



## Bringing the Pieces Together: Relational Psychoanalysis and Harm Reduction Therapy in Treatment with Substance Abusers

Debra Rothschild PhD

To cite this article: Debra Rothschild PhD (2007) Bringing the Pieces Together: Relational Psychoanalysis and Harm Reduction Therapy in Treatment with Substance Abusers, *Psychoanalytic Perspectives*, 5:1, 69-94, DOI: [10.1080/1551806X.2007.10473013](https://doi.org/10.1080/1551806X.2007.10473013)

To link to this article: <http://dx.doi.org/10.1080/1551806X.2007.10473013>



Published online: 14 Feb 2007.



Submit your article to this journal [↗](#)



Article views: 46



View related articles [↗](#)



Citing articles: 3 View citing articles [↗](#)

**BRINGING THE PIECES TOGETHER:  
RELATIONAL PSYCHOANALYSIS AND HARM  
REDUCTION THERAPY IN TREATMENT WITH  
SUBSTANCE ABUSERS**

*Debra Rothschild, PhD*

**Abstract**

For many years, there has been a rift between the fields of psychoanalysis and substance abuse treatment. Today, with the advent of a relational perspective in psychoanalysis and harm reduction therapy in addiction treatment, the two fields are coming together. This paper describes a relational psychoanalytic approach to treating addictions, defines harm reduction therapy, and elaborates how each can contribute to the other. Both harm reduction and relational psychoanalysis promote a context of mutuality and a collaboration between two fully functioning participants. With harm reduction as a background philosophy, relational psychoanalysis is ideally suited to the treatment of addictive disorders, especially in the ways relational analysts focus on process, self-states, and the use of transference, countertransference, and enactments. This paper elaborates the ways the analyst and patient can work together to recognize and integrate various dissociated self-states in the treatment.

“It’s not my field.” “I couldn’t do that.” “I have no expertise to offer.” “I’m sorry, I’m just not interested.” These are the responses of several renowned psychoanalysts who were asked to participate in a conference on psychoanalysis

---

Debra Rothschild, PhD, CASAC, is a psychoanalyst, substance abuse therapist, and supervisor in private practice in New York City. She is a graduate of the NYU Postdoctoral Program in Psychotherapy and Psychoanalysis.

and addiction in the spring of 2004. Some of those who refused were asked if they might suggest somebody else. Most could not. What is going on here? Have psychoanalysts so totally rejected the treatment of substance abuse that no one is even willing to speak about it? Is there any other diagnostic category so completely dismissed by our profession?

For some time now, psychoanalysis and substance abuse treatment have indeed resided in two entirely different and separate worlds. There appears to be a belief that psychoanalysis has little place in the treatment of addictions and likewise, that the study of addiction does not belong in the work of psychoanalysis. Yet, a rich and often compelling body of psychoanalytic literature on the topic of substance use and addiction exists (e.g., Burton, 2005; Director, 2002, 2005; Freud, 1897, 1929; Glover, 1932; Khantzian, 1985, 1990; Krystal & Raskin, 1970; McDougall, 1989, 1991; Rado, 1933; Weider & Kaplan, 1969; Wurmser, 1974, 1992). It is striking that such a small subset of analysts knows about this literature and so few are willing to treat people with addictions.

This rift has developed gradually for reasons inherent to both sides of the equation. In this paper I will elaborate the reasons I believe the schism grew, and describe what is happening today that is bringing these two fields back together. Recent developments in both psychoanalysis and substance abuse treatment are facilitating a convergence of the two in ways that specifically expand and benefit each.

In order to understand what is happening today, it is helpful to understand something of the history of substance abuse treatment and how the rift originally developed. Years ago, addiction was considered and treated as a moral failure. In response to that, a medical model developed that advocated the treatment of addiction as a disease rather than a weakness of character (Jellinek, 1960). That medical model flourished and was certainly an improvement over its judgmental predecessor. Many people were helped by it. However, it did not address the needs of all who abused substances. The belief that addiction was a disease that had to be treated as such fostered a culture that involved treating substance abusers with rules and a standard procedure, which the clinician set out and enforced. Many, therefore, who would not be convinced that they had a "disease" or were not willing or able to follow the rather rigid prescriptions for treatment (e.g., stop all use immediately and go to Alcoholics Anonymous [AA] meetings) dropped out and did not receive help. Sometimes clients who did not comply were asked to leave treatment, sometimes referred on to another professional and sometimes instructed, "Come back when you are ready to work." There were those who could not stop using at the outset of treatment and, frequently, they were asked to wait until they were ready, with the assumption that

if they “hit bottom” they might then be ready to stop. When substance abusers did enter treatment, they were instructed on what they needed to do to get well.

This method became increasingly accepted, as many of those who were helped by it went on to help others in the same way. It became standard and its standardization affected clinical practice. Some clinicians learned the techniques and successfully helped some addicted patients recover using them. However, many did not, and those who treated substance abusers without following the protocol were frequently labeled “enablers.” Not wanting to hurt their patients by enabling a disease to progress, but not wanting to work in that style, many psychoanalysts removed themselves from the process. I believe, therefore, that the proliferation of this medical disease model significantly contributed to the exclusion of mental health expertise and psychoanalytic practice from the treatment of substance abusers, as those who were not comfortable taking this stance increasingly refused to treat patients with substance use issues. Rather, they would refer to “specialists” who would take an educative and behavioral approach, teaching the patient exactly what to do to get well. For the purposes of this paper, I will refer to this disease model instructive approach as “traditional substance abuse treatment” or “substance abuse counseling.”

That, in brief, is the addiction treatment side of the equation. Trends in mental health practice, and particularly psychoanalysis, contributed to the schism as well. Historically, there was some question about whether psychoanalysis was appropriate for treating addictive disorders. Freud (1897) believed that all addictions were a substitute and replacement for the primary addiction—masturbation—and he doubted whether such an addiction was curable or if “analysis and therapy must stop short at this point.” Classical analysis was deemed appropriate primarily for neurotic patients and therefore not meant for those with conditions such as addiction (Yalisove, 1997). When addictions were treated, it was through modifications of the technique. Simmel (1929), for example, spoke of treating “victims of morbid cravings” at a sanatorium by providing those patients with transitory substitute gratifications such as allowing them to eat massive quantities of food, break dishes, or otherwise express aggression in the transference. Stone (1954) spoke of “widening the scope” of psychoanalysis to treat patients outside the neurotic range and he specified that this could include addicts. It appears, therefore, that throughout psychoanalytic history there has been some attention to the problem of addiction; however, classical psychoanalysis was not considered appropriate and therefore most analysts were not interested.

The disease model flourished, and many analysts refused to treat anyone who abused substances. Others found that people in their practices were substance-dependent, but they did not address the addiction. In the service of free association, these analysts would not introduce any subject not broached by the patient. We repeatedly hear stories told in AA about people who spent years on their analysts' couches talking about their childhoods or current-day miseries as addictions got worse but were never addressed. At that time, the twelve-step-based programs, including twenty-eight-day inpatient facilities and intensive outpatient group-based programs, were the most popular and, despite their limitations, probably the most successful treatments available. They addressed the substance use directly and took a stand for sobriety, offering concrete suggestions and lessons about how to attain it. It may be that some analysts recognized that their own methods were failing and, uncomfortable with doing anything else, they began referring their patients to such programs whenever substance abuse was revealed as an issue.

