
Partners in Treatment: Relational Psychoanalysis and Harm Reduction Therapy



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A relational psychoanalytic harm reduction orientation to the treatment of substance misusers is presented and illustrated with a clinical example. Both harm reduction therapy and relational psychoanalysis rely on a two-person model in which the therapist and client are collaborators in the treatment. In both, substance use is seen in the context of the user's internal psychodynamics and external environment, and there is an emphasis on treating the person as a whole individual whose substance use is one aspect of life, rather than focusing on the substance use itself as was often done in the past. Historically, psychoanalysis and substance abuse treatment were so different from each other that their paths rarely crossed. The introduction of harm reduction therapy to substance abuse and the relational orientation in psychoanalysis have brought the fields closer together such that the valuable contributions that each can make to the other can now be appreciated. © 2010 Wiley Periodicals, Inc. *J Clin Psychol: In Session* 66: 136–149, 2010.

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Psychoanalytic theories about substance abuse have existed since the inception of psychoanalysis. However, the mainstream of substance misuse treatment, based upon a disease model with a 12-step solution, was so different from traditional psychoanalytic practice that they rarely overlapped. In fact, there has been a rather overt repudiation of psychoanalytic technique by substance misusers and addiction professionals over the years. Likewise, few psychoanalytic practitioners treated addictions. Today, however, both fields have changed in ways that are allowing productive cross-fertilization based on common values and assumptions. The abstinence-only, disease-based model is giving way to a philosophy of harm reduction, while the one-person Freudian psychoanalytic paradigm is turning toward a two-person relational orientation. These developments have allowed the

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best of both fields to come together to form comprehensive, humane, and effective treatments.

In this article, I describe how contemporary relational psychoanalysis coincides with the philosophies of harm reduction therapy and present a treatment that utilizes both principles. A case illustration demonstrates how I use these principles in treatment. It shows that both harm reduction and relational psychoanalysis are utilized as underlying principles rather than techniques or methods of treatment. In fact, the case illustrates how cognitive-behavioral and traditional substance abuse treatment techniques can be included in a therapy based in a context of relational psychoanalysis and harm reduction. I begin by defining the terms “harm reduction” and “relational psychoanalysis” as they are meant to be understood in this article.

Harm Reduction Therapy

Harm reduction is a field of philosophy and practice with many applications. This article will focus specifically on its application as psychotherapy, which will be referred to as harm reduction therapy or, in brief, harm reduction. What constitutes harm reduction therapy is simply that: the goal is to reduce harm. In other words, an explicit aim of harm reduction therapists is to help individuals increase safety and decrease risks they may be imposing on themselves or others, and any steps towards this goal are supported and praised. Although this sounds like an obvious position for most therapists to take, it is in fact counter to what has prevailed in the substance abuse field of the recent past. Beginning with Jellinek (1960), who defined addiction as a disease needing treatment rather than a moral failure needing redemption, addictive disorders have been subject to interventions that traditionally began by demanding total abstinence as a prerequisite for participation. Reductions in risky behavior or steps toward abstinence were not considered successes, and often not even praised as progress, but were seen merely as continuations of a deadly disease.

The concept of addiction as a medical disease led to the development of a specific prescription for treatment, with a protocol that entailed becoming abstinent, participating in group and individual counseling to learn specific techniques, and joining a 12-step recovery program. Many people were helped by this method, and those who were helped often went on to recommend it to others. Unfortunately, it did not work for everyone. Yet, in the absence of any alternative, this protocol became standard and considered not just one possible way of treating those who used substances, but the only way that would work. Any variation, including working with people while they struggled to get sober, was labeled “enabling.”

Harm reduction presents an expanded way of thinking about treatment, which allows for individualized approaches based upon the needs and desires of the specific patient. As Marlatt (1998) explains it, harm reduction is a pragmatic orientation, compatible with a public health approach that “shift[s] the focus away from drug use itself to the consequences or effects of addictive behavior” (p. 50). In harm reduction, the substance use is explored for its meaning, its benefits and pitfalls, its dangers and risks, and its place in the life of the user. Through this exploration, the client sets goals for herself that are continually evaluated and modified through the course of the treatment. Goals may be anything from small steps toward reduction of harm (e.g., using needle exchange) through total abstinence and major life change. Examples from my practice include students whose goals were to stop drinking before exams or important classes, adults who wished to return to social drinking and stop all cocaine or other illicit drug use, people who wanted to smoke pot with

friends but not in their home alone, and many overdrinkers who attempted moderate, social drinking to help them decide whether they needed to abstain totally or not.

