Psychoanalysis Meets Harm Reduction Psychotherapy

erica c. ernst, LCSW, RDDP, EMT-P, CADC
Gina Shropshire, LCSW

Comorbidity of Substance Use and Mental Illness

One-third of the people who experience emotional symptoms like depression and anxiety and one-half of the people who are living with severe and persistent mental illnesses like schizophrenia are using substances, often as a form of self medication.

Comorbidity of Substance Use and Mental Illness

The reverse is also true.

Between one-third and one-half of people who use substances also report experiencing some form of emotional symptoms or mental illness.

Who am I?

- Gina Shropshire, LCSW, ginshrop@gmail.com
  - Psychoanalytic psychotherapist and clinical social worker. Harm reduction friendly.
  - Began career in community settings with people with co-occurring mental illnesses and substance use disorders.
  - In private practice since 2004.
  - Candidate at the Chicago Institute for Psychoanalysis.
  - Advanced doctoral student and instructor at Institute for Clinical Social Work.

Why am I here?

The people we encounter in our work suffer from co-occurring emotional distress and substance use issues.

Psychoanalytic therapies have not been the go-to treatments for people with co-occurring substance use and emotional issues, but they can be useful (and potentially transformative), especially when combined with harm reduction strategies.

I’m going to tell you about this!

What are psychoanalytic therapies?

Psychoanalytic therapies are psychotherapies that utilize psychoanalytic theories and ideas to understand human behavior.

These therapies range in intensity from classical psychoanalysis (four – five times weekly sessons on the couch) to weekly psychotherapy.

Psychoanalytic therapies are interested in:

- The unconscious mind and the way it influences behavior.
- The persistent influence of the developmental history throughout life.
- The ways the past is repeated in the present.
- In particular, the ways the relationships from the past are repeated in the dynamic between the client and the therapist – in the transference and countertransference.

Psychoanalytic therapy with a person who uses substances:

A one-time (or more) weekly psychotherapy that utilizes psychoanalytic theories and ideas, but also makes use of modifications that could include supportive or direct interventions to assist the client, as well as outside support to assist the therapist.

Pronouns

I use the word “they” when I’m talking about a general client and “she” when I’m talking about a general therapist. This is just for clarity’s sake.

In the past I have – for clarity’s sake - used the word “he” to mean the general client. I apologize if some “he’s” remain in this presentation.

Confidentiality

We will be talking about clinical material. Please keep this information confidential. We take care to disguise our clients thoroughly, but we still ask that you don’t discuss any cases outside this room.

Psychoanalytic Theories about Substance Use

Have been few and far between . . .

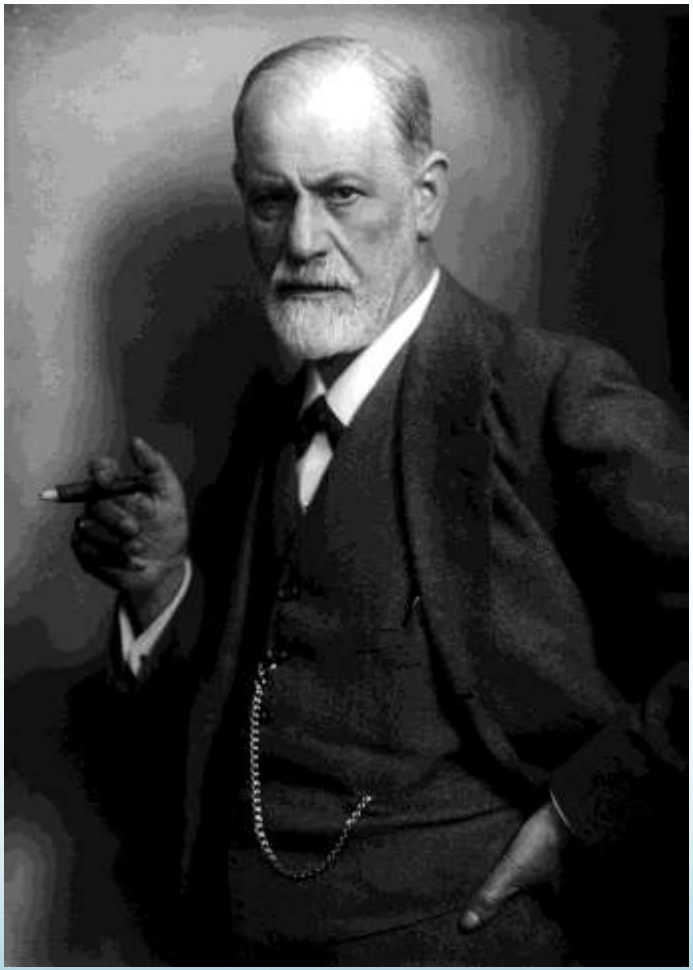
Once upon a time . . .

Addiction was seen as a moral failing.

And then . . .

Addiction was seen as a disease.

And then came . . .



