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The Psychoanalytic Contribution

Mrs. G.: One Woman's Struggle for Dignity
—Mark Sehl

During the twenty years that I have worked with people with drug problems, my conviction has grown that psychoanalytic thinking about these issues offers the most powerful framework for helping people address them. A psychoanalytic perspective sees an understanding of the total person as relevant to one's personal difficulties and the treatment process: needs, feelings, self-image, expectations of others, ideals, strengths, vulnerabilities, interpersonal skills, judgments, coping skills, and environmental factors. Based on this, psychoanalytic treatments are thoroughly individualized treatments. Thus, psychoanalytically informed treatments can vary widely in their appearance from the classical four- to five-times-per-week psychoanalysis to once weekly, behaviorally oriented therapy, and everything in between, depending on the needs of the client. This individualizing of the treatment process, the emphasis in matching the treatment to the needs of the client, and the primacy placed on the therapeutic relationship as anchor in the process and area for exploration of the issues are all in accordance with the framework of harm reduction.

The treatments described in the stories in this book all have psychoanalytic elements. The variety in the stories reveals the diversity of forms that psychoanalytic psychotherapy can take. Yet all share the commitment to the central psychoanalytic idea

that problematic drug use reflects personal meanings that are not fully in the user's awareness and that the process of bringing these meanings more fully into awareness opens up possibilities for positive change.

BRIEF OVERVIEW OF PSYCHOANALYSIS

Since Freud established psychoanalysis at the turn of the twentieth century, many different schools of psychoanalytic thought have evolved, each emphasizing different elements in its theories of human functioning or therapy. The thread that runs through the variety of psychoanalytic approaches that currently exist is the idea that human behavior is shaped and driven by a number of different elements within each individual that are personally meaningful and that a conscious awareness of these meaningful elements increases our possibilities for greater choice and freedom in our lives.

This perspective begins in the late 1890s with what is to me the most important of Sigmund Freud's (1895) contributions to understanding of human suffering: his discovery of what he called the "dynamic unconscious." Simply put, he proposed that there are forces—dynamics—partially outside of our awareness, that motivate our behavior. By forces he meant needs, wishes, judgments, and beliefs. In short, he discovered a hidden dimension of personal meaning within human behavior. Further, he suggested that these forces are kept out of our awareness by another part of the mind, another force called "ego defenses," because they are threatening to us and cause anxiety, guilt, or shame. The anxiety-provoking threat leads to various defensive ways of keeping these aspects of ourselves out of awareness. The defenses also operate out of awareness. As long as these dynamics remain outside of awareness we are relatively powerless over them. Their ability to push us into compulsive or impulsive behavior gives rise to intense inner pressures and creates painful feelings of anxiety, guilt, shame, and despair, all for no apparent reason. Following this idea, psychoanalytic treatments then generally have the goal of helping people to become more consciously aware of these inner motivations and

defenses against them, to understand more fully how their minds operate, so they can see new possibilities for addressing or expressing what has been outside awareness.

While this idea remains at the core of all psychoanalytic or psychodynamic schools of psychotherapy, a variety of schools of psychoanalysis have proliferated that differ in almost every other aspect of psychoanalytic theory: what are the important dynamics, how they come into being, how the human psyche is constructed, how to understand human suffering, how to conduct the treatment, and even what to call psychoanalysis (Mitchell and Black, 1995). Psychoanalysis has evolved as a field of study and treatment since being founded by Sigmund Freud more than 100 years ago. Many of Freud's original ideas continue to inform the field of psychoanalysis as well as the world at large and the substance use treatment field, often unbeknownst to practitioners. But it has also proliferated into many different schools with different theories of normal development, emotional and personality problems, and treatment. Many of these developments within the field have led to ideas that have very specific powerful value for understanding and addressing the needs of people with drug problems. In fact, a look at Levin and Weiss's (1994) collection of psychoanalytic papers on drug addiction reveals that each new development within psychoanalytic theory was also reflected in its application to understanding and treating people with drug problems.