In sum, as twelve-step programs and diagnosis-specific rehabilitation facilities became the venue for addiction recovery and treatment, most mental health practitioners referred out of their practices and into those programs. Of those who sought help by these methods, many, but not all, were successfully helped. However, research found that *most* substance abusers did not enter self-help groups or substance-focused treatment at all, and those who did often entered late in the progression of their condition (Marlatt et al., 1997). More to the point, however, is that this practice resulted in mental health clinicians, and psychoanalysts in particular, believing that doing substance abuse treatment was not for them.

### **Harm Reduction Psychotherapy**

Today there is a new development in the substance abuse field. A harm reduction approach to treatment is becoming increasingly accepted. Harm reduction is literally that. It is a field of practice whose aim is to help individuals reduce the harm they are doing to themselves or others in any possible way. Even minor reductions in danger or harm or enhancement of health are considered successes with this approach. Harm reduction practice has many facets, including therapies, programs, and policies, some of which have been in use for years. The idea of reducing harm as a goal, a tenet of treatment, however, is new and the term "harm reduction" is only recently gaining acceptance in the United States. An example of this practice is the nicotine patch for cigarette addicts. Nicotine is still harmful, but much less so than inhaling the smoke. Nicotine patches have been in use

for some time, but only recently have they been recognized as a harm reduction approach. It is through this example that one can see that “harm reduction” does not in any way mean condoning continued harmful drug use as has sometimes been stipulated. Other examples of harm reduction in common use today include needle exchange, methadone maintenance, and moderating patterns of use. In this paper I will speak specifically about harm reduction psychotherapy—the facet of harm reduction that applies directly to psychoanalysis—and clinical treatment.

Harm reduction psychotherapy is a therapeutic approach taking as its basic tenet that any reduction in harm or risk to an individual is a good thing. Tatarsky (2002), quoting Marlatt et al., calls harm reduction psychotherapy “compassionate pragmatism.” Tatarsky goes on to say, “As a pragmatic approach, active substance use is accepted as a fact, and substance users are engaged where they are, not where the provider thinks they should be” (p. 21). Denning (2000) describes harm reduction therapy as based on the fundamental principle, “First, do no harm,” taken from the Hippocratic Oath. It is essential, she says, that the treatment do no more harm to the person than the drug use may, and that terminating a patient from treatment because he is using puts him at risk for further deterioration. Hasty diagnosis and unrealistic treatment planning can also result in harm. In harm reduction psychotherapy the goal is always to move the patient along the continuum from more harmful to less harmful behaviors, even if this happens in seemingly small steps, such as using clean needles to inject heroin or drinking alcohol only after the children have gone to bed.

Harm reduction psychotherapy is not so much a technique as it is an approach or a philosophy that underlies treatment. That philosophy is one of reducing harm and respecting the individual and his or her particular needs and desires. This could mean anything from addressing homelessness before drug use, helping a student not drink before finals, or supporting an executive’s decision to get sober. In the harm reduction psychotherapy approach, the focus is not on a particular substance, or even 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 these are fruit for discussion. Denning (2000) also states, “The result is a holistic treatment model . . . that is pragmatic, flexible, effective, and allows clinicians to treat addicts as people with problems, not as problem people” (p. 35).

In terms of actual substance use, *harm reduction does not in any way exclude abstinence as a viable goal of treatment*. In fact, abstinence is recognized as the ultimate reduction in harm. However, with this approach, and contrasting with the medical model above, abstinence is not the only

acceptable outcome of treatment. Moderation may be a goal and some people do successfully learn to drink or use a drug moderately. In some, moderation is a goal that does not work out and the goal is then revised to abstinence. Often, people who are not ready, or motivated, to abstain choose to attempt moderation at first. A frequent occurrence with this approach then, is that people find their way to an internally motivated goal of abstinence, not because it is what they have been told they should do, but because they have come to believe it when moderating use is just not working for them. Unfortunately, to this date, no research has been able to accurately predict who will successfully moderate and who will not. Therefore, unless there is immediate danger in continued drug use (e.g., an alcoholic with a bleeding ulcer or repeated cases of alcohol poisoning; a cocaine addict with serious nasal damage; a heroin addict with frequent history of overdose; or a parolee who will be sent back to prison), I will always support someone who wishes to attempt moderation. Very frequently, clients discover this is too difficult for them and one drink repeatedly leads to more or to other illicit drug use, or they cannot control their intake of a drug and they themselves decide to stop drinking or using.

An example of this can be seen in Maryanne, a thirty-two-year-old successful graphic designer and artist, whose social life revolves around her neighborhood bar. For many years, Maryanne drank socially in the bar, but gradually she began to drink more frequently and in progressively greater quantities. About three years ago, she was introduced to cocaine by some friends. At first, and for a long time, cocaine was secondary to alcohol for her, used only at times of drinking a lot and staying up late. Gradually, however, she began using regularly, about three times per week. Maryanne came to treatment wanting to drastically cut back on her cocaine use, if not stop it all together, and to learn to drink moderately again. In her ideal world, cocaine and alcohol use would be what she called "event driven." She imagined she would drink two to three drinks a few days a week, and that she might use cocaine two or three times a year at special celebratory events. She attempted a variety of plans to make this work and after six months in therapy could achieve some weeks cocaine-free and some incidents of moderate alcohol intake.

Maryanne was still getting drunk with more frequency than she was comfortable with and she had discovered that cocaine was not simply a reaction to getting drunk or someone else offering it to her, but that she actually craved it and pursued it on her own. This frightened and upset Maryanne greatly and it was this discovery, and her inability to consistently control her alcohol intake, that led her to suggest she needed to stop using completely. She has decided to supplement our therapy with an intensive

outpatient program, to attend AA meetings, and to tell her friends she no longer wishes to drink or do drugs. She still remains somewhat ambivalent, as this is a frightening step for her, especially given that it will entail leaving her primary social environment and she has difficulty being alone, this difficulty having led her to hang out in the bar in the first place. Maryanne is at the beginning of this process and she has a long way to go but she is very motivated, probably more than she would have been had she entered therapy and been told immediately that her original goals were impossible and she would have to get sober immediately or not be in treatment at all.

A defining factor of working in this harm reduction paradigm is that the clinician engages with clients in the setting of goals, helping clients to assess what they want and what they are ready to take on. Goals are then continually reassessed and modified as the treatment progresses. When reading the harm reduction literature (Denning, 2000; Marlatt, 1998; Tatarsky, 2002) what emerges as paramount is a respect for the individual, an engagement with the healthiest and strongest parts of that person, and a collaborative effort between clinician and client. At no time is a client discharged from treatment for not being “motivated enough” or for violating a plan or a goal. Rather, the implications of any choice or behavior are explored for that individual, with the goal of broadening understanding and increasing alternatives. With this approach it is generally recognized that as harmful as the substance may be, it is probably serving some function(s) for that person and it is as important to identify and articulate those functions as it is to discuss the harm that the drug use may cause.