There is more to harm reduction therapy than setting goals or using specific techniques. The underlying philosophy of the treatment honors the individual and aims toward collaboration between therapist and client. As I described in an earlier article (Rothschild, 2007, p.73), “the focus is not on a particular substance, or even on the use of that substance, but always on the individual involved and the context in which that person resides. The goal is improvement of mental and/or physical health, and, therefore, all issues impacting on these are fruit for discussion.”

With this orientation, the psychotherapy of a substance abuser looks more like the therapy of anyone else than substance use treatment did in the traditional model. No longer is the focus solely and absolutely on the substance misuse. The therapy, like any other, involves a whole, complex person who is facing challenges in life, one of which may be substance misuse. It is, as Denning (2000, p. 35) described it, a model that “allows clinicians to treat addicts as people with problems, not as problem people.” In harm reduction, respect for the patient and mutual trust are fundamental to the success of the treatment. I believe this could be said for psychotherapy in general, and it is striking that it needs to be made explicit when speaking of substance use treatment.

In harm reduction, the relationship between clinician and client creates a supportive context for the exploration and understanding of all that matters in the life of the client, substance misuse included. It is assumed, as Tatarsky (2002) suggests, that substance use problems result from a variety of psychological, social, and biological factors, unique to each individual, and important to understand for treatment to be successful. The goal is to get to know the whole person of the client and for the client to come to know herself. Using is explored with an eye toward understanding the complex meanings of the use as well as the benefits and pitfalls it has for the user. Through this expanded awareness, choices can be made, including choices about substance use. An approach such as this, which strives to understand meaning and encourages individuals’ curiosity about themselves, is inherently psychoanalytic. An approach that relies on a mutual relationship between clinician and client and works to engage multiple aspects of the client’s self, as described in the case below, fits relational psychoanalysis.

Relational Psychoanalysis

It is generally agreed that the concept of relational psychoanalysis originated with the seminal 1983 work by Greenberg and Mitchell, *Object Relations in Psychoanalytic Theory*, in which object relations, defined as “the general term encompassing people’s relationships with others” (p. viii), were given a central role in theory and clinical practice. In classical Freudian psychoanalysis, the emphasis was on the individual and intrapsychic processes. Drives and their transformations and derivatives were seen as the essential motivator of human behavior and the foundation of psychoanalytic theory. Relational psychoanalysis replaced drive theory with a “fundamentally different conceptual framework in which relations with others constitute the fundamental building blocks of mental life. The creation or re-creation, of specific modes of relatedness with others replaces drive discharge as the force motivating human behavior” (Greenberg & Mitchell, 1983, p. 3).

Today there are a variety of relational theories that use relationships, past and present, to understand people. The concept of relationship is meant to encompass relationships between the individual and others in current life and in history as well as relationships within a person: the images of others the person carries in mind and the relationships between the various aspects of the person's character or "self." An important part of therapy is helping patients become aware of aspects of themselves that may be dissociated from each other so that they can come to know themselves more fully.

Relational psychoanalysis is a two-person psychology in which both people, the therapist and the patient, are considered fully functioning, active participants who bring their own dynamics together to create a partnership through which the therapy takes place. This 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 as well as the shifting transference-countertransference over time" (Rothschild & Gellman, 2008, p. 31). The therapeutic relationship is the vehicle for expanded awareness and the context for growth.

Psychoanalysis and Substance Use Treatment

Psychoanalytic writers have made major contributions to understanding substance abuse. A common theme is that substance use has purpose and meaning, which is important to understand for each individual. Harm reductionists today hold a similar belief and may be surprised to learn that psychoanalysts expressed these philosophies over half a century ago.

In 1932, Glover stated that he did not see drug taking as a form of regression, but instead, as a "progressive phenomenon," which, like other symptoms, is "frequently a successful manoeuvre" (p. 26). One year later, Rado (1933) explicitly shifted the focus from the substance to the individual, saying "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, makes an addict of a given individual" (p. 53). These sentiments laid the ground for a psychoanalytic understanding of substance use as an attempt to cope with or compensate for psychological difficulties and/or pain. In 1985, Khantzian spoke of the "self-medication hypothesis of addictive disorders." He (Khantzian, 1985; Khantzian et al., 1990) and Wurmser (1974, 1992) described how individuals choose specific drug effects to address the painful affect states and psychiatric disturbances from which they suffer.

