Journal of Addictive Diseases, 28:28–38, 2009

ISSN: 1055-0887 print / 1545-0848 online
DOI: 10.1080/10550880802544922

Routledge
Taylor & Francis Group

Finding the Common Ground: Contemporary Psychoanalysis and Substance Abuse Treatment

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ABSTRACT. Recent changes in psychoanalysis and substance abuse treatment are healing longstanding rifts that had kept these two fields apart. This article elaborates the historical positions that contributed to the schism and describes how the harm reduction model of substance abuse treatment and the relational orientation in psychoanalysis can bring them together. Three clinical examples illustrate how integrating these methods can offer an approach that is effective and comprehensive.

KEYWORDS. Substance abuse, psychoanalysis, harm reduction, relational psychoanalysis

INTRODUCTION

The longstanding and sometimes antagonistic rift between psychoanalysis and the world of substance abuse that has characterized 20th century treatment is finally healing due to recent advances and modifications in both fields. In this paper we will briefly describe the history of each, elaborate how their historical positions contributed to the schism, and then describe what is happening today that is bringing the fields together. It is our contention that each has much to offer the other and that the integration of experience and expertise from psychoanalytic practice and substance abuse treatment results in an approach that is comprehensive and effective.

HISTORY

Substance abuse treatment was born on the front lines where lives were being devastated by alcoholism. Grassroots efforts brought alcoholics, and later their family members, together for supportive, tough, but nonjudgmental intervention with the explicit goal of abstinence. Many features of this approach, such as Alcoholics Anonymous (AA) and its 12 step program, peer support, and the notion of having a disease from which abstinence is the only possible remedy, have remained central to American substance abuse treatments. In addition, most treatment took place in inpatient or outpatient programs, which were structured and consisted of education, behavioral change, teaching skills, limit setting, and the threat of discharge if goals were not met. This paradigm was so at odds with classical psychoanalysis that most analysts felt unable to participate. However, due to limitations of their own practice described below, most had no effective alternative to offer. In addition, because substance abuse treatment methods were developed and practiced by those who

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had been helped this way, a belief was developed that this was not just a way of treating substance abuse disorders, but *the* way. Those who strayed from the model were labeled "enablers" who put addicted people at risk by "allowing" their "disease" to continue. Psychoanalysts, along with other clinicians, were thereby convinced that this abstinence-only disease model was the most effective but were so uncomfortable with the modalities involved that they increasingly refused to treat addicts. Instead, they referred those with addictive disorders to substance abuse specialists and the programs that used the standardized methods described.

Psychoanalysis originated at the turn of the 20th century with Freud's intention to root nervous disorders and the workings of the mind under the rubric of science. The emphasis of early Freudian psychoanalysis was on the exploration of repressed instinctual drives and psychosexual conflicts to cure the symptoms they caused. The goal of psychoanalytic treatment was to make the unconscious conscious with the belief that symptom relief would follow. Early in this project, psychoanalysts cast substance abuse outside their domain of treatable conditions. In a personal correspondence, Freud[1] explicitly expressed doubt about whether addiction was curable or if "psychoanalysis must stop short at this point" (p. 242). He was probably right, given the practices at that time. Freud's innovative technique was free association, where patients are instructed to say whatever comes to mind, uncensored, and continue with associated thoughts. The analyst would wait for the patient to raise a topic and then speak freely about it. Frequently, therefore, substance use was not introduced for discussion even at times when a person's addiction was obvious and severe.

The classical psychoanalyst's position was one of neutrality regarding the patient's emotional and practical experience. Analysts refrained from guiding content, showing emotional reactions, or making suggestions, even when patients were acting self destructively. In addition, it was believed that lying on the couch facing away from the analyst facilitated the associative process and a kind of regression that helped access the unconscious. This lack of structure and external input allowed the patient to go deeper within but also provoked anxiety that analysts at that time thought was necessary for optimal treatment to occur.[2] This could be dangerous for patients whose impulse in the face of anxiety was to reach for their substance. In other words, the treatment could provoke the symptom rather than cure it.

The early psychoanalytic understanding of addiction was that it was a regressive phenomenon due to psychosexual immaturity. It was considered an oral fixation or a substitute for masturbation. Interpretations along these lines did not address the problem that was often one of immediate concern. The techniques described above risked allowing dangerous addictions to continue uninterrupted. It is no surprise that psychoanalysts developed a terrible reputation among those who were actively intervening with alcoholism and other substance abuse.