### **Relational Psychoanalysis And Harm Reduction**

Recognition of substance use as serving a function is inherently a psychoanalytic idea. In fact, psychoanalysts have had much to offer to the field of substance abuse treatment and theory, but historically there has been a problem as well. During the time when “classical psychoanalysis” prevailed, the psyche of the patient was the primary focus of the treatment and the analyst was considered a neutral object of transference and interpreter of what the patient brought in. This approach did not work well for many patients whose substance abuse demanded a more active form of intervention.

Today, relational psychoanalysis has been applied successfully to work with substance abusing clients and, as will be described below, it is an approach that shares some notable tenets with harm reduction psychotherapy. I am using the term “relational” here to refer to the model described initially by Greenberg and Mitchell (1983) in their seminal book, *Object Relations in Psychoanalytic Theory*. Both Mitchell (1988) and Ghent



(1992) date the origin of relational psychoanalysis as a specific school of thought to this work. Each of them describes it as an approach that replaces the drive theory model with one that considers relations with others as fundamental to human development and life. There are a variety of relational theories, but they share a common vision that the “basic unit of study is not the individual as a separate entity whose desires clash with an external reality, but an interactional field within which the individual arises and struggles to make contact and articulate himself . . . The context of relatedness . . . defines meaning” (Ghent, 1992, p. 3).

Current-day psychoanalytic practice is becoming increasingly infused with relational thinking, and with that comes certain important changes in technique, which are effective with substance using patients. One example of this is the emphasis relational analysts place on working within enactments taking place between analyst and patient during the course of the work. Substance abusers in general tend to be action oriented, often without access to words. Reliance on interpretation of content, therefore, may not always work well. However, involvement with the dynamics of relationships, the processes of the moment, and the patient’s and analyst’s experience in the room can engage the patient in a way that can lead to understanding the dynamics and meaning of the action (e.g., drug use), and with that, can facilitate change (for an expanded discussion and elaboration of this aspect of relational treatment of addictions, see Director, 2002).

Relational psychoanalysis and harm reduction psychotherapy bring the two fields together. From the relational perspective, the real, live person of the analyst is acknowledged to be in interaction with the patient and the relationship between them is the context for growth. A two-person psychology in which both patient and analyst are recognized as fully experiencing and acting human beings together is compatible with a harm reduction approach. In other words, although there were tremendous differences between the substance abuse counseling approach, which dictated what the client should do and the classical analytic approach in which the analyst was more neutral and abstaining, they were similar in that, in both methods, the clinician was set up as the expert and might have been seen as a rather distant authority figure. It seems that the substance abuse field is moving toward harm reduction at the same time the analytic world is moving toward relationalism, both of which promote a context of mutuality and a collaboration between two fully functioning participants. In short, the advent of relational psychoanalysis and the growing acceptance of harm reduction have revolutionized each of these fields respectively, and are remarkably congruent in their philosophies and approaches to treatment.

I will now elaborate a psychoanalytic perspective and particularly a relational approach to substance abuse treatment, and will begin with a brief historical review. Although psychoanalysts from Freud on wrote about addiction, the analyst whose work most revolutionized analytic thinking about it was Glover. Glover, in 1932, was the first to conceptualize substance use as a progressive, rather than purely regressive, phenomenon. He described drug taking as an attempt at adaptation by the user and said specifically, "Drug addiction is frequently a successful manoeuvre" (p. 26). A perspective that recognizes substance use as something that may feel necessary or helpful in some way and may be facilitating some psychic function continues today. In 1985, Khantzian developed the "self-medication hypothesis" of addictive disorders, saying that the "drug of choice that individuals come upon is not a random phenomenon," but "the specific psychotropic effects of these drugs interact with psychiatric disturbances and painful affect states to make them compelling in susceptible individuals" (p. 1259). A few years later, Khantzian (1990) presented a formulation in which drug use was seen as the user's attempt to adapt to certain areas of vulnerability, including the ego functions and self structures responsible for maintaining and regulating self esteem, self care, interpersonal relations, and tolerating and managing affect. Similarly, Wurmser (1974, 1992) spoke of the relationship between intrapsychic distress and substance abuse. His emphasis was primarily on narcissistic disturbance and the related issues of shame and superego control. More recently, Director (2002) spoke of uncovering the meaning of drug use for the individual through the treatment process. "The aim of therapeutic action," she said, "would be to track, and deconstruct, the symptom from its extrapsychic form, concretized in drug use, to its intrapsychic life in the patient's object relations" (p. 555). Consistent throughout these writings is the notion that drug use has meaning and purpose and these are to be explored in the treatment.

In previous papers (1995, 1998), I have spoken about the importance of investigating the positive aspects of drug taking at the beginning of any treatment with a substance abuser. Asking questions about the first and later experiences with the drug of choice, what benefits the user believes the drug has for him/her, and what they imagine life would be like without it yields a lot of information, allows patients to begin to understand and articulate some things about their use, and initiates a process of self-reflection, while communicating an understanding that the use is not simply a hedonistic indulgence.

Understanding and explicitly discussing the notion that substance use is not something to quickly and unquestioningly be done away with may

help to engage a patient and begin to establish some trust. Equally, if not more important, however, is the expression of interest in the patient's perceptions and experiences and the invitation to self-reflect. This is one of the clearest differences between a relational psychoanalytic approach to substance abuse treatment and traditional treatment of addictions. In the psychoanalytic approach, it is the process and not just the content of sessions that is mutative. In traditional treatment, the goal is to teach tools for sobriety. In relational psychoanalysis, the goal is to begin a process of growth that includes re-finding and integrating parts of the self that have been dissociated or lost either due to the nature of substance addiction or to the trauma(s) that may have led to it in the first place. One of the first steps in this process (and possibly a defining characteristic of psychoanalysis in general) is getting the patient to be curious about his/her own mind. Following is an example that demonstrates how a process-oriented psychoanalysis differs from the traditional medical model with its emphasis on content.

A supervisee reported a session in which her client told her that instead of sending out job applications as he had planned to do, and which they had spent much time preparing him for, he had gotten high and then not done it. He felt terrible about this and about his failure to apply for the jobs he had talked about wanting so much. In a kind and supportive way, she sympathized, did not chastise or shame him, and said something like, "Well, maybe you can just make sure to remember this and how you feel now. Next time you evaluate the pros and cons of using your drug, you may remember this incident. Also, we are trying to teach you to think it through before you pick up, and this may help. When you think it through you'll remember that once high, you don't get to do the things you plan on doing and then may feel really bad about that and regret it." This response was not "wrong;" it was probably even helpful. But, it was clearly a substance-focused response. A psychoanalytic response would go something like this: An expression of sympathy for the pain he is in, an offer of support, and then a question, such as what do you think happened? Exploration of when the urge to get high came on and what had happened leading up to it would follow. Perhaps something irrelevant to the job applications, such as a troubling conversation or an argument or something painful, had occurred and the applications were just innocent bystanders. Or perhaps the client was more afraid of the application process than he had realized. Is he afraid of rejection? The shame of failure if he does not get a job? Or maybe he is more afraid of actually getting a job and returning to work than he had been willing to admit to himself or anyone else. This kind of mutual exploration will frequently lead to a recognition on the part of the client

of some feeling or part of him- or herself that had not been conscious before. Often, especially with people who habitually use drugs, unsymbolized emotions go unnoticed, unarticulated, directly from gut to action, e.g., substance use, without stopping in brain. Putting it into language gets it to stop in the mind where decisions can be made about actions. The client then no longer finds himself getting high, but can consciously decide to do it or not.