In terms of forms of treatment, in classical thinking there is a distinction between a classical full psychoanalysis that I described above and psychoanalytically oriented or psychodynamic psychotherapy (these terms are generally interchangeable). The former had as its goal as complete an understanding of the psyche as possible with a thorough resolution of early traumas believed to be at the core of current emotional problems. In this approach, the ideal was traditionally held to be a treatment in which the patient lay on the couch four to five times a week saying everything that came to mind. It was assumed that the patient would run into conflicts that would cause the person to stop and interrupt the flow of associations because the symbolic conflict caused anxiety. These conflicts were held to be related to the problems for which the person sought help.

The analyst's job was to listen for these moments and try to help the patient recognize and understand the conflict causing the anxiety. The latter, psychoanalytic psychotherapy, entailed the application of psychoanalytic understanding to therapy with more limited goals targeting specific problems only. This approach could be conducted in a once- or twice-weekly format.

However, in the current proliferation of schools of thought, the traditional distinctions between analysis and psychotherapy are being questioned by many prominent contributors, as are ideas about required frequency of sessions and most other hallmarks of the traditional distinctions between what is and what is not psychoanalysis. For a good discussion of these issues see Stephen Mitchell and Margaret Black's book, *Freud and Beyond.*

PSYCHOANALYSIS AND PSYCHOTHERAPY OF DRUG PROBLEMS

Psychoanalysis has gotten a bad rap regarding the treatment of people with drug and alcohol problems. Many people who have heard something about the role of psychoanalysis in the history of the treatment of these problems have heard that psychoanalytic approaches failed in the 1940s and 1950s and are no longer considered as viable treatments for these problems. The idea is that psychoanalysts put drug- and alcohol-dependent people on the psychoanalytic couch four times a week doing no more than listening to their rambling thoughts (free associations), occasionally muttering an analytic "uh huh" in response. The myth continues that while the analytic intention was often sincere, that is, to get at the underlying reasons for the drug use as a way to cure it, the result was usually continued or intensified drug use.

These "historical facts" are often used to justify the mistaken claim that Alcoholics Anonymous or coercive behavioral treatments are the only approaches that are helpful to drug users, as well as the related claim that drug users cannot benefit from insight-oriented therapy (i.e., therapy geared toward discovering

the meaningful aspect of drug use) until their drug use is stopped. These ideas are commonly held by laypeople, substance abuse treatment specialists, and psychoanalysts alike. These claims are versions of the one problem/one solution model that I discuss in Chapter 4.

In fact, the psychoanalytic therapies advocated for people with drug problems have never been of the sort characterized above. The stereotype of the silent, uninvolved analyst letting the patient ramble on incessantly with little positive result while life-threatening drug use rages on unaddressed is simply bad psychoanalysis or psychotherapy done by poorly trained professionals. The psychoanalytic approach caricatured in the popular claim is based on the classical approach to psychoanalysis I discussed above.

The claim that psychoanalysis failed drug users because of this approach can be easily put to rest. Classical psychoanalysis has never generally been advocated for people with serious behavioral impulse control problems or in severe life crises (Eisler, 1958). Classical technique was seen as an ideal to be deviated from as the particular client required. The deviations were geared toward greater activity, personal involvement, and direction by the therapist. The caveat was that the client's need for these things from the therapist would also be explored and understood when appropriate. The goal of all this was to maximize clients' sense of self-mastery and of being in charge of themselves, including how to use the therapy.

Since the early 1900s, shortly after the birth of psychoanalysis, this idea is expressed in a thread that runs through the major psychoanalytic writings on the treatment of people with drug problems: namely, that these people need something other than "classical technique." It was generally recommended that effective therapy with this group of people needed to be a more active therapeutic approach that included giving information and advice, emotional support, specific techniques for helping people change their drug using behavior, and the use of larger support systems in conjunction with the ongoing effort to help patients become aware of the meanings of their drug use and how it related to other issues in their lives.

These basic sentiments live on in the work of many psychoanalysts and psychoanalytically oriented therapists who have both a psychoanalytic understanding of problem drug use and how to apply these ideas in the service of actively helping drug users make changes in their drug use and other troubling life issues.

Given the proliferation of psychoanalytic schools of thought, it is risky to describe the basic features of a psychoanalytic approach to psychotherapy for people with drug problems. I do think, based on my own clinical experience and my own reading of psychoanalysis, that the following are some defining features that most psychoanalytically minded practitioners would agree characterize psychoanalytic approaches.