These early histories clearly rooted each of the fields in entirely different worlds with little trust for each other. Today, there are modifications in each that are bringing them closer together. Contemporary psychoanalysis is increasingly adopting a relational orientation[3,4] and substance abuse treatment is being significantly impacted by a harm reduction approach.[5–7] Because of these changes, each field is becoming more willing and better able to listen to and learn from the other**.** Education and awareness remains limited, however, and resistance persists from both sides. We will describe each and then discuss how treatment today can benefit from an integration of approaches. First, we will briefly describe how substance abuse treatment, expanding from its roots, is becoming more flexible and personalized. Then, we will elaborate the development of psychoanalytic thinking about substance abuse. Although psychoanalytic writers have had much to say about substance abuse for some time, most psychoanalysts remain unaware of what their own profession can offer this field and many continue to look disparagingly on active substance users. Substance abuse professionals who hold rather stereotypic views of silent, classical psychoanalysts continue to have misgivings about psychoanalysis as a treatment choice for individuals who use substances. It is our hope that awareness of contemporary thinking in both fields will diminish psychoanalysts' prejudice and pessimism about treating addiction and challenge substance abuse specialists'

notion that psychoanalysis is unsuitable for this population.

HARM REDUCTION THERAPY

Current substance abuse treatment has been significantly impacted by the harm reduction movement and, in particular, by harm reduction psychotherapy.[8] Harm reduction is a field of practice that includes policy, medical care, and psychotherapeutic or counseling aspects. The definition of harm reduction is simply that the goal is to reduce harm. In harm reduction psychotherapy, therefore, any reduction in risk or harm to the individual or to others is considered a success or a step toward success and is supported and praised. This is contrary to the traditional approach of substance abuse counseling in which no outcome other than total abstinence is accepted. In a harm reduction approach, abstinence is never excluded as a goal of treatment. In fact, abstinence is recognized as the ultimate reduction in harm. However, abstinence is not the only acceptable goal and also it may be a goal down the road. Goals are set collaboratively between therapist and client and moderation may be a goal. Some people do successfully learn to drink or use drugs moderately.[8] Others find after trying that moderation does not work for them and frequently they then revise their objective to abstinence. One common outcome of this approach is that people find their way to an internally motivated goal of abstinence and not because it is the only option they were presented but because they came to desire it through discovering that they could not sustain moderation.

The focus of traditional substance abuse counseling remains primarily, if not exclusively, on the use of the substance. Harm reduction therapy, on the other hand, is a holistic approach in which the entire person and the context in which the person resides are considered. The focus is always on the individual and that person's particular needs, fears, and desires. The goals are improvement of mental or physical health and of problems in living and, therefore, all issues that impact on these are fruit for discussion. Harm reduction therapy can involve such varied approaches as helping someone find housing before addressing addiction, helping a student remain sober before tests, or supporting an adult's decision to drink only on weekends. According to Denning,[7] harm reduction is a model that "allows clinicians to treat addicts as people with problems, not as problem people. She continues ". . . trust in and respect for the patient is the fundamental principle of any harm reduction approach" (p. 35–36).

Paramount throughout the harm reduction literature[5–9] is respect for the individual patient and engagement with all aspects of the patient's being or "self." This includes an exploration of the complex advantages and the pitfalls of using a substance for that individual. It involves inviting the patient to speak from various perspectives, not only the one that wishes to stop using, but also the parts of the self that feel dependent on a substance or that benefit from using it. In this approach, understanding the meaning and function of using is crucial. This is a psychoanalytic perspective. The mutuality of the work, the collaborative setting of goals and the engagement of multiple aspects of self dovetails with contemporary relational psychoanalysis.

PSYCHOANALYSIS REVISITED

Like the substance abuse field, the clinical practice of psychoanalysis is undergoing significant modifications. A relational paradigm has developed that supplements the classical technique and theory that exist today. A relational psychoanalysis is one in which relationships with others are considered fundamental to development and to ongoing life and treatment. Ghent[10] defines it as an approach based on a broad outlook that "human relations - specific, unique human relations - play a superordinate role in the genesis of character and of psychopathology, as well as in the practice of psychoanalytic therapeutics" (p. xviii). According to Ghent, it is the context of relatedness that defines meaning. Relationships are considered between the patient and others in the outside world as well as within the patient: the images of others the patient carries around in his or her mind and the relationships between the various aspects of the patient's character or "self." What this

looks like in practice is a treatment that embraces the vicissitudes of the patient-analyst relationship as not only a source of information, but also the mechanism for therapeutic change. Meanings unfold and histories are revealed through the patients' stories and the shifting transference–countertransference over time. Internalized patterns of relating are enacted and explored in the therapeutic encounter. Relational analysts work to facilitate patients' awareness of dissociated aspects of themselves so that they can come to know themselves more fully. The process of the relationship itself is the vehicle of change.

