched at all. Figure 7-2 summarizes the length of treatment, focus, and major techniques of various models of brief psychodynamic therapy.

Mann's Time-Limited Psychotherapy (TLP)

The goal of treatment in TLP is to diminish as much as possible the client's negative self-image through resolution of the central issue (Mann, 1991). Symptoms are reduced or eliminated as a byproduct of the process. TLP works via two main components of the treatment: the therapist's identification of the central issue and the setting of the termination date at the start of treatment. The central issue is always conceptualized in terms of the client's chronic and presently endured pain, resulting from painful life experiences. This pain is a privately held, affective statement about how the client feels about himself. Change comes about through the identification and exploration of the painful feelings about himself and through the feelings of loss surrounding termination. This model has a set treatment length of 12 sessions and promotes working through of termination issues.

Sifneos' Short-Term Anxiety-Provoking Psychotherapy (STAPP)

STAPP is a focal, goal-oriented psychotherapy that is usually practiced in 12 to 15 sessions and sometimes fewer (Nielsen and Barth, 1991). During the first session, the therapist and client agree on a clear psychodynamic focus, rather like a treatment contract. The foci that respond best to STAPP are unresolved Oedipal conflicts, but loss, separation issues, and grief may also be acceptable. Change comes about through the client's learning to resolve an emotional core problem, essentially problemsolving. Resolving the problem promotes a feeling of well-being and a corresponding positive change in attitude.

Davanloo's Intensive Short-Term Dynamic Psychotherapy (ISTDP)

In ISTDP, therapeutic techniques are used to provoke emotional experiences and, through this, to facilitate corrective emotional experiences or the positive reenactments, in therapy, of past conflictual relationships (Laikin et al., 1991). Change comes about by bringing to consciousness these past unresolved conflicts through intense emotional experiences, reexperiencing them in a more cognitive way, and linking them to current symptoms and problematic interpersonal patterns. Extensive use of analysis of the transference relationship also helps to bring the unresolved conflicts to

Figure 7-2
Brief Psychodynamic Therapy

Therapy (Theorist)	Length of Treatment	Focus	Major Techniques
Time-Limited Psychotherapy (Mann)	12 sessions	Central issue related to conflict about loss (lifelong source of pain, attempts to master it, and conclusions drawn from it regarding the client's self-image)	■ Formulation, presentation, and interpretations of the central issue ■ Interpretation around earlier losses ■ Termination
Short-Term Anxiety-Provoking Psychotherapy (Nielsen and Barth)	Usually 12 to 15 sessions	Unresolved conflict defined during the evaluation	■ Early transference interpretation ■ Confrontation/clarification/interpretations
Intensive Short-Term Dynamic Psychotherapy (Laikin, Winston, and McCullough)	5 to 30 sessions; up to 40 sessions for severe personality disorders	Experiencing and linking interpersonal conflicts with impulses, feelings, defenses, and anxiety	■ Relentless confrontation of defenses ■ Early transference interpretation ■ Analysis of character defenses
SE Therapy (Luborsky and Mark)	16 for major depression, 36 for cocaine dependence	Focus on the core conflictual relationship theme	■ Supportive: creating therapeutic alliance through sympathetic listening ■ Expressive: formulating and interpreting the CCRT; relating symptoms to the CCRT and explaining them as coping attempts

Figure 7-2 (continued)
Brief Psychodynamic Therapy

Therapy (Theorist)	Length of Treatment	Focus	Major Techniques
Vanderbilt Time-Limited Dynamic Psychotherapy (Binder and Strupp)	25 to 30 sessions	Change in interpersonal functioning, especially change in cyclical maladaptive patterns	■ Transference analysis within an interpersonal framework ■ Recognition, interpretation of the cyclical maladaptive pattern and fantasies associated with it
Brief Adaptive Psychotherapy (Pollack, Flegenheimer, and Winston)	Up to 40 sessions	Maladaptive and inflexible personality traits and emotions and cognitive functioning, especially in the interpersonal domain	■ Maintenance of focus ■ Interpretation of the transference ■ Recognition, challenge, interpretations, and resolution of early resistance ■ High level of therapist activity
Dynamic Supportive Psychotherapy (Pinsker, Rosenthal, and McCullough)	Up to 40 sessions	Increase self-esteem, adaptive skills, and ego functions	■ Self-esteem boosters: reassurance, praise, encouragement ■ Reduction of anxiety ■ Respect adaptive defenses, challenge maladaptive ones ■ Clarifications, reflections, interpretations ■ Rationalizations, reframing, advice ■ Modeling, anticipation, and rehearsal
Self Psychology (Baker)	12 to 30 sessions, not rigidly adhered to	Change intrapsychic patterns. Incorporate more diverse representations of others and changes in information processing	■ Analysis of the mirroring, idealizing, and merger transferences ■ Supportive, empathic
Interpersonal Psychotherapy (Klerman)	Time limited; for substance abuse, the trials have been 3 and 6 months	Eliminating or reducing the primary symptom; improvement in handling current interpersonal problem areas, particularly those associated with substance abuse	■ Exploration, clarification, encouragement of affect, analysis of communication, use of the therapeutic relationship and behavior-change techniques