The Inquiry into the Personal Meanings Expressed by Drug Use

This approach is committed to the idea that the more aware one is of the meanings expressed by drug use, the more possible change is. It seeks to discover or create alternative ways of addressing these meaningful elements. Psychoanalytic theory provides many different ideas about how we might understand the personal meaning that drug use has for people. Ideas that I discussed in Chapter 1 of this book all derive from psychoanalytic theories. The idea of the dynamic unconscious helps to point the way to developing curiosity about what these hidden meanings might be. It helps us to have understanding and compassion for why people may continue to use drugs despite increasing negative consequences.

An alternative model, the disease concept of addiction, suggests that this denial is a hallmark of the "disease." But it stops with the idea of the disease as a mysterious, unfathomable entity that can only be controlled.

Psychoanalytic thinking offers a more ambitious model. It suggests that we can get inside this "disease," decode the meanings it carries, and discover a deeper and more constructive resolution of them. I talk with my clients of the importance of us unwrapping their desire to use in order to unravel the multiple

personal meanings it carries. It alerts us to question why these hidden meanings may be difficult to keep in awareness and how they might be emotionally or psychologically threatening. How might they create inner conflict? What might be the payoff of staying in the dark about themselves? How might it be painful or scary to see the truth about themselves?

Integrating Active Cognitive and Behavioral Strategies

When drug use feels out of control to the user or is clearly causing suffering and negative consequences in his or her life, the inquiry into the meaning of his or her use is usually not sufficient. The myth of the failure of psychoanalysis to be helpful to drug users that I challenged earlier is based on a view of psychoanalytic treatment that only focused on the inquiry and not the problematic behavior. There is no doubt that there are practitioners who work in this way. However, therapists like this are working to uphold doctrine and not to respond to the needs of their clients.

An analogy that makes the point well would be a therapist working with an actively suicidal person who only focuses on the meaning of the suicidal feelings and does not address potentially life-threatening behavior.

Psychotherapy for people with drug problems does generally need to contain active strategies that address the drug-using behavior and the process of changing behavior directly. This is not at odds with psychoanalytic thinking; psychoanalysis has a framework for understanding why some people may need the therapist to offer more active help in this area. In Chapter 3 I tell the story of the experiences that led me to appreciate the essential value of using behavioral and cognitive strategies with drug-using clients. Here I will say a few words about how I see these two approaches working together in an integrative fashion.

Psychoanalysis contains important ideas relevant to understanding and helping people with excessive and complusive drug use. One important idea that I explore in greater depth in

Chapter 6 is viewing drug use as an attempt to cope, to adapt to painful circumstances, or as an attempt to self-medicate. If a drug helps to quell anxiety or other painful feelings, these feelings may come to trigger the intense desire, urge, or craving to use when they arise. In addition, the person may lack the ability to manage, tolerate, sit with, or soothe these feelings. In this event, the feeling triggers for the urge to use may be experienced as overwhelming. So drugs supply, fortify, or compensate for certain emotional management skills that are deficient or lacking. Psychoanalysis calls these "ego functions."

Ego functions (Freud, A., 1936) refers to a set of cognitive skills that are involved in self-managing our feelings and behavior. This includes self-awareness, or observing oneself moment to moment so that sequences of perception, feeling, thought, and behavior can be identified; judgment or thinking things through to see possible consequences of our actions; and emotional management skills like working with breathing, learning to relax, learning to express feelings in words, being able to identify and put feelings into words, and others. This is the area in which cognitive-behavioral strategies are very helpful.

So we can think of the psychoanalytic rationale for using active cognitive and behavioral techniques as helping the client learn or develop the functions that are lacking. As these functions are developed by the client in therapy, the pressure to use drugs will diminish as emotional pressure decreases.

The Importance of the Therapeutic Relationship

Psychodynamic approaches also place great importance on the therapeutic relationship. There are several reasons for this.

A good therapeutic relationship, part of the "right fit" that I discuss in Chapter 4, provides support and creates a feeling of safety that functions as a foundation for doing the often hard work involved with making important changes in oneself.

Today, most psychodynamic practitioners see this relationship as a collaborative effort at discovering the meaning of the

client's problematic drug use and suffering and finding new and better solutions. This collaborative quality is also inherently empowering to the client.