This relational turn in psychoanalysis has led to changes and greater flexibility in clinical practice that render it more suitable for treating addiction. Free association is no longer the predominant technique, though it remains a tool that may be used to explore a patient's inner experience. The premium placed on the analyst's neutrality has been elaborated to include active, authentic engagement. The analysis is collaborative, with goals and understanding negotiated rather than dependent on the authority of the analyst. Perhaps most critical to engaging substance abusers, relational analysts emphasize an environment of optimal safety, rather than optimal anxiety, where patients can work through crippling shame and risk being fully honest and known.

As mentioned earlier, there is a long history of psychoanalytic thinkers who did address the issue of addiction, culminating in writers today who take a relational approach and foreshadow a harm reduction perspective. Despite Freud's concern that psychoanalysis might not be appropriate for treating addictions, other psychoanalytic voices emerged beginning in the 1930's. Rado,[11] in a statement still relevant today, turned the focus away from the drug and toward the user when he wrote, "The psychoanalytic study of the problem of addiction begins with the recognition of the fact that not the toxic agent, but the impulse to use it, is what makes an addict of a given individual" (p. 2). Glover also focused on the individual rather than the substance. He radically altered all previous thinking with the idea that taking drugs can be an attempt at adaptation that is frequently a successful maneuvre.[12] Glover introduced the idea that substance use may actually be "progressive" rather than regressive. He laid the ground for what later became the self-medication approach in which taking drugs is seen as a misguided, but in some ways adaptive, attempt to find a remedy for what is lacking or damaged in the user's psychology. In a classic article, Khantzian[13] named the "self-medication hypothesis" in which he developed the idea that substance choice is not arbitrary. Users discover and become addicted to the specific drug that meets their psychological needs. Others[14–16] have also built on the idea that drug use is an attempt to cope and that treatment must stem from such an understanding.

In addition to attending to its function as a coping mechanism, psychoanalysts have suggested potential psychodynamics and developmental influences that predispose some people to become addicted to substances. Wurmser[17] spoke of preconditions of the personality structure which can lead to the development of an addiction. Among others, he named difficulties with affect tolerance, reduced ability to symbolize emotions and experiences, and superego pathology as contributors to the urge to continue using substances once they have been discovered. Khantzian et al.[18] described five specific areas of ego functioning that they believed made people vulnerable to developing addictions when they were compromised.

Krystal[19] emphasized affect disturbances and also spoke about the substance user's inability to "acknowledge, claim, and exercise various parts and functions of himself" (p. 174). He was referring to the failure of the addicted individual to internalize parenting or soothing functions. Instead, self-soothing is split off and attributed to another, often a substance. Krystal introduced here the idea of seeing the drug through the lens of object relations. He described the user's relationship with the drug and the function it serves as a replacement for relationships with other people as well as within the self. As psychoanalytic literature has become more relational, the corollaries between substance use and interpersonal relations are increasingly central to treatment. Director[20,21] provides a good example of relational theory applied to the treatment of substance abuse as she discusses discovering the significance of the substance use through tracking

the transference–countertransference patterns. Burton[22] and Rothschild[23] also take relational positions as they present substance use as embedded in specific self states or aspects of an individual's personality.