Obviously, this intervention would address the person and what was going on in his life, not just the use of the drug. Also important, however, is that it would actively engage him in the process, ask him to self-reflect and imply an expectation of his ability to participate and to think about himself and his actions. It would not treat him as a passive recipient of a lesson or service. This is also consistent with harm reduction psychotherapy, which emphasizes engagement with the healthiest and strongest parts of the patient and facilitating the capacity to make choices for him- or herself whenever possible. In harm reduction psychotherapy the clinician and client are partners in exploration and decisions are arrived at mutually. Also, as described above, in harm reduction psychotherapy, clients are related to as individuals with problems, one of which may be their use of a substance, not simply as substance using individuals. The analytic, exploratory response addresses the whole person; the substance-related response addresses only the use of the drug.

When working with substance abusers in a harm reduction paradigm the traditional “tools for sobriety” are always also included. Techniques that are frequently thought of as more behavioral than analytic, such as identifying triggers, thinking through the consequences of using, or calling a sponsor or friend when urges occur, are frequently a part of the treatment. In addition, clients are often encouraged to participate in other modalities like educational groups, psychotherapy groups, and family therapy, as well as twelve-step programs such as Alcoholics Anonymous, or other support groups like rational recovery or moderation management groups. The treatment is different from most traditional psychoanalytic therapies in this way, and it is important that clinicians who do substance abuse treatment are familiar with the techniques, the resources available, and the implications of using and withdrawing from various drugs. Following is an example of a treatment that integrated several modalities.

Sam was a married professional man in his late thirties with two children. He had been drinking heavily since mid-adolescence. Sam entered treatment due to his wife’s mounting anger and the fact that his twelve-year-old daughter had recently stated, “I hate beer.” He was unsure that he wanted to stop drinking, but convinced that he was ready to cut down. For

several months, Sam made efforts to drink less and in fact was successful in changing his pattern from drinking before he got home every night to drinking only after his children had gone to sleep. As a result of this change, he was able to have dinner with his family, help with homework, and put his children to bed. Several times however, he binged and missed work, and gradually his drinking escalated again. After a few cycles of this, Sam decided he needed to stop drinking completely. He was resistant to joining AA, but with my encouragement he decided to give it a chance and after trying several meetings in which he did not feel comfortable, he found some that were more to his liking and began to make friends. He was unable to be consistent, however, and even when he did go he would frequently stop at his local bar on the way home. His pattern became: go to the meeting, then get drunk. Eventually, Sam and I realized that he needed more structured support and I made a referral to an intensive outpatient program. Sam continued in individual treatment while attending the program five mornings a week for three months. Following that, he spent six months in a twice-weekly aftercare group. With the additional support, the motivation he had developed, and increased self-knowledge from our ongoing therapy, Sam stopped drinking. He has now been sober for over a year.

During our sessions, some time was spent tracking Sam's drinking and attempts to get sober and discussing his experiences in his outpatient program; however, much of our effort was spent exploring the meaning of drinking for him. It became clear that, for Sam, drinking was the only way he had found to express his individuality or independence. This was based both on his history as well as the dynamics of his marriage, which clearly replicated some of his early familial relationships.

Sam grew up in a rather repressive, small-town environment where he, a smart, artistic young man, was seen as deviant and "different." He quickly developed an identity as a troublemaker and rebel, taking cynical pride in his difference. Simultaneously, under the tutelage of a rather abusive father, he came to experience himself as a victim who could not do right and would be disliked regardless of his actions. Not only did this emerge in the content of our sessions, but also at times in his behavior toward me (e.g., baiting me, making sexist comments, generally showing what a "bad boy" he could be). At the same time, it was important to Sam that his intelligence and artistic nature were appreciated and he made sure to demonstrate that side of himself in stories he told and in most of his interactions with me. Together, we came to recognize that for Sam, drinking beer was a road to liberation, an identification with his working-class background, a disidentification with Dad (who never drank beer), a way of being tough—tough

enough to stand up to his father and peers—and a means of escape from his pain. His “bad boy” image held both positive and negative valences for him and was an integral part of his commitment to drinking. For Sam, getting drunk was a way of expressing his multiple identities as rebel, bad boy, and artist. It was also the only way he knew to escape the oppressive burden he felt to be a good citizen, husband, and father, who would be fully responsible and busily constructive at all times. We spent quite a bit of time discussing the symbolic and practical aspects of this. Sam realized he needed to develop ways of taking time out for himself that did not involve drinking. For example, he had to learn to be able to relax at home without feeling guilty that he was not doing chores in the house. In addition, the sober Sam had to find ways to accept and give life to those spirited, “bad boy” parts of himself he feared losing without drinking.

Bromberg (1998) states that a patient progresses as he moves to the point where all of his states of mind are explored in detail and that it is helpful for an analyst to appreciate that no one self-state is more important than another. My acceptance of the various parts of Sam that drank (the rebel, the bad boy, the frightened, victimized child) and the parts of him that wished to get sober (the responsible father, the artist, the smart kid with potential) and my ability to hold them all and relate to them at various times has created a space for Sam to build a coherent sense of himself. This has taken some time, and at this writing the work continues, but these shifts can be seen in Sam’s new friendships, many of which come from AA, and in some new ways he has found to interact with his wife and other family members.

In this process, Sam made his own choices about trying to moderate his drinking when he first entered treatment and then, after a time, to get sober. In the harm reduction model, the client has a fundamental choice to make of whether or not to use drugs and, if so, how much and how often to use them. An exploration of the experience of using the drug and what the client sees as the benefits and disadvantages of using facilitates this decision. It is equally important to explore both the positive and negative consequences of using and to encourage the client to articulate and expand upon each in a way that is very personal, and results in a verbal articulation of the ambivalence and conflict around using, or at least the beginning of a recognition that there might be such a conflict. Usually the patient will shift from one state (that of supporting sobriety) to the other (that of wanting to use) and the analyst is in a position to hear and hold both. This places the analyst in a non-adversarial position and allows for recognition of and empathy with the multiple aspects of the patient’s self. And again, it engages the patient in an active process of self-reflection and interaction with the clinician.

Virtually every addicted patient I have encountered has been ambivalent about using or about using in the way that they do. This kind of ambivalence is psychologically uncomfortable and can be difficult to tolerate. It is frequently defended against, often with splitting or dissociation. That is to say, one side or the other, the fear and the wish to keep using, or the desire to stop or cut back, may be dissociated at any one time. The conflict is unconscious; ambivalence not held in awareness. Some people vacillate back and forth; others hold one side conscious most of the time. The experience of conflict, that uncomfortable awareness of feeling both positions at the same time, is avoided. A therapist who fails to address both aspects ignores this dissociation and colludes with the defensive split while risking collusion with a projection that many patients engage in. A common defense of anyone who has difficulty maintaining ambivalence is to project one side of it onto another person, in this case the therapist. The therapist colludes with and invites the projection of the "wanting to stop" side when articulating only the negative aspects of using. This allows the patient to remain consciously conflict-free and able to feel clearer about wanting to use. It sets up the patient and therapist as adversaries where the therapist holds one side of the conflict and the patient the other when, in fact, both states of mind belong inside the patient.

