Integrating Psychodynamic Principles in Addiction Counseling:

An Idea Whose Time Has Come, Again

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Dr. Legg wishes to dedicate this article to the fond memory of the late Jan Middeldorf, PsyD, NCPsyA, his first psychoanalytic instructor. Had it not been for Dr. Middeldorf's knowledge, vision, insight, and passion for psychoanalysis, which he enthusiastically shared with others, this article would not have been possible.

Many of us may recall our introduction to psychology course that talked about Sigmund Freud and psychoanalysis. If your instructor was anything like mine, psychoanalytic theory was rapidly dismissed as being a pseudoscience and its practitioners inept, while emphasis was placed on more "contemporary" theories. The forces leading to the dismissal of psychoanalysis were based on a variety of factors, including but not limited to a generalized revulsion over the notion of infant sexuality and misogynist concepts.

Despite the objections raised by some, psychoanalysis has had a tremendous impact on modern life, as well as psychotherapy. Comedians such as Woody Allen have made us laugh at self-immolating jokes about his never-ending psychoanalytic journey. A variety of other shows have lampooned psychoanalysts as bungling therapists whose hubris led to them getting everything wrong about the patient, while the subject of their "analysis" recovered through serendipitous means. In our daily practice, we have unwittingly invoked psychoanalytic theory if we have heard ourselves say that a client is "in denial," or "being avoidant." We have all made the infamous "Freudian slip" (hopefully not with a new romantic partner, by calling them your previous partners name!), or perhaps we "forgot" about an "important" social event that we really did not want to attend and laughed it off by saying "maybe unconsciously, I just didn't want to go." While there are many other examples to be offered, I am sure you get the point.

In this article, psychoanalysis and its tenets are explored, along with its potential to help addictions counselors work with difficult clients. We will briefly discuss its evidence base and compare it to the evidence for other purported evidence-based approaches that we use daily. We will also examine how psychodynamic approaches can be implemented into your practice and conclude with what to do if you feel that your client may benefit from more in-depth psychoanalytic treatment.

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Efficacy in the Treatment for Addictive Disorders & the Nature of Evidence

Getting to the heart of treatment efficacy is challenging. Is "effective" treatment simply abstaining from using the substance (or engaging in the behavior) that has impacted the client's life, or is there more to it than that? While we would be tempted to presume that "effective treatment" is synonymous with abstinence, there are many more components to effective treatment than simply abstaining from substances. Effective treatment for substance use disorders can include a variety of seemingly unrelated concepts; it can include helping the individual improve interpersonal relationship patterns, improving relationships that exist within dysfunctional family units, and even career counseling. While one may think that this is not why we are "here" as addictions counselors, it is important to note that studies have demonstrated a link between stressful life events and a resumption of substance use (McCabe, Cranford, & Boyd, 2016). Additionally, Mate (2010) reminds us that drugs are social lubricants which allow the person to do something that they otherwise could not do without the help of the substance. From this perspective, it would make sense that our definition of "recovery" should be a bit broader than abstinence. From this perspective, do you invite the client to collaborate on treatment goals and to share *their* definition of "recovery"?

Abstinence is important, too. In fact, there is a justifiable preoccupation with abstinence from a variety of stakeholders including clients, their loved ones, and even insurers. Not only does substance use have a "human" cost, but it is also financially damaging. Current statistics suggest that the abuse of alcohol, tobacco, and illicit drugs cost the United States approximately $740 billion per year. These costs have been attributed to lost productivity in work, health care needs, and crime (National Institute on Drug Abuse, 2020). From the financial perspective alone, it would be desirable to define effective treatment. This brings us to another challenge. How effective is addiction treatment in America? Which treatments are effective? And, ultimately, are we really using "evidence-based" practices to provide effective treatment to everyone, including those who struggle with recovery?

Data provided by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2017), indicate that treatment admission rates for heroin abuse increased 40% in 2015 when compared with 2005. However, the same report may demonstrate some evidence of success with treating substance use disorders. For example, specific to treatment admission rates:

- Alcohol use disorder decreased from 298 admissions per 100,000 persons in 2005 to 189 admissions per 100,000 persons in 2015;
- Marijuana abuse admissions were 36% higher in 2005 than in 2015;
- Cocaine use disorder admissions were 75% higher in 2005 than they were in 2015; and
- Methamphetamine/amphetamine use disorder admissions were 28% higher in 2005 than they were in 2015.