When applied to substance abuse treatment, relational psychoanalysis is a robust orientation that considers the multiple meanings and functions of substance use as they manifest in patients' relationships to self and others. Although psychoanalytic approaches have historically attended to the meaning and function of using, a relational approach adds more. Its premise is that patterns of human relationships, and not just their results in intrapsychic structures and fantasies, are the most fundamental building blocks of character development and lived life. The relational psychoanalyst aims to thoroughly know the patient through welcome participation in transference–countertransference enactments and to identify how drug use plays an interpersonal and self-medicating role for the user. The substance itself has a dynamic presence in the relationship. Treatment is a highly individualized endeavor based on an understanding that, like any behavior, taking a substance is rooted in the particular person's developmental experience and present day life. An important aspect of the treatment, therefore, is unpacking the multiple symbolic and interpersonal meanings of substance use. For example, it might represent attempts to remain attached to or identified with a parent or significant other. Alternatively, using substances may be in the service of differentiation and separation. Substance use can reflect patterns of dependency, failure or fear of success; it might enact freedom, liberation, fun and abandon, rebellion, angry defiance, conformity, passivity, compliance, or containment, to name just a few. Relational psychoanalysis uses the interaction between the patient and analyst to understand the significance of a particular addiction, including all the rituals connected to using, and the interpersonal and emotional patterns it enacts. Corollaries between these patterns and the interactions between the patient and analyst become a powerful arena for therapeutic action. The key is to explore and never assume that we know what the substance use means or what function it serves for a particular person.

Relational psychoanalysts believe that such individualized understanding is crucial to helping people relinquish dependence in a way that feels internally motivated and integrated with who they are. The more thorough and personalized the understanding of use, the more heightened will be the patient's self awareness, ability to consciously and actively make choices about use, and to develop less damaging coping strategies.

DISCUSSION

We will begin with two vignettes and then describe a case that demonstrates a relational perspective in a long-term substance abuse treatment.

Vignette I

In a previous session, the client and counselor had discussed the client's wish to obtain a new job. They had sketched out a plan for the client to update his resume and respond to some classified ads and talked specifically about the steps he would take. He came to the next session ashamed and upset. He had not applied for the jobs. He had instead gotten high. The counselor spoke to him supportively about marking this incident in his mind and learning from it. One of the skills she was teaching him was to "think it through" before using. The counselor said this incident may help him remember that among the consequences of using is not doing what he intends to do and then feeling bad. This was a typical substance-focused response and one that may well have been helpful for him.

A psychoanalytic response, however, would be different. As we have described, the psychoanalytic paradigm is one that considers the whole person and not just the use of the substance. It seeks to identify conscious and unconscious meaning and motivation behind any substance misuse. The client's feelings and thoughts throughout the incident would be thoroughly explored. A detailed inquiry would investigate exactly when the decision to use had been made, what was happening then, and what led up to it. Like most treatments, an analytic approach looks

for "triggers," but the exploration goes further. It would not stop with the notion that applying for jobs may have been the "trigger," but would deeply explore the client's experiences around the job hunt and at that given time. For instance, it may be that the drug use was about a fear of getting a new job, fear of not getting a job, anxiety about interviews, or perhaps the client has a deeper identity as a "loser who doesn't work and does drugs" that he is not yet prepared to give up. The use may also have had nothing to do with the job search at all. Perhaps around that time the client had had an upsetting conversation with a parent or lover so he instinctively reached for something that has always worked in the past to quell his discomfort. We cannot know what his drug use was about at any specific time without exploring it deeply. Learning about each incident helps expand the picture of what substance use means in his life and what purposes it serves. Thus, the client can be helped to find alternative methods of coping. As he becomes aware of the symbolic meaning drug use has in his life and how it fits with his core sense of self, he can begin to build a new identity, a new sense of self that does not include substance use.

A relational psychoanalyst would take a further step and explore the meaning of the use between them. What was happening between them when they made the original plan? What was the client feeling at that time toward, and from, the analyst? Was there a simultaneous voice in his head that knew he didn't want to apply for those jobs? Were the analyst and client colluding to pretend he was ready when he was not? Was he ready at that time but something else honestly interfered? Is the disappointed, ashamed client who reports the incident the "same person" as the one who made the plan the session before? Perhaps there is a different aspect of this client's self who has not yet spoken up and who can be invited to speak now. Is the client attached to drug use or his identity as a user in ways he has not thus far articulated to a clinician or to himself?

This approach differs from the traditional substance abuse methods in a variety of ways. Rather than being didactic, it is open and investigative. The paradigm is not of an authority teaching a student, but rather a collaborative effort of mutual exploration and learning. It engages the whole person and elicits his capabilities in the expectation that he can participate in the work. The client is not a passive recipient of the service, but an active contributor to the process. What is addressed goes beyond his use of a substance to all aspects of his life and what is important to him. The exchange elaborated above moves away from traditional substance abuse methods toward harm reduction psychotherapy and a contemporary psychoanalytic approach.