Allowing patients to deny the negative consequences of drug misuse colludes with the split, but so does allowing for a ready willingness to stop using and an acknowledgment only of the negative impact it has. Frequently, we encounter patients who come in saying they are totally ready to quit using their drug or to modify their use. They are sick and tired of being sick and tired, the drug is ruining their life and they are ready to stop. For someone who has become dependent, relinquishing the object of dependence cannot be easy and to quickly agree to do that is a betrayal of the part of the self that benefits from or seeks refuge in the using. So, again, if we readily go along with this resolve without exploring what will be lost, we are colluding with the split. One of the goals of this type of treatment is to allow space for all aspects of the self to be recognized, known, and considered. It is an essential aspect of the treatment of substance abuse when this type of approach is taken.

Many addicted people suffer from the kind of traumatic histories that lead to a dissociative structure. Being addicted itself is traumatic, and dissociation is often enlisted as a defense against this trauma as well. A goal of treatment is to lessen the need for this defense and facilitate a loosening of the dissociative barriers. As Bromberg (1996) puts it, "[H]ealth is the ability to stand in the spaces between realities without losing any of them—the capacity to feel like one self while being many" (p. 274). In

other words, it is the ability to maintain a feeling of unity without losing awareness of the multiplicity of selves that comprise us all. Experiencing trauma interferes with this capacity. To quote Bromberg further, "When the illusion of unity is too dangerous to be maintained, there is a return to the simplicity of dissociation as a proactive, defensive response to the potential repetition of trauma" (p. 273).

Dissociation as a defense protects the individual from experiencing overwhelming conflict or from confronting painful or traumatic truths, memories or aspects of self. Substance use, with its high/not high dichotomy and the quick and absolute alterations of mood and mind, is inherently a dissociative experience. Also, rigid patterns and addictive behaviors like compulsive substance abuse can help maintain the dissociative defense. As Goldberg (1995) says, "stable dissociation is best maintained by compulsive regimes . . . . It is only when this regime is relaxed that symptomatic distress occurs" (p. 499).

Goldberg (1995), like others, recognizes that cessation of the addiction will result in distress. Like most psychotherapies, treatment of addictions involves acknowledging and abandoning defenses that have worked in some ways even if they have ultimately proved inhibiting or harmful. For those patients who have been traumatized in the past, a treatment that results in confronting that trauma can be experienced as a reenactment of it, often with the therapist in the role of perpetrator or abuser, as we encourage abandonment of the defense and emotional as well as intellectual acknowledgment of what has been defended against. Putting words to the experience, acknowledging the traumatic nature of the therapy itself, can be a way of managing the enactment that can provide a new and healing experience for our patient. And, of course, being clear from the beginning that any resolve to surrender the addictive defense originates from the client, and is not simply to comply with demands, minimizing the impact of the therapist being experienced as abuser.

Not only does the treatment entail abandonment of a defense, but often it entails abandonment of an identity, a way of being and perceiving oneself. For many addicted individuals, substance use has narrowed their actual lives or their sense of themselves to the extent that they cannot imagine who or what they would be without it. Society certainly reinforces this with its stereotypes and stigmatization, making it easy for those who have lost or never had a coherent self-concept to adopt a persona, a role they can play. Giving this up can be terrifying if it feels there is nothing else, or no one else to be. Bromberg (1993) refers to this dilemma when he says, "A person may feel himself so psychologically incapacitated and at risk in the world of people, that it is indeed similar to living alone in a



burning building from which one needs to be rescued. But *that* particular burning building is the only one that exists as a self, and one's individual selfhood, no matter how painful or unadaptive, must be protected at all cost" (p. 2).

Patients who are not ready to give up a substance that is obviously wreaking havoc in their lives may be holding on to the only identity, the only "home" that they know. Without it, they will be lost. Patients have spoken about this over and over again. A heroin addict described, "I know where I live. I know what I do. I just don't know who I am." Another said, "I am afraid to find out what's inside because what if there's nothing inside?" To some extent, the format of the twelve-step programs can unwittingly reinforce this idea, with the introduction, "I'm Mary and I'm an alcoholic," although they also supply a new possibility that specifically responds to this need by offering a world of recovery that the person may join. Nevertheless, when I run early sobriety groups and people introduce themselves to each other I work hard to encourage them to talk about the other aspects of their life and identity as well as their addiction. When someone says, "I'm John and I'm a cocaine addict," I will often say something like, "Yes we are here to talk about that, but aren't you also a carpenter/doctor/teacher, a father, a husband, a friend . . ."

As in traditional treatment, in harm reduction psychotherapy the substance use is always a topic for discussion and specific techniques for meeting goals will be taught (e.g., techniques and cognitive interventions such as those described in clinical examples in this paper). However, the therapy is about the whole person, with the substance use seen in that context having meaning that is to be understood. It is much more similar to general psychotherapy, and specifically to psychoanalysis, than to traditional treatment, especially in this regard. Rebuilding a coherent sense of self that includes the parts that have been split off or abandoned is a basic part of the process of treatment and is recognized as essential to attaining and maintaining sobriety or modified use. Burton (2005), describing a relational psychoanalytic approach, speaks to this when she says that addictive behaviors are embedded in particular self-states, and that therapeutic interventions must contact these states directly.

Rebecca, a 20-year-old college student, used cocaine and marijuana regularly. Rebecca came into treatment to try to cut back on her drug use, especially cocaine, after discovering that she had an infected "crater" in her left nostril. About three months into treatment she was using cocaine only occasionally rather than several times a week and much less each time. She had obtained some cocaine for a party and had some left over at home. Rebecca clearly stated her wish not to use the rest, and with my support,

made plans to dispose of it that night. She seemed firmly set on her plan and ready to end our discussion of it. I had happily gone along with the planning and wished desperately to be hopeful with her. Yet, I was uncomfortable. There was a nagging voice in me that I wanted to ignore, saying, "this is too easy." Wishing I didn't have to, I asked Rebecca, "And what is the other little voice in your head saying right now?" At that point, she paused, looked rather startled, and stared at me in double-take fashion. She said, "I'm not going to do it," and proceeded to wonder at her capacity to lie to herself. She said, "I can understand lying to other people, but I never realized I could lie to myself. What would be the point of that lie?" As she and I talked it through and explored what she had experienced in the recognition of her "lie," Rebecca began to recognize the extent of her ambivalence and the dissociative process that protected her from it. The self-state present when talking to me about her desire to discard the cocaine was completely alienated from, and unaware of, the part of herself that would emerge at home when confronted with the available drug. Addressing only the aspect of Rebecca present with me at that time would have done nothing to reach the part of her that wanted to use the cocaine. It was only in response to my question that she became aware of both those parts of herself and through our work that she could bring them into negotiation with each other. Becoming simultaneously conscious of both sides of her conflict enabled Rebecca to make a conscious decision about what to do with the cocaine at home. No longer would she "find herself" taking the drug. Now the part of herself that wanted to get sober was prepared for the part of herself that wanted to use emerging once she saw the cocaine. The internal negotiation is analytic; the open talk about drug use and whether or not to continue it is harm reduction. They work together to form a unified, comprehensive treatment of Rebecca the person, Rebecca the user.