The therapeutic relationship can also be a kind of laboratory in which the client's typical ways of relating to important others can be identified and new ways of relating can be explored and practiced. As this relates to our subject, the connections between drug use (or the desire to use) and interpersonal relationship factors may be explored by observing how the client's using relates to the feelings, fantasies, wishes, and fears that appear in the relationship with the therapist. This can work in two ways. How the client imagines or expects the therapist will react to drug use or the desire to use provides important information about how significant others in the client's life have reacted both to drug use but also, maybe more importantly, to what the drug use symbolically expresses, such as anger, fear, the wish to comfort oneself, a wish to be free from the perceived control of the other, and so on. On the other hand, drug use and wishes to use may come up as reactions to what is happening in therapy and to the therapist. Exploring this connection can help unwrap the way in which drug use is a meaningful response to the feelings evoked in the relationship with the therapist.

HARM REDUCTION IS CONSISTENT WITH PSYCHOANALYTIC APPROACHES

The central goals of harm reduction—meeting the client as an individual, starting from where the client is, assuming the client has strengths that can be supported, accepting small incremental changes as steps in the right direction, not holding abstinence (or any preconceived notions) as a necessary precondition of the therapy before really getting to know the individual, and developing a collaborative, empowering relationship with the client—are all consistent with psychoanalytic thinking.

The psychodynamic assumption that drug use holds important personal meanings suggests why some drug users may not be able to give up or otherwise modify drug use until other

alternative ways of expressing these needs are found. This provides theoretical support for the harm reduction assumption that many users need to continue to use drugs while in therapy until these alternatives are found. In speaking of the importance of defenses, a psychoanalytic tenet is that you don't take something away unless you have something with which to replace it. The safety and support of a strong therapeutic alliance can be a prerequisite within which clients can begin to develop the courage and skills necessary to make changes in their drug use.

I selected Mark Sehl's story of Mrs. G. to illustrate the topic of this chapter because it describes a psychoanalytic treatment that breaks many of the traditional ideas about what psychoanalysis is and challenges the myth of the passive uninvolved analyst. Yet it remains true to the psychoanalytic project of uncovering the hidden meanings of the patient's alcohol problems and, in this case, leads to a stable abstinence.

It is the story of an elderly woman who suffered from severe "alcoholic" drinking and depression. Using a psychoanalytic harm reduction approach that initially accepted Mrs. G.'s drinking, the treatment led to her stopping drinking, a lifting of her depression, and a general improvement in her health and quality of life. Sehl used an approach informed by the school of modern psychoanalysis, founded by Hyman Spotnitz (1985).

Mrs. G.: One Woman's Struggle for Dignity

by Mark Sehl

When I first met Mrs. G. she was literally lying in her urine, saying she didn't want to go on living any longer. She wasn't eating, the apartment smelled, and neighbors were complaining of the odor. Mrs. G. told me that she couldn't walk because she had fallen and broken a hip while she was intoxicated. The patient said she was just a social drinker and complained that the home attendants were refusing to let her have any more to drink. Mrs. G. said that she had two cocktails a day, while, to make sure I understood the point, the home

attendant was shaking the empty quart of scotch behind the patient's back. I said to Mrs. G. that on the one hand she seemed not to be concerned about her drinking, but on the other hand she was telling me she hurt herself badly due to drinking. I was hoping she could grasp the contradictions in her statements.

It is important to understand some of the events that led up to Mrs. G.'s deterioration. This 83-year-old woman came to the attention of the agency several years before I began my employment there. A concerned friend referred Mrs. G. for help. At that time, Mrs. G. required home care assistance due to her inability to care for herself after a hip operation. There was a passing mention of alcohol consumption on the intake form.

Several months later Mrs. G. was hospitalized for severe depression. The precipitating event was the loss of her dog. The evaluating psychiatrist diagnosed the situation as severe reactive depression with alcohol habituation and suicidal ideas. He recommended treatment for the depression, control of alcoholism, psychotherapy and antidepressant drugs, and coordination of health care and social rehabilitation. Mrs. G. was assigned shopping and home attendant services by the agency, but as far as I could ascertain, neither psychotherapy nor consultation regarding alcoholism treatment was ever mentioned in the record.