This emphasis on the individual and the desire to use, despite the fact that "the patient must pay for his enjoyment with severe suffering and self-injury" (Rado, 1933, p. 54), is a perspective that may have been temporarily obscured by the disease model and the "war on drugs," which focused more on the substance and its use than the individual who used it. Harm reduction returns us to a perspective that centers on the person as a whole and not simply the use of a drug. Harm reduction therapists, like psychoanalytic clinicians, are likely to heed the warning of Wurmser (1974) that suppressing an addict's attempt at self-medication with a substance, without massive support to that person's ego, may force more serious forms of decompensation.

The early psychoanalysts, such as those quoted above, tended to look at individual dynamics through the lens of intrapsychic drive-based theory. More recently, analysts have written about substance use from a variety of relational positions.

McDougall (1985), for example, taking an object relations perspective, described objects of addiction as “pathological transitional objects.” A transitional object is one that the infant creates as a halfway stage between the internal and external mother in the process of internalizing the function of self-soothing. McDougall observed that addictive objects create no lasting change in psychic structure and, therefore, must be sought ceaselessly in the external world, as symbolic substitutes for the mother of infancy.

Relational psychoanalytic authors writing about substance abuse (e.g., Burton, 2005; Director, 2002, 2005; Rothschild, 2007) emphasize the importance of the therapeutic relationship as a mechanism of change. They expand upon the traditional methods of substance use treatment and use the interaction between the clinician and client to explore the significance of a particular addiction for a particular individual, including all the rituals connected to obtaining and using a substance and the interpersonal and emotional patterns it enacts. Like relational psychoanalysis, the treatment “rests on the belief that it is in the recognition by another of the various aspects of the substance abuser’s self and the negotiation with them that the addicted patient can come to know him/herself as a fully functioning being” (Rothschild, 2007, p. 92). It is through a relationship with a living, dynamic person (the therapist), as opposed to an inanimate object (the substance), that the patient can begin to know and lay claim to the disowned parts of himself and a sense of self can begin to cohere.

Traditional Freudian psychoanalysis did not work well for people with substance use problems for a variety of reasons. In fact, Freud himself expressed doubt about whether addiction could be cured with his technique, saying it is possible that “psychoanalysis must stop short at this point” (Freud, 1897/1957, p. 242). The primary method of treatment was free association. Analysts did not raise issues, but rather waited for them to arise from the patient. All too frequently, therefore, substance use went unaddressed even when somebody was seriously ill or at risk. Relying on free association and interpretation, Freudian psychoanalysis was a verbally based enterprise. Substance users in general, tend to be action-oriented, often without access to words, especially words about feelings (Krystal, 1988). Rather than speak to process experience, they act, often without any awareness of what triggers the action. Traditional psychoanalysis, known as “the talking cure” therefore, would not have been the best choice. However, relational psychoanalysis, based upon the processes of the moment and an active engagement between analyst and patient can involve a substance user in a way that is immediate and vibrant.

Relational psychoanalysis and harm reduction therapy are both treatments based in partnership and collaboration. The traditional Freudian analyst, like the traditional substance use counselor, was considered an authority figure who knew more than the patient and whose interpretations were key. By contrast, the relational analyst is one who engages fully with the client, acknowledging that both the analyst and client are human and that the dynamic between them will be the ground for exploration and insight. Likewise, harm reduction therapists engage with clients in a context of collaboration and partnership. In this way, harm reduction therapy and relational psychoanalysis have moved each of their respective fields closer together.

A Relational Psychoanalytic Harm reduction Approach

One of the fundamental aspects of any psychoanalytic treatment is that it encourages curiosity about oneself with a goal of expanding self-knowledge. Whereas traditional

substance use counselors may teach skills, psychoanalytic practitioners encourage self-reflection. In this relational psychoanalytic harm reduction approach, skills are taught, but in a context that facilitates curiosity, exploration, self-awareness, and understanding. The treatment is explicitly not one-size-fits-all, but is continually responsive to the ever-changing needs of the individual as well as the vicissitudes and dynamics of what is occurring in the therapeutic encounter.