I referred earlier to substance use as something that can support fragmentation or dissociation. Many people describe themselves when high as "different" from the way they usually think of themselves, whether it be in becoming more emotional, less emotional, more social, more withdrawn, more confident, happier, calmer, whatever. Some describe their high selves as "not me," while others say, it is the "true me." Some simply see their use as completely split off from the rest of their lives, like the highly successful corporate executive who came to treatment for cocaine and sex addiction. Long after the cocaine use had stopped and this man was actively involved in AA, he continued to act out sexually, to have rather marginal, nontraditional friends and to rebel in any small way that he could. He called himself a "vampire," functional but dead during the day and alive but destructive at night. It became important to acknowledge that both the

day life and the night life and the feelings and experiences engendered by each were important aspects to the totality of this individual. It was only with the recognition that recovery would not require the vampire part of himself to die off that he was able to give up some of the more self-destructive behaviors without threat to his sense of identity or being alive. A small example of this was his refusal to wear the required tie at his job. He felt it represented too much of a succumbing to convention. As he felt more secure with the rebel, non-conformist parts of himself, he no longer needed to make his statement that way and he was able to stop risking his job by refusing to meet the dress code.

Frequently, substance users who present for treatment expect that the road to health is to “kill off” the part of themselves that use, the part that parties, or in the case of the patient above, the vampire self. I am reminded of my work with patients who have full Dissociative Identity Disorder (DID), those we used to call “multiple personalities.” In patients with DID, each part has a specific function, yet there is always a risk of treatment being sabotaged by a part of the self that is afraid successful treatment would mean the end of her or his existence in the system, meaning that that function would no longer be necessary, viable, or acceptable. A goal then, is for the patient to come to understand that the choice is not one of an isolated function/self or nothing, but that the purpose that activity, structure or part is serving can be negotiated amongst all the parts of the self and eventually integrated in a less destructive way into the system. Steps toward this goal include internal communication so that all parts can become aware of each other and what functions they serve, and getting the parts that are frightened or angry to come out and talk so that the therapist and patient can learn who they are and what it is that they do. “Nobody has to die” (meaning no part or personality has to die) has actually become a mantra of some of these treatments. Once convinced that no part will be considered unnecessary, the hidden part will emerge and negotiation becomes possible. Ways are found to keep that part alive and to keep the function fulfilled while modifying the destructiveness of the behavior when necessary.

Similarly, when people who are addicted enter treatment, the “addicted self” may feel literally threatened with death. We must find ways of inviting all parts of the self to speak and to reassure them, like with the patients with DID, that nobody has to “die.” It is through the development of a coherent sense of wholeness that includes all parts of the self that an ability to function in the world and to trust in one’s own ability to tolerate emotion and stress can develop. For those who have relied on a substance to fortify their own internal resources, this development is crucial.

## Transference Countertransference Issues

At this point, there must be at least some readers thinking, “Yeah, all this is great, but meanwhile her patients are killing themselves with dangerous drugs. The building is burning and she wants to help them build a new one before they get out—well, people die when buildings burn down.” Substance abuse is dangerous and at times creates crises and emergencies that must be handled with action, and immediate action at that. In this way, the treatment is not at all like most others. Like with other life-threatening behaviors, it can be scary to do. There are judgment calls to be made all the time and sometimes we must act in ways that feel counter to our training. If somebody is mandated to treatment, we must report; if we believe that someone is truly in danger, we must intervene. We each have our own limits of tolerance. Clinicians have varying abilities to tolerate suicidality, self-cutting, sadomasochistic behaviors, and also dangerous substance abuse. This is one of the transference-countertransference paradigms that can pervade a substance abuse treatment. The therapist is afraid of the risks and the client can hold us hostage with that. Despite our best intentions, we end up engaging in a power struggle that probably repeats a familiar dynamic entrenched in the life of our patient and very possibly in the clinician’s as well.

There was a moment in my treatment with Sam described above in which I met my limits of tolerance for accepting what felt to me like unsafe and unacceptable behavior. It came during the period in which Sam had revised his pattern of drinking to begin only after he had had dinner with his family, done homework, and put his children to bed. His wife was going away for the weekend and Sam would be alone with the kids. I asked if he was planning to drink and he said only after they were asleep. I felt massively uncomfortable and, I must admit, disappointed in Sam. I had imagined he was becoming more responsible. I wanted to tell him he could not do that, but struggled, as simply saying “you cannot drink” felt counter to everything we had worked on in terms of his making his own choices and being respected as an adult and not a naughty child. It felt like if I said that, then just as his wife was going away I would be filling her position as the nagging woman who sets limits for him. In addition, it was clear that I had no real leverage with which to enforce these demands. I was not willing to threaten to stop treating him if he drank while watching his children, yet I knew I could not stand by and let that happen. That would be too scary for me. Finally, I said to Sam, “Getting drunk when you are the only responsible adult is not okay, even when the kids are asleep. What if somebody wakes up to get water and slips and falls, through no fault of yours. Do you drive her to the emergency room drunk? What do you think will happen if

you show up with an injured child and alcohol on your breath? Less dramatic, what if a child has a nightmare and needs comfort?" I continued, "You may choose to drink this weekend, but if you do, you must get a designated caretaker. It would be like a designated driver, the person who stays sober and responsible while others drink." Sam decided that he could not ask someone else to watch his children while he got drunk and he stayed sober that weekend. I had found a tactic that communicated to him the seriousness of his decision, how strongly I felt about it, and yet left him in control of his ultimate choice. A difficult and often painful aspect of doing this work is seeing patients do self-destructive things, or worse yet, putting others in danger. We do what we can to intervene, but ultimately we cannot control what they do and it can be frightening and upsetting to watch or to wonder what is happening over a weekend or a night when we are not with them.

The specific dyad of each patient and therapist will, of course, generate its own dynamics, its own transference and countertransference patterns, its own enactments, and its own interactions, all of which will shift continuously over time. It is risky, therefore, to speak about it as if the people involved were all uniform with each other and static over time. Nevertheless, there are certain fairly common phenomena that I find to be particularly poignant or particularly interesting in work with substance abusing clients that may be worth mentioning here.

One is the issue of envy. Harris (1997) writes about envy in psychoanalysis, and she speaks of envy going both ways between therapist and patient. This can be applied to addiction treatment in subtle and not-so-subtle ways. Particularly with this kind of treatment, there is often an implicit understanding, frequently agreed to by both, that the therapist is "good" and the addict-patient is "bad." The therapist is the role model leading the presumably fulfilling, functional life the patient could lead if only she or he would stop using drugs. Recently, an alcohol-abusing young man described the ideal white-picket-fence life he so desperately wished for, concluding, "I'm sure you and your husband have that." Another patient, a heroin-addicted professional, refers continuously to the stable life she believes I must be leading, with the notion that she too could have that if only she could stop being so bafflingly self-destructive in her choices. Neither of these patients is able to acknowledge directly the envy they feel of my perceived perfect life or the hostility that might engender. For the man, it reveals itself most closely in a projected reversal in which he believes I must disdain him and behaves in ways sometimes even designed to bring this about. The heroin-addicted young woman denies any anger or hostility at all and continues to idealize me as the role model she needs.