Sources: Crits-Christoph and Barber, 1991; Klerman and Weissman, 1993; Rounsaville and Carroll, 1993.

the client's consciousness so that they can then be explored and resolved.

SE Psychoanalytic Psychotherapy

This model of dynamic therapy can be offered as an open-ended or a time-limited approach (Luborsky, 1984; Luborsky and Mark, 1991). The term "supportive" refers to the techniques aimed at directly maintaining the client's level of functioning—that is, "supporting" the client. The term "expressive" refers to techniques that intend to facilitate the client's expression of problems and conflicts and their understanding. Therapists using this approach will

- Develop a good therapeutic alliance
- Formulate and respond to central relationship patterns
- Understand and respond to how the symptom fits into the central relationship pattern
- Attend to and respond to concerns about separation (therapy termination)
- Make interpretations that are appropriate to the client's level of awareness
- Recognize the client's need to test the therapeutic relationship (in transference terms)
- Frame the symptoms as problem-solving or coping attempts

Change comes about through three curative factors: a positive helping relationship, gains in self-understanding, and internalization of these gains.

The Vanderbilt Approach to Time-Limited Dynamic Psychotherapy (TLDP)

The primary goal of this therapy is to foster positive change in interpersonal functioning, which will then have beneficial effects on the more circumscribed symptoms (Binder and Strupp, 1991). Interpersonal problems are conceptualized in a specific format termed the "cyclical maladaptive pattern," which includes four categories of information:

- Acts of the self toward others
- Expectations about others' reactions
- Acts of others toward the self
- Acts of the self toward the self (introjection)

The theory of change is that therapy is a set of interpersonal transactions through which the client learns and is then able to change the maladaptive interpersonal patterns in her life. Analysis of the transference relationship and the therapeutic relationship as a model for healthier relationships are important components of the therapy.

Short-Term Dynamic Therapy of Stress Response Syndromes

This approach to brief dynamic therapy was developed for use with clients who are dealing with recent stressful events, such as traumatic experiences or the death of a loved one (Horowitz, 1991). The therapist establishes a working alliance with the client and then, using techniques appropriate to the client's state of mind and control processes, helps the client to integrate the life event and its meaning into his schema (a schema is one's way of understanding oneself in relation to others). The therapist fosters this process of integration and understanding by focusing attention, correcting distortions, making linkages, and counteracting defensive avoidance. For research, this model is offered as a 12-session therapy, but it can also be used as an open-ended therapy in clinical practice.

Brief Adaptive Psychotherapy (BAP)

BAP is a short-term analytic model developed to treat clients with personality disorders, although it is applicable to other groups of clients as well (Pollack et al., 1991). The theory of change is that through cognitive and affective

understanding of the origins and operations of the maladaptive pattern, the client can change and construct more adaptive patterns. The techniques used include maintenance of a focus, much work on transference, and a high level of activity on the part of the therapist. The major maladaptive pattern is an interpersonal pattern, and it is explored in the present, in the past, and in the client-therapist relationship. These three areas are repeatedly linked to one another. The maximum number of sessions offered is 40, which Pollack and colleagues point out is more than some of the other brief models because of the higher level of psychopathology of the clients.

Dynamic Supportive Psychotherapy

Supportive therapy is widely practiced clinically but historically is defined mainly by the absence of expressive or interpretive components of psychoanalytic therapies (Pinsker et al., 1991). It evolved as the psychodynamically based therapy used for lower functioning or more fragile clients for whom the expressive work of therapy might be too distressing. The therapist has a cohesive psychodynamic formulation of the client but only shares parts of it in a manner intended to foster the client's adaptive functioning. The goals of supportive therapy are to ameliorate symptoms and to maintain, restore, or improve self-esteem, adaptive skills, and ego function. Change comes about from learning and from identification with or introjection of an accepting therapist with whom the client has a good relationship. The techniques used include reducing anxiety, respecting defenses, clarification, limiting confrontation and interpretation, enhancing self-esteem, reframing, offering encouragement, advising, and modeling.