While these statistics suggest that things are improving (i.e. fewer people are needing admission to inpatient care), these statistics only represent admission rates to inpatient facilities. They do not account for those who receive treatment from private therapists. The Affordable Care Act has increased health insurance for many Americans, which has increased access to substance use disorder treatment services and other mental health care (Baumgartner, Aboulafia, & McIntosh, 2020). Therefore, more people may be receiving help before they are on the cusp of an act of desperation that often brings them to the attention of the medical establishment and inpatient treatment.

Also missing from the statistics are rates of sustained abstinence once initial treatment has been provided. These statistics are particularly difficult to come by for several reasons. First, each study published exploring longitudinal treatment effectiveness seems to use its own definition of "abstinence," and "sustained." Another issue is what can only be described as the "legendary" status of certain often-cited statistics. One example suggests that 40-60% of persons will relapse in one calendar year. This statistic haunts many contemporary texts/studies on relapse rates in addictive disorders, including the 2016 U.S. Surgeon General's report *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* (p. 4-15). If we were to trace the origins of the "40-60%" statistic so often cited, we would discover that it came from the year 2000 and was cited at that point using work completed in 1992 & 1998. From this perspective, will the real relapse rates please stand up?

What About "Effective Treatment?"

While we are tempted to say that "evidence-based" treatment is "effective treatment," recall the issue described above in the Surgeon General's report. While this is but one instance where we find "recycled" statistics from decades ago, the same phenomenon has occurred in "evidence-based" literature, as well. When we read a research study, how many of us turn our attention to the citations and drill back through those citations to see where the evidence came from? Another challenge is that several scientific disciplines, psychology included, are dealing with the "replicability crisis" (Weir, 2015), meaning that the findings of one study are not supported by findings of a later study. One way to overcome this has been suggested by Pieper (2016), who suggests that we need to recognize a heuristic paradigm to study therapy outcomes. In consideration of the existing evidence, this may be our best approach as clinicians. Interestingly, this was the approach used by early psychoanalysts. Their "evidence" was that the client got better.

These shortcomings also have resulted in a variety of stakeholders wanting to know if our treatment will "work." While clients want to know if our treatment will help towards alleviating suffering, insurance companies want to know from a financial perspective what their "subscriber" is getting for the money. While most clients who are given a reasonable explanation understand why treatment approaches and results vary, and why one approach may not work for everyone, insurance companies have come to demand the use of "evidence-based" treatments. While nothing is inherently wrong with using the best available evidence to treat addictive disorders, Shedler (2015) points out that where insurance companies are concerned, evidence-based treatments have come to be "a code word for manualized treatment-most often, brief, highly-structured cognitive behavioral therapy (CBT)" (p. 47). From a financial perspective, this makes sense: paying for ten sessions is much cheaper than paying for more.

If you find that your current approaches to treatment are not working, perhaps it is time to consider incorporating a psychodynamic approach.

Current "Evidence-Based" Treatments for Addictive Disorders

The literature is replete with studies opining the most effective approaches to treating addictive disorders. While a comprehensive review is beyond the scope of this article, it is important to note that while CBT is the preferred approach among many insurance companies, its evidence is not as iron-clad as we have been led to believe. In their 2019 meta-analysis, Magill et al. concluded that while CBT is more effective than "no treatment" at all for adults with alcohol and other drug use disorders, it did not show superiority of efficacy in contrast to other modalities (2019). Capone et al. (2018) attempted to apply integrated cognitive behavioral therapy to a sample of military veterans with co-occurring posttraumatic stress disorder (PTSD) and substance use disorder (SUD). They concluded that the efficacy of the treatment in this population was not as robust as outcomes observed with the non-veteran populations. Macedo et al. (2018) concluded that there is "no proper methodological basis to assert that CBT has lasting effects in the treatment of PTSD" (p. 352). Specific to internet gaming disorder (IGD), Stevens, King, Dorstyn, & Delfabbro (2018) noted that the effectiveness of cognitive behavioral therapy to reduce actual time spent gaming in those with IGD remained unclear, and that more rigorous studies were needed to determine the potential long-term benefits for the use of CBT for this disorder (p. 191). The findings of these studies are important. How many times have you applied CBT to someone it clearly was not working for, only to blame the client for lack of improvement by saying "you're not trying hard enough!" or in supervision, maybe heard yourself say "he's just not 'engaged' with his treatment"?