Envy can also arise from therapist to patient, also often denied or disguised. I believe that the impatience and anger therapists often feel in the face of their clients' continued use or relapses are primarily, of course, due to concern and fears for the patient, a sense of impotence, and many other factors, but also at times to a sense of envy they may feel of the patient's capacity for abandon or intensity that the drug experience may bring. Selzer (1957) referred to the hostility a therapist might feel due to unconscious envy of the hedonistic aspects of an alcoholic's behavior. A clinician may also feel hostility or envy at the notion that the patient can "get away with it" and the therapist can't. I am not suggesting here that they really "get away with it," or that the therapist would really want to be in their shoes. Both know that substance use is not a solution that works. However, disgust or disdain felt for a client who is using is sometimes based on envy of that client's ability or willingness to abandon control, to medicate pain, to indulge a felt need. Whether or not the therapist drinks or uses drugs recreationally at times, he or she probably does not give in or give up at moments of depression or despair or when responsibility is called for. The envy, then, goes something like this, "I suffer through my pain, why shouldn't you suffer through yours?" Again, this is not usually conscious, or if it is, it may be fleeting, compounded with many other feelings and thoughts, primarily the rational one that the patient is in fact suffering pain. When present, however, because it is irrational and not usually conscious, it can contribute to a subtle hostility, unspoken but palpable, or to the "moral superiority" attributed to the therapist by collusion of both.

I have found myself particularly vulnerable to this feeling when patients begin to speak with awareness about using drugs to self-medicate discomfort. When the use is automatic, with motivation unconscious, remorse overwhelming, and a sense of mystification about how it all happened, I usually feel sympathetic and can step in and help analyze. When I find myself feeling irritated with a patient's continued drug use, I have learned that it frequently means we are entering a different stage of the treatment where substance use and emotional regulation are beginning to be connected and, in fact, the moment of choosing to use can become increasingly conscious, a significant step toward abstinence or control.

Many of the addicted patients I have worked with present themselves as worthy only of contempt or of punishment for their acts. An alcoholic woman used to continuously tell me how manipulative and "bad" she could be. When it seemed we were beginning to establish an alliance she routinely missed a session, usually without calling. She told me I must enforce rules and there should be consequences for her actions. She, like many others, is more comfortable with me as an authority figure—one she can rebel against

and provoke—rather than risking a potentially disappointing collaboration. Wurmser (1992) relates this to the trauma he finds in the backgrounds of so many who are addicted. He says criticism, retaliation, and punishment are often invited and, all too often, the invitation is accepted. Substance abusers often provoke, and then accept, scorn, hatred, and anger. For those who have been traumatized, he says, this is a far safer position than the risking of trust or expectation of acceptance, understanding, or respect. And, I would add, for those whose substance use has narrowed their relational world, risking a relationship at all can be an alien and extremely threatening idea.

Tim, the man referred to above who believes my life must be perfect and that I disdain him, can be highly provocative and also is easily provoked into a rage. When I moved my office from one place to another, this man spent months pacing my office, screaming that I should rent another space more convenient for him, relationships were about compromise, and if I cared about him at all I would provide a location he could easily get to. If I wouldn't rent office space at least one day a week convenient for him, he wanted a referral to somebody new. I tried to address his feelings and talk about it in a variety of ways to no avail. At times I despaired of making any headway, and I eventually found myself spending hours trying to find somebody nearer my old office who would take the referral. I offered referrals and he rejected each one, yet continued to rant. I finally realized he didn't want to leave me. He felt rejected by my move for a number of reasons and my cooperating in his request to find someone new compounded the rejection he felt.

When Tim was 13 years old, his parents—an abusive father and an anxious, narcissistic mother—informed him that they would be moving. Tim was devastated and enraged. They had not consulted him nor involved him in the process of choosing a new home at all. He never made friends in his new neighborhood, was teased and rejected in school, and Tim numbered this move as one of the many traumas of his life. Once I was able to make this connection, to accept his anger, and to allow the rejected child part of him to be heard, he began to calm down. He was able to speak about how he had allowed himself to become attached to me and wanted to stay along with the intense betrayal he felt when the person he was beginning to trust (me) sprung a move upon him just as his parents had done. For many reasons, he did not want to leave (not least of which was that he had begun to drink appropriately and moderately, which he has maintained for almost three years now), but it was only after the raging, childlike part of him could be heard that the adult aspect that wanted to keep working could speak. It was important that I held them both, not negating one while communicating with the other, but bringing them into acknowledgment of and negotiation with each other, that we were able to work through this.

Note, also, that this exchange made no specific reference to Tim's substance abuse. In this method, the whole person is addressed, and treatment often looks like any other analytic treatment. However, it is never forgotten, and when the patient is actively using, we check in about it regularly regardless of what else we are talking about.

Drug use often provides a sense of identity and community, one in which users can feel acceptance and belonging. In this sense, it can be a relational phenomenon and one that must be respectfully considered when working with someone to change or give up their use. However, in a deeper sense, drug use is a specifically non-relational solution to psychic discomfort, vulnerability, or distress. A drug is an inanimate object; it does not have a mind or a subjectivity of its own. Non-recreational drug use, therefore, can be seen as a non-relational act, although it will often contain a host of fantasized object relations. Those who use drugs often use them in lieu of what personal relationships can provide. Krystal (1988), McDougall (1991), and others have referred to drugs as transitional objects or substitutes for human caretakers and soothing. Krystal, quoting Glover (1931), describes patients who give up their substance until the "last drop." They hold tenaciously to this last drop, he explains, because "it contains the symbolic expression of the fantasy of taking in the love object" (p. 114). Here Krystal is referring particularly to the love object's functions including physical care, soothing, and conscience. He speaks of people who are addicted as being unable to own parts of themselves, including those that perform those functions which should be originally provided by parenting others,<sup>1</sup> saying that "the kind of person who is likely to become drug dependent is one who uses the drug to help him carry out basic survival functions that he otherwise cannot perform" (p. 129). Understood in this way, drugs are a substitute for loving others and the functions they serve. It is in the transference-countertransference matrix, in the therapeutic relationship with a real, live other that those functions can be (re)found in the self and the capacity to self-soothe can begin to develop.