A Self-Psychological Approach

The essential aspects of the theory of Self Psychology (Baker, 1991) include the following:

- Empathy
- The concept of the selfobject
- The importance of the self in motivating behavior
- The role of symptoms as the client's way of restoring self-cohesion

In this brief self-psychological therapy approach, one or two goals are established collaboratively in the initial sessions. The duration of treatment typically is 20 to 30 sessions, with fewer or more as needed. A selfobject is something or someone else that is experienced and used as if it were part of one's own self (Baker, 1991). For example, a child is dependent on the parent's love and praise to develop a sense of self-worth and self-esteem. In that way, the child internalizes a part of the parent as the selfobject. The theory of change is that understanding, followed by interpretation, leads to change. Success in therapy requires that dysfunctional intrapsychic structures be changed and/or that compensating new structures be added.

Interpersonal Psychotherapy (IPT)

IPT was developed initially as a time-limited, weekly psychotherapy for nonbipolar, nonpsychotic, depressed clients (Klerman et al., 1984). It has since been summarized in a manual for research and modified for treatment of other types of depression (dysthymia), other populations (adolescents and couples), and other problems (substance abuse disorders and bulimia). The goals of this approach are primarily symptom reduction and improvement in interpersonal functioning. The main techniques include the following:

- The problem is explicitly diagnosed and the client is given the "sick" role.
- The client is educated about the problem, its causes, and the treatments available.
- The interpersonal context of the problem and its development are identified.

- Strategies for dealing with the interpersonal context emerge and are tried by the client (problemsolving).

Other Research

In addition to Supportive-Expressive psychotherapy, both IPT and MGDT have been studied as therapies for use in the treatment of substance abuse disorders.

IPT has been evaluated as an adjunctive treatment for a full-service methadone clinic (Rounsaville et al., 1983). This was a collaborative research project that paralleled a study by Woody and colleagues (Woody et al., 1983). Seventy-two methadone-maintained, opiate-dependent subjects who were diagnosed with a psychiatric disorder (e.g., depression) were randomly assigned to one of two treatment conditions, each lasting 6 months. The treatments were IPT offered once a week and low contact, consisting of one 20-minute meeting per month, when symptoms and social functioning were reviewed. Both groups also received treatment as usual in the methadone-maintenance program that included a weekly 90-minute session of group counseling. The main findings were that it was extremely difficult to recruit and retain clients in the program and that although both treatments were associated with significant clinical improvements during the 6-month period, there was essentially no advantage to IPT over low contact. This study was done in a program in which clients were suspended after 3 months if they continued to use illicit drugs, thus providing a potent behavioral intervention. For the control group, clients were forced to do well or leave the program.

A second study (Carroll et al., 1991) compared IPT with Relapse Prevention (RP), a cognitive–behavioral therapy (Marlatt and Gordon, 1985) for the treatment of ambulatory cocaine-using clients. This study evaluated the efficacy of 12 sessions of weekly individual psychotherapy, without adjunctive pharmacotherapy, as the sole treatment for 42 subjects who were randomly assigned to either IPT or RP. Rates of attrition were significantly higher for IPT than for RP, with only 38 percent of those in IPT compared to 66 percent of those in RP completing the 12-week course of treatment (Rounsaville and Carroll, 1993). On most outcome measures there were no significant differences between the two treatment conditions; both were associated with favorable outcomes. However, for clients with more severe psychiatric symptoms or more severe drug use, those who received RP were more likely to become abstinent than those who received IPT. Clients with more severe substance abuse disorders may require the greater structure and direction offered by the relapse prevention approach (Rounsaville and Carroll, 1993). This is entirely consistent with the observation that substance-focused interventions are perhaps the optimal approach for treating substance abuse disorders (Strain, 1999). Based on the rather modest empirical support, Rounsaville and Carroll suggested that the role of IPT in the treatment of substance abuse disorders might be the following:

- To introduce clients into treatment
- To treat clients with lower levels of substance abuse
- To treat clients who did not benefit from other modalities
- To complement other ongoing treatment modalities
- To help clients maintain and solidify gains following the establishment of stable abstinence

Khantzian and colleagues developed MGDT to address the characterological underpinnings of substance abuse disorders (Khantzian et al., 1990). The group has four main goals:

1. The development of affect tolerance
2. The building of self-esteem
3. The discussion and improvement of interpersonal relationships
4. The development of appropriate self-care strategies

This approach has shown efficacy for abuse in research, but the research was not comparative, so it is not known how effective this approach is in contrast to other approaches.

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