Even when CBT does appear to work, its benefits may not be long-lasting. In a 2015 review, Shedler pointed out that the majority (more than 50%) of patients who receive "evidence-based" treatment "seek treatment again within six to twelve months for the same condition" (p. 52). While there are many studies which demonstrate evidence for the efficacy of CBT, it does not work for everyone and if it does work, its effects may not be enduring.

What About Psychoanalysis/Psychodynamic Approaches?

Psychoanalysis has a considerable body of evidence to support its efficacy. Research studies consistently find that patients who receive psychoanalytic treatment continue to make psychological gains after the therapy is over (British Psychoanalytic Council, n.d.; Shedler, 2010). When reading about psychoanalytic concepts, it is not uncommon to find terms like "psychoanalytic" or "psychodynamic," which can be confusing to readers. Gabbard, Litowitz, & Williams (2012) deferred to Freud's original definition that described psychoanalysis as a theory of mind, an investigative method as well as a form of treatment. The treatment happens several days per week, for several years, and uses such techniques as free association, and examines transference and countertransference to understand and therapeutically influence the patient (p. 581). "Psychodynamic" on the other hand is typically used to describe "treatments that are less intensive than the procedure Freud invented yet depend on ideas that derived from his theories" (McWilliams, 2004, p. 13). From this perspective, many

providers may be better positioned to provide psychodynamic therapy because of the limits insurance companies place on reimbursement and treatment duration. Plus, to provide psychoanalysis, one must be trained as a psychoanalyst, which takes considerable time.

In describing what makes a therapy "psychodynamic," Shedler (2010) outlines seven key features distinguishing the psychodynamic approach from other therapies. These include (1) the focus on affect and expression of emotion; (2) exploration of attempts to avoid distressing thoughts and feelings; (3) identification of recurring themes and patterns; (4) discussion of past experiences; (5) focus on interpersonal relations; (6) focus on the therapy relationship; and, (7) exploration of fantasy life (p. 99).

A common barrier to using a psychodynamic approach with clients is the concern that it takes a long time to learn. While it is true that psychoanalytic training is lengthy, not all psychodynamic therapy is delivered by certified psychoanalysts.

Regardless of opinion on the matter, it behooves addictions counselors to expand knowledge, skills, and abilities to provide patients with the treatment they need. If you find that your current approaches to treatment are not working, perhaps it is time to consider incorporating a psychodynamic approach. There are many in-person and online workshops available to help a counselor learn psychodynamic principles. For example, the Philadelphia School of Psychoanalysis offers distance education courses in the area of modern psychoanalysis. Recall that the NAADAC Code of Ethics challenges us to "remain current with treatment modalities, theories and techniques" (2016, p. 1).

How Do I Start?

The first place to begin is by engaging in self-assessment. Other elements of the NAADAC Code of Ethics tell us that we must never hold ourselves out as competent in an area that we are not competent in, and we need to work within the boundaries of our competency (2016). Similarly, we should never attempt a technique that we have not been trained in. When learning about a new technique, we typically use a combination of education and clinical supervision to safely and effectively integrate new knowledge and skills into our existing repertoire. In these cases, we must be transparent with our clients and let them know that we are using a new technique, and that we are obtaining education and clinical supervision in the area. We must also be certain to gain their informed consent and allow them the option to opt out of this treatment approach and make appropriate referrals when indicated. Doing this diligently protects both the client and the practitioner (Falender & Shafranske, 2004).

Once ready to proceed, there are a variety of resources to help with application of the psychodynamic approach. Integrate concepts as you learn about them, where they seem "natural" and a good fit in your work with your clients. While some "purists" believe that psychodynamic therapy should be provided "exclusively," many therapists combine psychodynamic approaches with CBT, twelve-step programs, relaxation training, among others (McWilliams, 2004).

Sublette & Novick (2004) offer some great advice to the therapist beginning psychodynamic work with clients. While this may sound strange to tell therapy professionals, the first step in implementing psychodynamic therapy is to talk less and listen more. Attend to what the patient is saying and be present. Listen for both what the patient is and is not saying. Do not simply sit there waiting for the patient to "stop talking" so that you could jump in with advice. Psychodynamic approaches to therapy

Ask yourself "why does the client need to act the way they act?"

begin with understanding the client. When you do talk, focus on establishing safety, explaining concepts of the psychodynamic approach, and encouraging the client to expand his or her capacity to speak freely (McWilliams, 2004, p. 140).