## Conclusion

Traditional substance abuse treatment, like classical analysis, is primarily a one-person model. A significant aspect of harm reduction psychotherapy as it is described here is that it is specifically relational and is in that way

---

<sup>1</sup>Krystal's description can be seen as analogous to the self-state model described in this paper. What he calls the "unowned parts of the self" might in this context be referred to as dissociated aspects of self.



consistent with the principles of 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. Through the vicissitudes of the relationship a sense of self can begin to cohere. To quote Bromberg (2003):

What holds it all together—the piece of the mystery upon which self-state coherence and continuity of ‘I-ness’ most depend—is *human relatedness* . . . when the therapist . . . is able to relate to each aspect of the patient's self through it's own subjectivity, each part of the self becomes increasingly able to coexist with the rest, and in that sense is linked to the others. It is a sense of cohesiveness, coherence, and continuity that comes about through human relatedness. (p. 704)

Relational psychoanalysis has much to contribute to substance abuse treatment, especially with a harm reduction approach. Harm reduction therapy is inherently relational in that the whole person, including the parts of the person that use, is acknowledged and engaged in the treatment. With harm reduction as a philosophy, a relational psychoanalytic treatment of addictions is not only possible, it is also an extremely promising approach. In this way of working, what is curative is not merely the content of each session but rather the relationship itself and all the vicissitudes of it. It is the engagement of two real people and the interactions and negotiations between them that can lead to a broadening of the addicted client's self-perception and way of being in the world. Ultimately, it is this growth that facilitates a newfound security and strength to attempt to live without dependence on substances, motivated from within and with full awareness of the struggles to come. In this approach, the goal is to form a relationship with the whole person, acknowledging the sense of helplessness and incompetence that may exist along with recognizing competence and strength. The client is treated as a full, complex person, not merely one who abuses a substance, and for this to happen, the therapist must be fully human as well and as conscious as possible of what he or she brings to the relationship and what is evoked. In this context of open, respectful relating, a space can be opened that cannot exist in either a relationship with an inanimate substance or with an authoritarian expert. Here the addicted patient can have an experience of self that is ever-expanding and that includes a full range of needs, desires, wishes, thoughts, and emotions that can be expressed and heard.

## REFERENCES

- Bromberg, P. (1993). Shadow and substance: A relational perspective on clinical process. *Psychoanalytic Psychology*, 10, 147–168.
- Bromberg, P. (1996). Standing in the spaces: The multiplicity of the self and the psychoanalytic relationship. In: *Standing in the Spaces: Essays on Clinical Process, Trauma and Dissociation*. Hillsdale, NJ: Analytic Press, 1998, 267–290.
- Bromberg, P. (1998). Staying the same while changing: Reflections on clinical judgment. *Psychoanalytic Dialogues*, 8, 225–236.
- Bromberg, P. (2003). On being one's dream: Some reflections on Robert Bosnak's "embodied imagination." *Contemporary Psychoanalysis*, 39, 697–710.
- Burton, N. (2005). Finding the lost girls: Multiplicity and dissociation in the treatment of addictions. *Psychoanalytic Dialogues*, 15, 587–612.
- Denning, P. (2000). *Practicing Harm Reduction Psychotherapy: An Alternative Approach to Addictions*. New York: Guilford Press.
- Director, L. (2002). The value of relational psychoanalysis in the treatment of chronic drug and alcohol use. *Psychoanalytic Dialogues*, 12, 551–579.
- Director, L. (2005). Encounters with omnipotence in psychoanalysis of substance users. *Psychoanalytic Dialogues*, 15, 567–586.
- Freud, S. (1957). Letter no. 79 in *The Origins of Psychoanalysis: Letters, Drafts and Notes to Wilhelm Fliess (1887–1902)* (original letter written 1897).
- Freud, S. (1961). *Civilization and its Discontents*. New York: W.W. Norton. (Original work published 1929).
- Ghent, E. (1992). Forward to: *Relational Perspectives in Psychoanalysis*, ed. Skolnick, N. and Warshaw, S., Hillsdale, NJ: Analytic Press, xiii–xxii.
- Glover, E. (1932). On the aetiology of drug addiction. In D. Yalisove (Ed.), *Essential Papers on Addiction*. New York: New York University Press, 1997, pp. 24–51.
- Goldberg, P. (1995). Successful dissociation, pseudovitality, and inauthentic use of the senses. *Psychoanalytic Dialogues*, 5, 493–510.
- Greenberg, J. & Mitchell, S. (1983). *Object Relations in Psychoanalytic Theory*. Cambridge, Mass: Harvard University Press.
- Harris, A. (1997). Envy and ambition: The circulating tensions in women's relation to aggression. *Gender and Psychoanalysis*, 2, 291–325.
- Khantzian, E. (1985). The self-medication hypothesis of addictive disorders: Focus on heroin and cocaine dependence. *American Journal of Psychiatry*, 142, 1259–1264.
- Jellinek, E. (1960) *The Disease Concept of Alcoholism*. New Haven: College and University Press.
- Khantzian, E., Halliday, K. & McAuliffe, W. (1990). *Addiction and the Vulnerable Self: Modified Dynamic Group Therapy for Substance Abusers*. New York: Guilford Press.
- Krystal, H. (1988). *Integration and Self Healing: Affect, Trauma, Alexithymia*. Hillsdale, NJ: Analytic Press.

- Krystal, H. & Raskin, H.A. (1970). *Drug Dependence: Aspects of Ego Function*. Detroit: Wayne State University Press.
- Marlatt, A. (1998) *Harm Reduction: Pragmatic Strategies for Managing High Risk Behaviors*, New York: Guilford Press.
- Marlatt, A., Tucker, J., Donovan, D. & Vuchinich, R. (1997). *Help Seeking by Substance Abusers: The Role of Harm Reduction and Behavioral Economic Approaches to Facilitate Treatment and Retention*. National Institute on Drug Abuse (NIDA).
- McDougall, J. (1989). *Theaters of the Body*. New York: W.W. Norton.
- McDougall, J. (1991). *Theaters of the Mind*. New York: Brunner Mazel.
- Mitchell, S. (1988). *Relational Concepts in Psychoanalysis: An Integration*. Cambridge, Mass.: Harvard University Press.
- Rado, S. (1933). The psychoanalysis of pharmacothymia. *Psychoanalytic Quarterly* 2, 1–23.
- Rothschild, D. (1995). Working with addicts in private practice: Overcoming initial resistance. In A. Washton (Ed.), *Psychotherapy and Substance Abuse: A Practitioner's Handbook*. New York: Guilford Press, 192–203.
- Rothschild, D. (1998). Treating the resistant substance abuser: Harm reduction (re)emerges as sound clinical practice. *In Session* 4, 25–35.
- Selzer, M. L. (1957). Hostility as a barrier to therapy in alcoholism. *Psychiatric Quarterly* 31, 301–305.
- Simmel, E. (1929). Psychoanalytic treatment in a sanatorium. *International Journal of Psychoanalysis* 10, 83–86.
- Stone, L. (1954). The widening scope of indications for psychoanalysis. *Journal of the American Psychoanalytic Association* 2, 567–594.
- Tatarsky, A. (2002). *Harm Reduction Psychotherapy: A New Treatment for Drug and Alcohol Problems*, Northvale, NJ: Jason Aronson.
- Wieder, H. & Kaplan, E.H. (1969). Drug use in adolescents: Psychodynamic meaning and pharmacogenic effect. *Psychoanalytic Study of the Child*, 24, 399–431.
- Wurmser, L. (1974). Psychoanalytic considerations of the etiology of compulsive drug use. *Journal of the American Psychoanalytic Association*, 22, 820–843.
- Wurmser, L. (1992). Psychology of compulsive drug use. In *The Chemically Dependent: Phases of Treatment and Recovery*, ed. B. Wallace, New York: Brunner Mazel, pp. 92–114.
- Yalisove, D.L. (1997). *Essential Papers On Addiction*, New York: New York University Press.

30 West 70 Street #1C  
 New York, NY 10023  
 deroth@mindspring.com