Substance users often look like people who have been traumatized as they enter treatment. Frequently, a history of trauma is connected with substance misuse, and even when it is not, being addicted can create a traumatic life. One of the hallmarks of trauma is dissociation, defined as a discontinuity between various aspects of self or an inability to hold conflicting views of self at the same time. This results in an impoverished capacity for self-reflection and an inability to thoroughly know oneself. An important goal when treating trauma and dissociation is to help people get to know the various aspects of themselves and to be able to hold them and look at them simultaneously (Bromberg, 1998, 2006). Until one can do that, one cannot genuinely experience conflict and, therefore, cannot make fully informed decisions or take control of one's life.

Unrecognized dissociation frequently leads to setting goals that are not met and possibly a sense of failure, disappointment, or shame. The aspect or part of the person sitting in the therapist's office making plans to be sober or use less is usually not the same as the part of the person who uses. When dissociation is at play, the part that uses may be literally absent from the discussion as the part who wants to be sober makes plans. In the moment, the patient is involved and committed and both therapist and patient may feel encouraged and hopeful about the work they are doing. They may both be unaware that there is another aspect to the patient's self who is not involved in this discussion and who may only emerge under different circumstances outside of the therapy room. With this integrated relational harm reduction approach, cognitive-behavioral methods are used and skills are taught, but always with the awareness that unless the part that uses is involved, these methods may easily fail.

Relational analysts believe that all aspects of the self are valuable and should be heard. Therapists may invite the parts of the patient that the patient prefers to keep hidden into the therapy room to help the patient accept, understand, and value those parts of herself (Davies, 1996). It is especially important in engaging a substance user in treatment to communicate the understanding that using serves a function that needs to be understood and honored and that the "part" of the person that uses is not under threat from this treatment. All too often in substance use therapy, there is a goal, either implicit or explicit, of silencing or even "killing off" the aspect of the person that is addicted or enjoys using a substance. For example, the phrase "that's my disease talking" frequently represents a way of dismissing what may be valid feelings arising from the desire to use. In this kind of treatment, rather than silence the wish, we actively engage with it and find out what purpose(s) it serves and how we can meet its needs without dangerous substance use. If the client believes that the therapist does not want to hear about a desire to use, or that it is dangerous or wrong to speak from that place, the client may agreeably go along with learning tools for sobriety without articulating doubts about wanting to use them.

Related to this is that many people, especially those who are more dissociated, are unable to experience ambivalence or internal conflict. This may manifest in a variety of ways, but particularly relevant here is the decision about whether to use substances and if so, how much. People who cannot hold ambivalence tend to vacillate between sides of a conflict rather than feel them together. One of the

hallmarks of dissociation is that whatever is experienced in the moment feels like absolute truth. There is an inability to take perspective and recognize that either another person or oneself at a different time may hold a different truth. Hence, in a moment of wanting to be sober, there is no capacity to imagine feeling in any way different. Likewise, when wanting to use, the person “forgets” the wish for sobriety. It is for this reason that it is so important to explore both sides of the conflict and to encourage a client to articulate them together as much as is possible. It is the therapist’s job to hear and hold both, to be in a nonadversarial position from which she can recognize and empathize with the multiple aspects of the patient’s self, helping to unite them into a coherent whole. Harm reduction and motivational interviewing (Miller & Rollnick, 1991) therapists encourage their clients to examine the pros and cons of using to make a conscious decision. This helps bring dissociated self states to simultaneous consciousness, allowing for all parts of the self to be part of any decision arrived at and, therefore, on board with carrying through. In addition, it actively engages the person in the relationship and process of treatment rather than placing them in a passive, subservient position of receiving information from an authority figure.