Next, ask yourself if you can truly empathize with your client. Ask yourself "why does the client *need* to act the way they act?" What has happened in their life that made this behavior come into existence? What is the "function" of the behavior that they are engaging in? If you cannot empathize with your client, you probably will not be very effective in the psychodynamic approach to therapy. If the client is explaining something to you and you just do not understand, ask for clarification. Do not assume understanding, as this can get in the way of a trusting therapeutic alliance. Do not allow yourself to fall into the "I've heard this all before" trap that some therapists fall into. Approach each client situation with a sense of wonder and curiosity. Asking questions is one of the best ways to learn about how that client has interpreted and responded to past life events (Sublette & Novick, 2004).

Confrontation can be a useful tool, but not the typical confrontation that we do in our work with clients who struggle with addictions. You have probably heard a colleague (or maybe even yourself) say "well, today I had to confront Susan – she had a positive urine drug screen, again, after she swore that she hasn't used in over a month!" Confrontation in psychodynamic work refers to pointing out behaviors (for example, repetitive behaviors) that may be detrimental to the patient, of which they are largely unaware. These can include recurring maladaptive patterns that become apparent to you through your focused listening, use of empathy, and examining your notes from previous sessions (Sublette & Novick, 2004). It can also include confrontation of dysfunctional beliefs which is a strategy with which many cognitive-behavioral therapists are familiar (Gabbard, 2010).

While you want to jump to interpretation, which is a commonly misunderstood technique in psychoanalysis and in fact rarely used, be judicious in your use of interpretation. Part and parcel of interpretation is understanding the client. This is accomplished through listening, seeking clarification, confrontation (when appropriate), and empathizing. If you have not attended to the other skills, you will probably not make particularly good interpretations, and recklessness with this technique can damage the therapeutic alliance.

We also need to be staunch advocates for our clients with their insurance companies. While most insurance companies are difficult to deal with on a good day (or maybe that is just my perception), they can get more obstinate when we tell them that our treatment plan incorporates psychodynamic elements. We need to be able to respond to insurers' arguments

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that psychodynamic approaches are not evidence-based, and we need to be able to invite the client as consumer to advocate on their own behalf as well.

When Should I Refer a Client?

Despite our best efforts, clients do not always improve (and I encourage you to consider your definition of "improvement" and to formulate it in collaboration with the client). While the research literature clearly indicates and our own experience shows us that some clients will experience relapses, and that these should be viewed as an opportunity to learn from mistakes, you should also be mindful of repetitious patterns that the client cannot seem to break. You may want to consider referral to more intensive psychodynamic or even psychoanalytic therapy. While there are challenges associated with referral, such as finding a certified analyst in your geographic area, the client's ability to afford the cost of analysis, or committing to the time analysis requires, it may be what some clients need.

While these challenges may seem like deal-breakers for some, discuss them with your client as there may be solutions of which you are unaware. Some analysts may have a sliding fee scale, and some analysts may offer limited pro bono or even "low bono" work. Some clients may see price as being "worth it," meaning worth the increased time and effort if the results differ from their former experience with treatment. One client who sees me several times per week informed me that despite the out-of-pocket fee (as his insurance company will not pay for psychoanalysis), it is still "cheaper" than what he was spending on liquor each month. Still another client's family has paid for their loved one's sessions. As one of the family members told me "Over these past few months, I have seen changes in XXX that I never thought would happen – how do you put a price on that?"

Conclusion

While useful for many clients, it is important to acknowledge that CBT and other manualized therapies are not the only "evidence-based" treatments. For many they do not work, and for others, they only work for a while. While we often find reasons to blame the client (e.g. "they aren't trying hard enough" or "they just aren't 'invested' in their treatment"), we often recoil from the idea that it is our methods which are not working.

Principles of psychodynamic psychotherapy, another evidence-based treatment, can benefit clients for whom other treatments have not worked. Unfortunately, this approach is often underutilized in people who suffer from addictive disorders. Fortunately, the internet has made training in this modality more readily available. While we all do not have to become psychoanalysts, we can certainly learn to apply psychodynamic principles to our work. Psychodynamic approaches were used for years to help individuals with addictive disorders. Perhaps psychodynamic work in addictions is an idea whose time has come, again.

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