Vignette II

In her third month of treatment for cocaine addiction, Hillary had a slip. She had obtained some cocaine for a party and used it. Unlike her previous pattern, however, she had not finished it all and there was some cocaine left at home. She clearly stated her wish not to use the rest of it and with the therapist's support and participation a plan was constructed for her to dispose of the remaining cocaine as soon as she got home that night. Hillary seemed determined and happy with the arrangement and was ready to end the discussion. The therapist then asked, "If you concentrate, can you detect any other little voice in your head saying anything else right now?" Hillary looked shocked. After a moment of silence she said, "I'm not going to do it." She went on, "How can I lie to myself? Why would I? I can understand lying to somebody else, but I never realized I could lie to myself. Why would I do that?" The part of Hillary's self that wanted to use drugs and the part of her self that didn't had been completely dissociated and estranged from each other until that point. If the therapist had not asked the question and invited the part of Hillary that wanted to use to speak up at that moment, Hillary would have left the office convinced that she was going to dispose of her cocaine and when she got home another aspect of herself that she did not consciously know about in the office would have emerged and used it. This is the kind of set-up for Hillary to feel baffled by her own behavior, believe that she has no control, that she "finds herself using," and possibly to set up the therapist to be disappointed, angry, or feel lied to. By bringing the two sides of Hillary into the room at the same time, she was

able to begin to experience her conflict about using. It was no longer black and white, all sobriety one moment and using the next. She was able to begin a negotiation within herself and a discussion ensued in which she could talk about why she might discard the cocaine and why she might not. When she got home, she was not surprised by the urge to use. She was prepared, she felt her ambivalence and she was able to make a conscious decision to throw it away.

Case Example

Dan was initially coaxed into treatment by a girlfriend concerned about his beer drinking. He was highly ambivalent about therapy, but after a period of assessment he admitted that he was overly reliant on substances. He was drinking heavily through the weekends and sometimes had 4 or 5 beers after work. He used cocaine occasionally. After several months, he revealed that he was smoking marijuana daily. As Dan began to accept that he in fact had a problem, he was able to give up cocaine fairly easily and cut back on smoking pot. His drinking, however, persisted. After considerable preparatory work over the first 18 months of therapy, Dan agreed to participate in an outpatient treatment program with a goal of sobriety. He wanted to remain in weekly therapy through this process. Dan did beautifully and was highly regarded by the staff for his self-control, intelligent insights, and helpful group contributions. He became sober and graduated a success to himself, the program, and his referring therapist.

Some years later, however, Dan decided that he did not want to be substance free. Life was going well, and he figured that since he had already stopped drinking once he could stop again if necessary. He drank socially, avoided previously dangerous triggers, and his family and work life progressed over time. He had remained in therapy and assured his therapist that he was drinking in moderation and that it was not causing any difficulties.

As the years passed, it became clear that alcohol was again contributing to Dan's failure to thrive. Although he could discuss this with insight and emotion, he remained adamant in his plan to continue drinking and wished to stay in treatment to work on life issues. His therapist, however, was concerned about the escalation in his drinking. A process of renegotiating the treatment contract ensued, which involved reading about harm reduction, ongoing discussions of use, control, and its interaction with all areas of his inner and outer life. Together, Dan and his therapist agreed to monitor his drinking and to set about unpacking the complex meanings and feelings his substance use carried, which included exploring more specifically painful childhood psychodynamics. The first matter of importance was the need to look back together to understand his earlier bout of abstinence. Although clearly a laudable achievement, multiple meanings rippled through this endeavor in a way that had set a shaky foundation for enduring sobriety. They came to see that compliance, pleasing, and unconscious motivation to regulate the other's well being were involved in Dan's success.

Dan's history was one of chronic sadness and benign neglect. His parents divorced and his mother left home when he was 9 years old, taking his 2 younger brothers with her. Throughout his earlier childhood, she had been physically present but a chronic marijuana user. By age 11, Dan was traveling alone on weekends to visit his mother. Dan appeared to cope well and was careful to cause no additional family strain and to avoid any rejecting or aggressive feelings between himself and his mother. The toll of his efforts was that by age 13 he was self-medicating with alcohol and pot. His early reliance on substance use went unnoticed by either parent.

Beyond complying with his mother, Dan carried a sense of responsibility throughout his childhood to preserve her good feelings about herself. He maintained the impression to himself and others that she caused him no pain, disappointment, anger, or damage. He idealized her motives and valued her behavior as progressive and interesting. He recalled rare but memorable incidents when his angry feelings broke through or when sadness preoccupied him privately. Dan's emotional history was accessed not by stories he could tell but by affective relational patterns that were recreated in his treatment. In turn, emotions experienced with his analyst triggered more memories.