Not long after her return home Mrs. G. was ambulating badly, had swollen legs, refused to leave her home, and was combining high doses of aspirin with alcohol. By the following year, the patient had completely deteriorated. In other words, within one year the client was almost non-ambulatory. The agency terminated shopping and home care services because the patient was now on Medicaid, which provided daily home attendant care.

Three years later the same family friend contacted the agency again complaining that home attendants were going home early. In addition, she was concerned

that Mrs. G.'s Medicaid coverage might be terminated due to the discovery of a cash surplus not allowed by Medicaid. It was at this point that I met Mrs. G.

As I began working with Mrs. G., she gradually told me of her drinking habits and history. Mrs. G. mentioned that she was embarrassed about her loss of bladder control. I suggested that drinking might be affecting her bladder control, loss of appetite, and depression. I said I was convinced that if she could stop drinking, her incontinence and her life in general could improve. She was interested in the fact that her incontinence might improve if she stopped drinking.

In the meantime, her friend told the liquor store owner not to sell her any more liquor. Mrs. G. told me she wished her friend would mind her own business. It seems that many people were telling Mrs. G. what to do—the home attendants, her friend, and the agency. I said maybe she was also telling me to mind my own business. She said no. I noticed in the first months of working with her that this patient had a very defiant attitude, although she couldn't express this defiance directly. It seemed more important for her to be defiant than to take better care of herself.

I was wondering whether my approach might be wrong for her. I was trying to encourage her to stop drinking. She was defiant, but in a passive-aggressive way. She couldn't tell her best friend, or the agency, to leave her alone. Mrs. G. was defeating herself and everyone around her. I was concerned that if she followed my suggestion to stop drinking, she might be inclined to sabotage her own efforts.

On several occasions I asked Mrs. G. again if she didn't feel like telling me to mind my own business. After all, I was trying to get her to do things just like everyone else. First there were many denials. I was different, she said. She didn't feel that way about me. However, at one point Mrs. G. revealed that she was afraid that if she told me to mind my own business I would go away and not come back. She admitted that

she did get angry when I was trying to get her to stop drinking, even though she knew it was for her own good.

I used every opportunity I had to elicit some feelings of dissatisfaction with what I was doing. Mrs. G. told me to mind my own business. Because Mrs. G. was discharging angry feelings, the depression lifted. The self-attacks ("I'm no good") associated with the depression can be seen as a way of avoiding attacking the person upon whom one feels dependent. Although the self is attacked, the recriminations belong to someone else. This pattern often stems from early childhood experiences when children are overly reprimanded, punished, and/or abandoned if they misbehave or criticize adults. Ironically, those same adults, unaware of the emotional impact of their upbringing, use methods that were once used on them to exert control over their children.

The school of modern psychoanalysis advocates "joining the resistance," which eventually lays the path for the client's expression of unacceptable aggressive impulses. Instead of suggesting that Mrs. G. stop drinking, I joined the resistance. At times I would say that she might need to drink because it made her feel better. I said I could see her point in wanting a few cocktails to relax her. Other people did that, why shouldn't she? At times I noticed she was surprised at my reactions, but she said nothing. By joining the resistance, Mrs. G. did not have to fight me. Resistance can be viewed as a person's strength until he becomes more aware of his conflicts. It is often difficult to say yes without the capacity to say no. I did not bring up the drinking again.

With the exception of medical emergencies, this patient had not been out of the apartment in two years. I ordered a wheelchair. Mrs. G. was terrified of falling. However, she managed to tolerate these feelings and ventured outside. She greeted Joe, the doorman, who was very happy to see her. She wanted me to come back the next day to take her out again. She enjoyed sitting in the sun and watching people.

Some months later, Mrs. G. told me that lately, when thinking about having a drink, she remembered that I said her life could change if she stopped drinking. She said that thought made an impact on her. She told me she wanted to try to stop drinking. About that time the home attendants noticed that Mrs. G. had been unusually groggy. I asked if she had been taking any medication. The attendants showed me a bottle of Percocet on the dresser. Percocet was known to produce drug dependence of the morphine type; it was dangerous when mixed with alcohol because the patient could exhibit an additive central nervous system depression. It should be given with caution to the elderly and those with liver or kidney impairment. I called her doctor and asked him about the prescription. After our talk, the physician visited Mrs. G. and took the medication with him.