An example is Ken, a graduate student who wished to stop his use of cocaine. Early in treatment, Ken would make plans that would preclude his using on a particular night. He would come in the next session disappointed in himself, saying “it happened.” During one of the planning sessions, I asked him, can you search inside yourself carefully now and feel if there is any resistance to this? Surprised at himself, he said, “You know, I’m not sure I want to do that. I can’t imagine my night after work without it.” Until that moment, he had believed that he was completely invested in his plan not to use. Once he could feel the desire to use along with the wish to be sober, he was able to make an informed decision and to prepare for the urge when it arose. At this writing, Ken still struggles with his use of cocaine, but he thinks and talks about it in very different terms. For the first time, he has claimed ownership of his impulse to use. Previously, he experienced his use as something that “happened,” and his participation as a passive response. Ken now feels his desire and is aware when he makes a choice about using. It has become an active choice, and along with that has come the opportunity, with increasing frequency, to actively choose to not use. Ken has also come to understand his use better, and to respect it rather than wish it would just go away. Once, when speaking of his frustration about not yet being sober, I said, “I don’t think you’ve ever fully decided to stop using. It always remains an option for you.” “I believe that. But how do I make myself believe that,” Ken cryptically replied. Based on prior discussions, I said, “I think the party boy doesn’t believe it.” Ken asked, “Can’t we just kill him off? He’s such a small part of me.” I said, “No. We can’t kill off any part of you and especially not a part that is obviously so very important, small though it may be. Maybe we can find out what he wants and give it to him in other ways.” Ken then opened up for the first time about his profound body dysmorphia and social anxiety and how cocaine allows him to have fun socializing and flirting. Without it he fears he would isolate at home and never go out.

Joe provides another example of how bringing in the “part” of the person who uses can help understand and consequently modify substance abuse and how simply teaching skills to stay sober may not be enough. Joe was despondent and baffled. Despite his best intentions, he had gotten high on cocaine again the weekend before, putting an end to his longest run of sobriety (3 weeks) to date. I tried to explore the context of this latest binge and he said, “It’s useless. The Joe you are talking to is the

Joe with the sinus infection and hangover. The Joe who uses is nowhere around.” I then began delving into the minute details of the day of his use. Affect and experience lie in the details and recalling those can reawaken the state in which they were lived. Joe described his loneliness, boredom, and depression that day. He told me of his wish to hole up and stay in, then feeling antsy and bored. Now he remembered the conflict he had felt as he thought cocaine would make him feel better. He had forgotten until that moment that he had taken a Vicadin to “quiet the voice of dissent,” and then he called his dealer. At the end of the session, Joe said, “That was good. In talking about the depression I felt the part of me who uses enter the room.”

The work with Ken described above also provides an example of how enactments in the therapeutic relationship reveal issues and contribute to healing. At the beginning of treatment, Ken would say “it happened,” rather than, “I used.” This was symbolic of the passive stance he took not only around his using, but in his life in general. When I pointed out the significance of his language and asked him to explore the experience, Ken realized that he had never felt his impulse to use as emanating from himself or his own desire. It was as if it happened to him. Likewise, Ken would ask me if he was an addict, would ask friends if they thought he had a problem, and seemed often to rely on others, including me, to define and describe himself. As long as he remained in this passive position, as if a victim of and separate from the active Ken who used, Ken felt no ability to intervene with his using. The therapy not only drew his attention to this phenomenon, but engaged him in an active participation that served to gradually increase his sense of subjective awareness. By participating in our exploration, Ken developed a self-reflective capacity for the first time. Through his involvement in making choices about goals and his active collaboration in his own treatment, Ken began to experience self-efficacy and the potential to take control of his life.

In summary, the relational psychoanalytic harm reduction approach described here uses a variety of techniques to help people learn to control their substance use in a context in which the therapeutic relationship is key. It is a two-person collaborative therapy in which curiosity and exploration are facilitated with the goal of expanded self-knowledge and an enlarged capacity to make choices and take charge of one’s life. An example follows.

Case Illustration

Maggie was referred to me for “alcohol counseling.” She had had plenty of psychotherapy in her life, was seeing a psychiatrist for medication and therapy, and asked only to learn skills to stop drinking. I explained on the telephone that it would be virtually impossible to separate her drinking from the rest of herself and that “alcohol counseling” would inevitably result in more therapy. Maggie was skeptical, but agreed to come in. She told me that she was under “duress” from her husband who was threatening to leave if she did not get her drinking under control. Likewise, her psychiatrist, to whom she was extremely attached, had said he would discontinue their treatment if she continued to drink.

Maggie, a 39-year-old youngest of three siblings, had grown up in a family that moved from state to state and sometimes out of the country every few years. She and her husband were living in a loving but sexless relationship. Maggie had been drinking most of her adult life, beginning in college with her boyfriend of that time. She had been drinking nightly, often to blackout for many years and had recently

begun drinking during the day while at work. She had fallen while drunk several times, bruising herself badly and often not remembering what happened. Maggie's father was an alcoholic who had stopped drinking without help or support but the family rarely spoke of his history.