As Dan's history unfolded, the dynamics of loss turned out to be central to his experience and identity. Substance use had come to play complex layered roles in negotiating attachment, separation, and loss. After Dan's family split up he continued to live with his father, who had stopped using substances but was absorbed in his own feelings of loss. Loss of his marriage was seemingly dwarfed by the unresolved loss of his own father during World War II. Dan absorbed this intergenerational loss sincerely and dutifully by, for example, seeking solace in keepsakes and making regular memorializing donations. Attachment to the grandfather he never met created a special feeling of closeness to his relatively nonverbal father and grandmother. Though he craved this connection, weekly visits to his grandmother's home were ritualized, deadening, and depressing. At home, his father was often preoccupied and avoidant of deeper contact. Using drugs allowed Dan some defiant separation from his father while simultaneously maintaining their strong bond, and the drugs themselves relieved the immediacy of his felt sadness. At the same time, drinking and smoking marijuana provided a means of attachment to his mother who seemed to respond to loss by not looking back. His mother's dissociation offered a more appealing and hopeful alternative to the sadness of his father's side of the family, despite her consequent inability to care for Dan or respond to his feelings. Dan thus identified with his mother's coping style. He always knew that they were both substance users. Through using drugs, Dan shared something private, unquestioned, and essential with his mother. Ongoing substance use evolved to symbolically enact the primacy of maintaining maternal attachment and warding off rejection.

Dan's case illustrates a shift from a therapy informed by a traditional substance abuse model to the challenges of working in a contemporary psychoanalytic way with an active substance user. Although he initially responded well to a traditional substance abuse treatment plan, there were layers of underlying psychodynamics that needed to be addressed. Dan began therapy with some reluctance but soon enacted his dutiful dependency and commitment in treatment. He felt genuinely relieved and happy that his drug problem was taken seriously and that the resistance he presented did not convince his therapist otherwise. In both practical and symbolic terms, he had entered into a relationship with a responsible adult who noticed, accepted him, and extended effective care. His girlfriend's concerns were not enough. The transference relationship embodied the blend of dynamics necessary to motivate change. Part of the dynamic that unfolded, however, was that the recognition he had longed for came with a demand to perform and cope well to please another woman. Complying had been paramount to staying in good favor with his mother, and Dan had enacted this dynamic with his therapist. This resulted in the important outcome of abstinence but unfortunately on shaky ground. Without understanding what he had given up and why he had agreed to do so, sobriety could not be maintained.

Once Dan began drinking again, he insisted that he was not relapsing but making a choice to drink moderately. He refused to return to AA or seek other auxiliary support for sobriety but wanted to remain in treatment. Dan's therapist had to decide if she would continue working with him, intensifying both direct harm reduction strategies and psychoanalytic exploration of his active using, or refer him back to the outpatient program and offer to resume therapy once he was sober. During an extended period of renegotiation, she struggled with conflict between participating in what might seem and become an enabling relationship from a traditional point of view or ending an established trusting therapeutic relationship with the abandonment Dan so dreaded. The therapist discussed her dilemma with the patient, who likewise shared corresponding suspicion about his own intentions and fears that his choice might negatively affect others. They agreed to proceed in this mutually open but difficult way that respects Dan's autonomy, his therapist's authenticity, and their shared desire that his drinking remain controlled and nondestructive to his life and relationships.

Engaging in this way was sometimes more difficult than simply setting up the contract. For a long time, Dan had adamantly denied that negative feelings toward his therapist or treatment might affect him. He reported only cheery

responses to his therapist's absences or appreciation for her concern when she questioned his drug use. As if preemptively shutting her out, he gave his therapist, like his mother, a free pass, exonerating her from having any negative impact on him. Dan had created narratives where he could feel less dependent or affected by his therapist and, if anything, responsible to help her feel competent despite his continued use. The entire enactment served the purpose of protecting his drug use from outside interference.