I discovered that the home attendants were indeed leaving Mrs. G.'s home early. This was partially in response to Mrs. G.'s hostility and belligerence when she was inebriated. I think Mrs. G. told the attendants to go home so she could drink. Furthermore, she had a rather snobbish attitude toward "help" and had a self-pitying personality that invited attack, especially when drinking. I talked with the home attendants, explaining that alcoholism was a disease. Mrs. G. really wasn't in control as long as she continued to drink. As a consequence, they didn't feel so angry, alone, and helpless with this problem. They no longer showed up late and they did not leave early.

Mrs. G. struggled with her desire to drink. She felt overwhelmed with the idea of never drinking again. She was often tearful and frustrated. I said it was important to try to tolerate getting through a minute or an hour a day without drinking. She was winning the battle as long as she resisted the impulse in the moment. I tried to enlist the help of Alcoholics Anony-

mous to see if counselors would visit, but at that time they were not receptive to making home visits. As Mrs. G. drank less, she became more motivated and less irritable, and the home attendants were more interested in working as a team. One home attendant appeared for work in a starched uniform. She made milkshakes for Mrs. G., which I suggested might help fight the urge to drink. Mrs. G. was also eating better, because her appetite improved once she stopped drinking.

During this time, Mrs. G. talked to me at length about the death of her dog, which in turn brought up the loss of her husbands. In her more sober moments, she was intelligible. She was a strong, independent woman, tall and striking in appearance. She had a strong handshake, which she said she got from riding horses. I learned more about her background. She used to get up at 6:00 A.M., go riding with her husband, and then go to work with him. She survived three husbands, all physicians, and she worked with all three, managing the day-to-day details of their offices.

Talking relieved much of Mrs. G.'s depression. I could see that throughout her life, her husbands were the focal point of her existence. I believe the relationship with her therapist, another man, stimulated her and countered the loneliness in her life, particularly while she was giving up her reliance on alcohol, which is often felt to be a "friend."

She began to dream of her sisters. Three sisters died within a short period of each other, but the facts were not available to Mrs. G. because she had a difficult time remembering any details. However, the facts were not important. She had someone who listened; someone who liked her and cared about her life story.

During this period, Mrs. G. had one relapse and started drinking again. I used to visit her on Saturday mornings, and it was on one of those mornings that I discovered her asleep with a bottle of liquor next to her chair. I became irritated, and Mrs. G., after my lecture,

asked me to pour the bottle down the drain. After I left the house, I felt uncomfortable with my behavior. Perhaps Mrs. G. needed to drink. After all, alcohol was a way of self-medicating and managing intolerable feelings of helplessness, anger, and low self-esteem. I felt I had made a mistake and returned to Mrs. G.'s home. I said that I didn't have the right to tell her what to do. She might need to drink, and she had a right to make that choice. I offered to get her another bottle. She said she didn't want one. She was just worried that she lost a friend when I got upset and left.

The therapist's feelings (technically called countertransference reactions) guide the therapist's interventions and provide clues to the dynamic interactions involving *both* client and therapist. Mrs. G. could have been testing me to see how I would react if she drank again. It is likely that Mrs. G. was unconsciously seeking to provoke a negative reaction (my anger), which would prove to her I could not be trusted. Also, she was hoping for a different reaction from me. Her drinking could be seen as an attempt to liberate herself from an internal feeling of being controlled, with the consequent guilt feelings and physical deterioration as punishment for her wish. Admitting I was wrong (what I call a "countertransference slip") gave Mrs. G. the assurance that even if she did rebel (drinking) I would not leave her. In this instance *both* the client and therapist created a different ending to an old but familiar pattern of relationships.

Mrs. G. was on the wagon again. She became friendly with a neighbor whom she hadn't seen in a long time. The smells going through the vents to another neighbor's apartment stopped. Mrs. G. had difficulty remembering the day of the week, an obvious source of frustration. Together we developed a method to help her memory. Mrs. G. began to practice regaining her ability to remember things by organizing herself around a calendar we kept. She put ND for no drinking on each day she refrained from taking a

drink. This helped her remember what day it was. I was attempting to stop smoking, so I also put NS on each day I managed to win the battle. I have fond memories of those times sitting with Mrs. G. by her window overlooking Manhattan. She talked about whatever came to her mind. These moments together were calm, unlike the times spent with Mrs. G. when she was drinking.