On our first visit it became clear that Maggie did not really wish to stop drinking, but that she was frightened by the recent increase in how much and how often she drank, and especially now that she was drinking at work. She also did not want to lose her marriage or her psychiatrist. Maggie loved having wine at night and said she wanted to return to the level at which she had been for years, drinking a few glasses of wine each night on her way home. We agreed to try to work toward that goal. She continued to see her psychiatrist for medication only and began therapy with me.

During our initial sessions I asked Maggie many questions about her experiences of drinking, what it felt like when she was drunk and how she felt when sober. We explored what she would lose if she gave up alcohol as well as what she would gain. Maggie said she was afraid, terrified really, to stop drinking completely. She described living with intense anxiety and a frequent feeling of being out of her body, apart from herself. She said, "alcohol puts me back in my body. I am no longer floating above." She said that a few drinks made her feel calmer and better able to function, but then she would drink too much and get "stupid and angry, somebody David [her husband] does not want to be with." Maggie also expressed fear of losing all sense of herself, meaning her sense of identity or who she knew herself to be. She said, "If I am not Maggie who drinks, who am I?"

Maggie struggled to drink only at night. She could keep it up for a few days but then slipped back into daily drinking from noon on. About 9 weeks into our treatment, she was caught drinking at work and was put on probation. For the first time, she seriously contemplated total abstinence, but still felt very afraid. One day about this time, I got a call from Maggie's sister. The family had gathered in New York and was planning to meet at Maggie's apartment to confront her about her drinking. Their plan was for her to go to an inpatient rehabilitation facility for which they were willing to pay. I tried hard to convince her that this course of action would probably not work, to no avail. They were already there; they loved Maggie and felt compelled to intervene. They did, and Maggie was packed off to rehab for 3 weeks.

Maggie loved the rehab. She felt safe there and enjoyed feeling sober. She took a car service home, had the driver stop at a liquor store on the way, and began drinking before she even walked in her door. She drank for 3 days straight, then stopped for 1 day and came in to see me. She said she had thought in rehab that she wanted to be sober but then on the way home could not wait to get drunk. I asked about the decision to buy the wine and what she had felt during the car ride home. She was baffled. She didn't remember deciding. She had loved rehab so much; she didn't know why she had done it. I began exploring more deeply the details of her trip home. Suddenly there was a visible change in her demeanor and voice and she said, "I think it was a plan all along." I asked her to talk from that place, the place that knew of the plan. She told me how lonely she felt and how drinking soothed the loneliness. In rehab, she had community, felt cared for, and was not lonely at all. As soon as she left, those feelings returned. Drinking would make her feel better, no longer alone. It was her secret, she said, her secret love.

Maggie dissociates. When feeling anxious, she feels she leaves her body and floats to the ceiling apart from herself and looks down on her body below. She makes decisions with one part of herself and other parts have no knowledge of them. Hence, Maggie surprised herself by buying the wine and at first the Maggie sitting in my

office could not explain how it happened. When I probed and made it clear that I welcomed hearing about buying the wine, she switched to the part of herself that had made the decision and spoke to me from there. I was now in a position to know two sides of Maggie that did not know each other. I had heard from the part that wants to be sober and is baffled when she gets drunk and then from the part that wishes to drink. My job was to hold them both, to value them both, and to familiarize them with each other. Maggie continued to struggle. As we worked together, I used many traditional cognitive-behavioral and “tools for sobriety” techniques to help her to structure her days, get through urges without drinking, and call upon friends and sober supports when needed. She had days of sobriety, and then drank. Her drinking was always in secret, hiding and sneaking. She drank on the roof of her building and in the alley behind it. It was her special ritual, her ever-ready companion, and her self-soothing, private love. She claimed she wanted to stop, was afraid what would happen if she did not, and was increasingly recognizing the toll it took on her life and the risk it posed to her life as she knew it. However, she continued to drink every few days saying, “I walk into the liquor store and I think, what am I doing here? Yet, it feels like an imperative, like I must.” Maggie tried some Alcoholics Anonymous (AA) meetings, hoping the support would help, but she felt uncomfortable and did not like going to them. She had tried these years before as well and felt the same way. AA just did not work for her. She did, however, join an outpatient group at a treatment center and became quite involved with that.