By not accepting the free pass as his mother had, his therapist eventually broke into Dan's narratives and they began to trace the impact of what transpired between them. Dan experienced and reported how substance use could have meaning in the context of their relationship, such as noticing how her vacations might trigger a binge, or how his improvement evoked anxiety about termination. Dan came to deeply understand his proclivity toward compliance and his grandiosity in taking responsibility for the other. Seeing himself this way was illuminating and liberating, but also unleashed an angry rebellious side of himself previously dissociated and masked by substance use. Dan became furious at his parents for their neglect and with himself for his complicity. He grew stronger and more self-confident as he located his anger, which he initially chose to express by becoming more defiant about drinking and starting to smoke marijuana again. He reported with gleeful hostility a new social ritual he initiated with friends. His buddies gathered weekly at a bar that he affectionately dubbed "church," mocking Alcoholics Anonymous and his therapist's concern about social isolation and moderation.

The emergence of Dan's previously forbidden anger launched a terribly rocky period of treatment. With newfound bravado, he dismissed the contract and proudly flirted with greater danger. He suspended the self-monitoring that kept his drinking controlled and reclaimed his cravings as a justifiable part of himself to gratify. His therapist was concerned about real consequences in his life and that the treatment was now enabling and contributing to greater harm. She considered threatening to terminate if he continued on this binge and spoke to colleagues about organizing an intervention.

Remaining within a psychoanalytic mode, however, Dan's therapist considered the depths of anger and despair that he had learned to handle with substance use. She saw in his upheaval an opportunity to work through these feelings. Earlier sobriety was superficial and had failed because he had not integrated his profound feelings of abandonment and rage. Now, by deciding to tolerate the strain of staying within Dan's flagrant relapse, his therapist focused on its meanings, his perceptions of her role, and her authentic responses to his state. In this difficult period, she tolerated self-doubt and moments of feeling as ineffective and out of control as her patient. She understood these feelings in part as a communication of how Dan feels and shared with him how difficult they were to bear. She acknowledged how sad and frustrating it was to watch him act so self-destructively, even though she understood the depth of his anger and loneliness. Simultaneously, she focused him to discuss the consequences of his behaviors and attitudes toward his family and job. She guided him to look more concretely at interactions and choices where he might contain any harm done. She used the concept of "damage control," which Dan found appealing, to work together to curtail certain risks like drinking at lunchtime on workdays.

Hearing his therapist's reactions engaged Dan in exploring his role in bringing about the interpersonal consequences of his behavior. He responded by acknowledging times he was driven to defeat her effort and concern by being irritable, uncooperative, and flaunting his drinking escapades. At other times, Dan fended off rejection by resuming compliance. He tried to appease his therapist by investigating rehabs and had gone for a medication evaluation. As Dan learned to identify these patterns, he gradually took more responsibility for his behavior and realized how he had used substances in the service of controlling their relationship.

Dan and his girlfriend had married and she became pregnant. When Dan first learned of the pregnancy, his drinking escalated further. In therapy, it became clear that he was angry about being "pressured to grow up and become responsible." His therapist neither remained neutral nor did she direct him to stop drinking. Instead, she

reiterated the dynamics they had come to understand about his drinking and speculated with him about the function his drinking served at this time. She reminded him how he had identified with a mother who experienced her children as intrusions and how lonely he had felt in the face of his father's self-absorption. She imagined with him how it would feel if his children lost their father prematurely to substance abuse, or once they figured out what Dad had been drinking all these years.

In this context, relational psychoanalysis and harm reduction together supported Dan to reduce the role of drug use in his life. The working through of complex dynamics connected Dan with the sadness, neglect, and anger of his childhood. As a father, Dan identified with being an emotionally neglected child in the family configuration and with his desire to be an appropriately protective adult. From this emotional understanding, Dan gave up marijuana and devised plans to curtail his drinking. He significantly reduced the amount of alcohol he consumed and the harm done to himself and his most important relationships. It became clear that he was not bucking up to others' demands, but that real results in his life were personally meaningful and motivating.

Accordingly, Dan's relationship with his wife grew closer and more stable. He became more assertive with his parents, rather than avoidant or quietly angry. Dan came to experience himself as the active, attuned, and involved father he had become rather than worry that his children would remember him with a glass in his hand or alcohol on his breath. Anxiety at work was greatly reduced as he learned to take in successes and grow more confident. When treatment ended, Dan was drinking recreationally in social situations, was engaging meaningfully in his personal relationships, and was no longer preoccupied with the rituals and substances he had abused.