Mrs. G. gradually regained an interest in food, purchasing fruits on our walks together. "There are two melons, let's buy them," she would exclaim. One night she had a significant dream in which she was at a dinner where there was lobster served and twelve people appeared. If this was a reference to the Last Supper, neither the savior nor the apostles actually came. However, on several occasions the home attendants and I did have dinner with Mrs. G. These were enjoyable visits, far removed from the hostility that once existed between Mrs. G. and the home attendants.

Mrs. G. finally allowed the attendants to wheel her outside, whereas before she only trusted me to do this. One day she proudly called me into her room and with great enthusiasm said, "See, I can walk on my own!" She was now able to maneuver in her apartment with her walker. This made it possible for Mrs. G. to go to the bathroom without the assistance of the home attendants, alleviating some feelings of humiliation. The incontinence improved considerably, and so in turn did Mrs. G.'s sense of self-respect. Her loss of bladder control was what originally motivated her to consider giving up alcohol.

Psychotherapy managed to stabilize this client's life. She did not have a drink in fourteen months. Instead of a thirst for liquor, she became in her words "people hungry." She progressed from a state of self-absorption to having a desire to be more connected to people. In her words, "it's not so good to be so used to being alone."

Mrs. G. was able to walk on her own, had a nutritious balanced diet, and developed a more satisfying relationship with the home attendants. In many ways she regained her sense of pride and self-worth.

Countertransference is a very useful tool in understanding ourselves and our clients. The therapist needs to be aware of attitudes and reactions that can interfere with the treatment—reactions such as having too much invested in the success of the treatment. Also, there is a tendency to infantilize older adults because of their more helpless and dependent state. I have experienced professionals who, on their first meeting, automatically address older adults by their first names when they would not normally do this with a younger adult population.

This treatment was successful because I accepted the patient's expression of angry feelings. If I needed only to feel successful or was threatened by negative, critical feelings, I might not have been able to tolerate Mrs. G.'s angry feelings. Mrs. G.'s ability to be angry at me, the one she depended upon, served to lift her depression, and it helped to foster a sense of identity and inner strength. It is important to remember that Mrs. G. had experienced a number of losses in her life—three husbands, her sisters, and her dog. It was the loss of her dog that triggered one hospitalization for depression. She felt vulnerable to the expectation of losing me if she did something she felt I wouldn't like. Mrs. G. did mention that her parents were very strict, controlling, and impatient with her. One might hypothesize that as a child Mrs. G.'s expression of negative feelings or misbehavior was met with punishment and/or abandonment. Framed in the context of fear of punishment and vulnerability to loss, it was essential that Mrs. G. find a place to experience being able to be angry at someone upon whom she felt dependent and survive. When this capacity is not achieved within the safety of the client-therapist relationship, the self-

attacks and self-depreciation related to depression and low self-esteem may remain unchanged.

Mrs. G. benefited from professional therapeutic intervention because the funds and professional expertise were in place at that time in that agency. As a result, Mrs. G.'s condition improved remarkably. She stopped drinking. As a consequence, her incontinence diminished and she was able to regain her appetite. She could walk again, freeing her up to leave her apartment for the first time in two years. She became people hungry. Above all, instead of feeling ashamed and hopeless, Mrs. G. regained her dignity and self-respect.

Commentary by Andrew Tatarsky

The story of Mrs. G. is another example of how powerful harm reduction psychotherapy can be in helping to bring about dramatic positive change for people with serious drug problems who may be simultaneously depressed, withdrawn, socially isolated, and experiencing numerous medical problems. In this case, an elderly, isolated, depressed, alcohol-dependent woman was able to use therapy to ultimately stop drinking, resolve her depression, become more physically healthy, and improve her social life and interpersonal relationships.

While the broad outlines of the psychotherapy described in this story do not fit that of the classical psychoanalytic model, it is clearly psychodynamic in its commitment to discovering the multiple meanings and functions of Mrs. G.'s drinking and the importance placed on the therapeutic relationship. The story also illustrates how a harm reduction approach naturally flows from a psychodynamic point of view.