Maggie and I had been meeting twice weekly since her return from rehab. As the weeks went on and she continued to drink, Maggie started to say that she knew I would kick her out of treatment if she did not become abstinent soon. I repeatedly asked her where she got that idea, and over and over again she realized I had never said any such thing. Yet, a few days later, she would say it again and would become quite upset at the prospect. Clearly, our relationship had become important to her, as I realized it had become important to me. I was not going to “kick her out of treatment,” but I was becoming frustrated and concerned by my inability to help her not drink. In fact, I was beginning to feel rather helpless and like a failure with her. What if she was fired or got seriously hurt while I impotently stood by and watched? I questioned my own competence and wondered what I could do differently. I asked her if she wished I would threaten termination to motivate her. She replied absolutely not. Maggie had had a psychotherapist 8 years prior who had threatened to stop seeing her if she did not join AA and stop drinking. At that time, Maggie stopped for 3 months. She then resumed drinking and the therapist refused to see her again. Maggie still felt hurt and abandoned by this abrupt loss. Her current psychiatrist was threatening to terminate if she continued to drink and her husband continually threatened to leave her. All these threats and the unbidden intervention by her family had not helped.

Maggie told me I was the first person ever in her life that she felt she could be honest with about her drinking. She said that with me she felt accepted unconditionally for the first time. She said that she believed I liked her and that was so important to her, but that she also feared that I must be getting frustrated with her and her inability to make progress. I told Maggie she was right on both counts. I do like her very much and I was in fact getting frustrated and feeling quite helpless. We had now been working together for several months, making plans for how she would get through days without drinking, exploring her urges to drink, developing strategies and alternatives. Then she would leave my office and it was as if the sessions never had happened. I was worried she would lose her job or fall down

and get hurt and I felt totally powerless to stop it. Although it took several more months, this work we did around our relationship was key to Maggie's eventually becoming sober for the first time in her adult life. She felt liked and accepted and was able to be honest about how much she drank.

Maggie told me about each time she snuck off to buy a bottle of wine or to drink on the roof. This was the first time she had shared her secret ritual, the first time she spoke it aloud. In doing so, Maggie heard herself say it and confronted it herself for the first time. What she was doing began to penetrate and she began to acknowledge how out of control it was and also the dangers involved. In addition, the shame associated with it abated somewhat. It still felt shameful and bad, but speaking it aloud and having it accepted by another human being alleviated the dark dirtiness of it, bringing it into the light as something that could be talked about and looked at. Without this relational context, this development could not have occurred and Maggie's drinking would probably have remained her private secret for longer.

When I talked about my experience of helplessness, Maggie said other therapists had told her before that they felt impotent with her. We realized this must be an important dynamic that she enacts with her therapists. In fact, Maggie herself felt helpless. In her conscious mind, she wanted to stop drinking, and then she would find herself in a liquor store feeling she doesn't want to do this, yet doing it anyway. She began to understand what I meant when I described it as a dissociative phenomenon and how it could be that the plans we made in the office simply did not stick once she was outside. More and more through these discussions and my bringing both sides together at the same time, she was able to at least remember what we had talked about after she left the session.

One day, Maggie told me she had been cleaning the house and found an old bottle of wine. For the first time in her memory, she consciously felt a struggle over whether to drink it or not. She decided to throw it away. This was a huge step for her. She remained sober for several weeks, and then relapsed again. When drunk, she fell on the street and woke up in an ambulance on the way to the emergency room. This kind of thing had happened before, but not for a while, and this time it both frightened her and embarrassed her deeply. Although she was terrified of what she might feel, Maggie really wanted to stop drinking.

We came up with a plan. Maggie would go on antabuse (Disulfiram) and she would ask David to give it to her each morning. Taking the pill would have to be an integrated action. It was a decision she made in session that she would carry out at home and that would be with her as a reminder throughout the day. It was her idea to involve David as she did not trust herself to take it daily.

Once she began taking the antabuse, Maggie stopped drinking. It was clear, however, that she attributed taking the pills to David's daily administration of them and that she attributed not drinking to taking the pills. A few months into this routine, David was going away for a week. Maggie made arrangements for other people, including her psychiatrist and myself, to observe her taking her antabuse. She did not trust herself otherwise. David's vacation time went smoothly and when he returned, he resumed administering the pills.