CONCLUSION

Harm reduction therapy and relational psychoanalysis have set the stage for two fields that were so drastically separate to come together. Aspects of both approaches overlap in philosophy and practice. Each presumes a nonjudgmental, respectful therapeutic relationship between two functioning adults at the core of the treatment. In both, the patient is a full collaborator in the work. Neither approach presents a "cookbook" or preconceived idea of what promotes or constitutes recovery. Both respond to the individuals involved and to the moment at hand and are flexible, with expectations, goals, and foci constantly shifting over time. Harm reduction therapists and relational psychoanalysts both strive to facilitate personal choice and responsibility for who one is and what one does.

An approach to treating substance misuse that derives from a relational psychoanalytic position and a harm reduction therapy model was described. As demonstrated in the case examples, facilitating an integrated sense of motivation, desire for health, and personal responsibility are emphasized. Rather than suggest compliance with lessons or rules, the therapist strives to involve the whole person in decision making based on guided exploration of the consequences of behaviors as well as their psychodynamic meanings and functions. In this way, a process can take place in which the loss of the substance can be fully understood and grieved so that its purpose in the patient's life can be filled in new ways. An internal desire to live a full life without substances can be nurtured and supported by an integrated sense of self and increased competence and strength to face the inevitable struggles ahead.

REFERENCES

1. Freud S. Letter no. 79 in The origins of psychoanalysis: Letters, drafts and notes to Wilhelm Fliess (1887–1902) (original letter written 1897) Garden City: Doubleday; 1957.

2. Mitchell SA. Hope and dread in psychoanalysis. New York: Basic Books; 1993.

3. Aron L, Mitchell SA. Relational psychoanalysis: The emergence of a tradition. New Jersey: The Analytic Press; 1999.

4. Bromberg P. Speak to me as to thy thinkings: Some reflections on "interpersonal psychoanalysis' radical façade" by Irwin Hirsch. J Amer Acad Psychoanal. 2002;30:605–20.

5. Marlatt GA. Harm reduction: Pragmatic strategies for managing high-risk behaviors. New York: Guilford Press; 1998.

6. Tatarsky A. Harm reduction psychotherapy: Extending the reach of traditional substance use treatment. J Substance Abuse Treatment. 2003;25:249–56.

7. Denning P. Practicing harm reduction psychotherapy: An alternative approach to addictions. New York: Guilford Press; 2000.

8. Tatarsky A. Harm reduction psychotherapy. New Jersey: Jason Aronson; 2002.

9. Rothschild D. Treating the resistant substance abuser: Harm reduction (re)emerges as sound clinical practice. In: Session: Psychotherapy in Practice, 1998;4:25-35.

10. Ghent E. Forward. In: Skolnick N, Warshaw, S. ed. Relational Perspectives in Psychoanalysis, Hillsdale, NJ: Analytic Press; 1992:xiii-xxii.

11. Rado S. The psychoanalysis of pharmacothymia (drug addiction). Psychoanal Q. 1933;2:1–23.

12. Glover EG. On the aetiology of drug-addiction. Int J Psychoanal. 1932;13:298–328.

13. Khantzian E. The self-medication hypothesis of addictive disorders: Focus on heroin and cocaine dependence. Am J Psych. 1985;142:1259–64.

14. Wurmser L. Psychology of compulsive drug use. In: Wallace B, ed. The chemically dependent: Phases of treatment and recovery. New York: Brunner Mazel; 1992:92–114.

15. Weiss R, Mirin S. Substance abuse as an attempt at self-medication. Psych Med. 1987;3:357–367.

16. Weider H, Kaplan E. Drug use in adolescents. Psychoanal Study Child. 1969;24:399–431.

17. Wurmser L. Psychoanalytic considerations of the etiology of compulsive drug use. J Am Psychoanal Assoc. 1974;22:820–43.

18. Khantzian E, Halliday K, McAuliffe W. Addiction and the vulnerable self: Modified group therapy for substance abusers. New York: Guilford Press; 1990.

19. Krystal H. Integration and self healing: affect, trauma, alexithymia. Hillsdale, NJ: Analytic Press; 1988.

20. Director L. The value of relational psychoanalysis in the treatment of chronic drug and alcohol use. Psychoanal Dial. 2002;12:551–79.

21. Director L. Encounters with omnipotence in psychoanalysis of substance users. Psychoanal Dial. 2005;15:567–86.

22. Burton N. Finding the lost girls: Multiplicity and dissociation in the treatment of addictions. Psychoanal Dial. 2005;15:587–612.

23. Rothschild D. Bringing the pieces together: relational psychoanalysis and harm reduction therapy in treatment with substance abusers. Psychoanal Perspectives. 2007;5:69–94.