Mrs. G.'s drinking was both a way of comforting herself in her depression and isolation and a way of expressing her defiance of other people's attempts to tell her what to do. Her need to be defiant may have been a way of sustaining a feeling of personal power and control over herself and her life in the face of the loss of power and control connected to aging and a series of significant personal losses. Yet, Mrs. G. felt unable to express her defiant feelings directly because of her fear of alienating others, and she discovered drinking as an indirect way of expressing them.

In recognizing these meanings of her drinking, Sehl knew that he could not also try to "*get her*" to stop drinking, as other people in her life were, because she would likely have to defy him by continuing to drink. He needed to address her depression before she would likely be motivated to give up alcohol. Sehl's pyschodynamic understanding of Mrs. G's depression, a turning in of anger on herself, led him to actively encourage her to express her anger toward him. When she did so, her depression lifted. In the process, she was simultaneously encouraged to express her defiant feelings directly in words. This took the juice out of defiant drinking, so to speak.

Because Sehl did not try to get her to stop drinking but, instead, encouraged her to express her defiant wishes to keep drinking and empathized with her reasons—that drinking helped her—she was freed from a struggle with him and could explore the problematic aspects of her drinking. In this process, Mrs. G. discovered better alternatives to drinking and became more motivated from within to stop. Talking about the reason for her depression—losses—in therapy and the relationship of Sehl were more effective antidepressants than alcohol; she became people hungry. Sehl helped her work on developing strong emotional management skills to tolerate periods of time feeling her feelings rather than drinking.

Here we see the collaborative discovery of the meaning of Mrs. G.'s drinking leading to a particular response from Sehl that helped create the therapeutic relationship. This in turn made it possible to relieve her depression and increase her motivation to stop drinking.

We can also see how this psychodynamic understanding of the reasons for Mrs. G.'s drinking made it necessary for Sehl to take a harm reduction approach with her. Namely, he had to accept her in therapy while she was drinking and with no expectation that she would stop. An expectation that she stop would likely have triggered her defiance and continued drinking.

This issue is a common reason why many people are not

successful in treatments that require that they stop. Harm reduction approaches do not trigger this defiance and lend themselves, as in Mrs. G.'s case, to positive alliances on the side of exploring all sides of a person's feelings about using drugs.

Another psychodynamic harm reduction strategy was evident here. Sehl helped Mrs. G. to gradually reduce her drinking by supporting her in learning to tolerate increasing periods of time without alcohol. This stepping down of the intensity of drug use is a hallmark of harm reduction approaches. As Mrs. G.'s drinking decreased she became less irritable, her relationships with her attendants improved, she was more emotionally available in the therapy, and she became motivated to stop drinking. Small positive changes led to further positive changes.

This story is also about the power of the therapeutic relationship to heal as a context for working on the issues and as a source of support, caring, and a positive experience of oneself and others.

Mrs. G.'s return to drinking after she stopped illustrates another important meaning that drug use can carry. Mrs. G. seemed to be testing Sehl's sincerity; was he really on her side, genuinely concerned about why she drank and how it related to her suffering, even if she resumed drinking? It was also a way to find out if he would stick around even if she abandoned her stated goals and "rebelled." His acceptance and openness to the meaning of her drinking enabled her to have a powerful positive experience that she could use to build a more hopeful sense of herself and relationships in general.

Sehl's empathy, acceptance, flexibility, willingness to examine and not just react from his own feelings, and ability to be spontaneous and try new things are all reflective of the psychoanalytic tradition and hallmarks of harm reduction psychotherapy.

References

Eisler, K. R. (1958). Remarks on some variations in Psychoanalytical technique. *International Journal of Psycho-Analysis*: 39: 222–229.

Freud, A. (1936). *The Ego and the Mechanisms of Defense.* London: The Hogarth Press.

Levinson, V. and Straussner, S. L. A. (1978). Social workers as "enablers" in the treatment of alcoholics. *Social Casework*, 59: 14–20.

Mitchell, S. A. and Black, M. J. (1995). *Freud and Beyond: A History of Modern Psychoanalytic Thought.* New York: Basic Books.

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