During this time and beyond it, we talked about many things and focused much on Maggie's need to develop a new life and with it, a broadened sense of herself. She had to learn what she enjoys, what makes her feel good. She discovered yoga and cooking, and she renewed several old friendships. She began going to movies and museums. Maggie was building a life. Yet, she continued to disown the sobriety she had attained by attributing it to David, me, and the pills. This seemed like an

enactment related to her earlier belief that I would “kick her out” of treatment if she didn’t stop drinking and to the passivity she had felt when confronted with the “imperative” to drink. It was as if she could not experience her own agency despite the fact that it was she who made the decision to take the antabuse in the first place, she who arranged for David (or somebody else) to give it to her, and she who chose to remain with David and in therapy rather than go off on her own and drink.

Maggie enacted the sense of helplessness that had been with her her whole life and had always been an integral part of her desire to drink. As the child of an alcoholic father and a depressed, uninvolved mother, Maggie had received little parenting or care as she grew up. Children learn to care for themselves and self-soothe by internalizing the caretaking they receive from parents. Maggie did not have this experience. Her needs were not met, even when her distress was clear. Consequently, she did not learn to take care of herself nor to self-soothe. In fact, siblings and friends teased her, calling her “Maggie who goes sleeveless in winter.” She grew up feeling alone and at the mercy of her anxiety and other overwhelming emotions. She could not have spoken this. She communicated her needs through enactments rather than reflecting on them. She expected me to abandon her, “kick her out” of treatment when her needs were greatest, and when she began to take care of herself by taking antabuse and abstaining from drink, she attributed it to my demands and David’s supervision and threats.

As this pattern became clear, we put words to it, thereby making it real and something on which she could reflect. I repeatedly reminded Maggie that she was choosing to take the antabuse, it was her plan, and she had made it because she no longer wanted to drink. About 6 months later, David was going away again. This time Maggie decided she would take the antabuse herself. She was nervous that she might be surprised by the parts of herself who still felt lonely and sad and that wanted to drink, who might emerge in David’s absence and then take advantage of the freedom to skip the antabuse and drink. She also felt fully committed enough and involved in the life she was having to risk it. We prepared for several weeks, inviting all parts of her to speak up in therapy and reminding her again and again that in fact she could have fooled David and not swallowed the pills, but she never had. David went and Maggie took antabuse daily. David returned but Maggie never returned the responsibility to him. She continued to take her pills by herself.

Maggie now took responsibility for taking the antabuse. However, she continued to attribute her sobriety to the daily pill. It took another 6 months before she could fully claim her desire to be sober and the fact that she herself had attained sobriety and had developed a life with interests, activities, and friends. She went off the antabuse and has remained sober for a year since. The therapy continues as Maggie can still get into self-destructive or compulsive patterns of behavior. When she feels stressed or unhappy, she often turns to something external, such as shopping or food to soothe herself, but now she is aware of what she is doing and is therefore able to talk about it. She is working on turning to other people or more constructive activities, like yoga or swimming, to help herself feel better.

Clinical Issues and Summary

Some mental health professionals maintain that deep psychotherapy cannot be done until a person is sober. It is my strong belief that it was the therapy and the experience of our relationship that enabled Maggie to risk living without alcohol. There were times during our work that Maggie became deeply depressed. I listened

and sat with her at the frightening precipice of darkness. It was the first time in her life that she was not alone there. I was interested in and heard all the parts of her, even those that felt shameful or “bad.” In getting to know them all, I introduced them to each other and through me, the various parts of Maggie came to know and accept each other. As she became whole, she was able to make fully informed decisions and acknowledge not just the previously disowned parts that drank, but also her self-love and ability to take care of herself. She was then able to take risks, live sober, and grow.

Maggie’s treatment illustrates a way of working with substance misusers based upon the principles of relational psychoanalysis and harm reduction psychotherapy. These two disciplines have brought the previously estranged fields of substance use treatment and psychoanalysis closer together as their underlying philosophies and tenets of treatment are similar. Both rely on a mutual collaboration between therapist and client and both aim to reduce harm and enhance growth. The focus in this kind of therapy is not on a substance or even specifically substance use, but on the full individual and that person’s ever-changing needs and desires. This comprehensive treatment facilitates a self-reflective capacity and the ability to make informed decisions about how to live. The goal is to nurture and support an integrated sense of self as a strong competent person who can withstand challenges and enjoy a full life.

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