Sigmund Freud

- **The father of psychoanalysis** (1856-1939).
- Developed psychoanalysis, **"the talking cure,"** a dialogue between doctor and patient utilizing free association and the interpretation of dreams, to treat hysteria.
- Developed theories about **human/personality development** that remain influential to this day.
  - **The drives** – only two things drive us – love (life) and aggression (death).
  - **Topographical theory** – our minds have three parts, the unconscious, the preconscious and the conscious. The things that are unconscious cause illness. To cure them, we have to bring them into consciousness.
  - **Structural theory** – id/ego/superego. Our id is the part of us that's all impulse/drive. Our superego is our morality and the way we wish we could be. Our ego is what we think of as our self. Our id, especially, but also our superego can make us ill. Bringing the id into consciousness and inline with the ego, and softening the superego, brings health.
  - **Psychosexual stages of development**.
  - **The Oedipus complex**.
  - And **a bunch of other stuff** . . . I could go on all day.

Sigmund Freud

He didn’t get everything right – in fact, he got many things wrong - but he developed new ways of thinking about the personality and treating suffering people that revolutionized and transformed how we understand our lives, and his theories served as a jumping off point for generations of thinkers and clinicians.

The Talking Cure

- Freud developed with Dr. Josef Breuer and his patient, **Anna O**.
- **Patient talks and doctor listens**. By remembering her story, repeating it, and working it through, Anna O. was cured of a crippling, hysterical illness.
- Patient reclines on couch and **free associates** (says what come to mind). Analyst listens – out of sight – neutrally, objectively, and without inserting herself into the situation. Analyst **interprets** what she hears patient saying.
- Sessions are **regular, frequent, at predictable intervals**, and they take place over months or years.
- Working through the stories of his past, the patient understands where they came from, how and why they developed their suffering, and develops self understanding. **Self understanding promotes freedom to choose** new ways of being, and brings about cure.

Freud on Substance Use

- Said a great many things about a great many things, but didn't have much to say on the topic of substance use.
  - He thought cocaine was *the greatest thing* early in his career.
  - He wrote in private correspondences that it was *obvious* that intoxication was a substitute for masturbation.
  - He wrote in *Civilization and its Discontents* that life is hard and unhappy, and substance use can effectively distract us from awareness of that for brief periods.

In the early days of psychoanalysis

- People who used/misused substances were not considered to be appropriate analytic patients.
  - They had disturbances in the pre-Oedipal phases of development. (That meant they were more ill than the ideal patient.)
  - They were perversely arrested at those early phases (in particular, the oral phase).
  - They were latent homosexuals (which, at that time, was also considered to be a perverse developmental arrest).
  - And, as mentioned, they used drugs as a substitute for masturbation.
- Ideal patients were neurotic people.

Years passed . . .

Along the way, ideas were voiced by theorists about substance use that softened (somewhat) these earliest assessments.

- Edward Glover, 1930's
- Herbert Rosenfeld, 1950's
- Heinz Kohut, 1970's

(Also in the 1970's, psychoanalysts in Chicago were working at methadone clinics! That's harm reduction!)

Over the years, substance use has been described in psychoanalytic literature as:

Compulsive, **obsessive,** *a re-enactment of trauma,* evidence of guilt and the need to punish the self, *symptom relief,* **evidence of profound ambivalence,** a love/hate relationship, **a both/and situation,** *identification with an idealized object,* identification with an ill or dead object, **identification with a destructive, rageful object,** *evidence of disturbance in early relationships,* projective/introjective process, **repetition compulsion,** *narcissistic rage,* defense against helplessness, **attempt to self-soothe,** *need to self-punish,* attempt to satisfy longing, **symptom management for depression, manic states, tense depressive states, anxiety, trauma . . . narcissistic crises, paranoid-schizoid states, omnipotence, splitting, dissociation, self-destruction . . .** An act that makes the user feel better . . . Or worse . . . . Or something . . . Or nothing at all, *not merely a symbol, but an actual intoxicating event,* **an act filled with meaning.**

Psychoanalytic Clinical Practice:

- Traditional psychoanalysis:
  - Four – five times weekly.
  - On the couch.
  - Silent/neutral/abstinent/invisible psychoanalyst.
  - Free association – golden rule.
  - Psychoanalyst intervenes through interpretations.

(Trivia - Freud seated himself behind his patients because he didn't want to impinge upon their free associating, but also because he didn't like being stared at nine hours a day.)

These days, this way of practicing is generally not practical . . .

- Fortunately, psychoanalytic therapy can be practiced in many ways.
- What makes a psychoanalytic therapy psychoanalytic is not the couch or the frequency of sessions. It's the use of psychoanalytic ideas to inform understanding of the client.
- (When Freud wrote his papers on technique, he probably didn't mean for them to get set in stone. He was probably suggesting guidelines.)

Leo Stone, 1960

- In his book, *The Psychoanalytic Situation*, Leo Stone stated that the classical frame of psychoanalysis was too rigid for many patients, and the analyst who was wedded to silence, abstinence, neutrality risked damaging his patient in critical moments when a real, human interaction was needed.
- Using psychoanalytic ideas within a modified frame or an adjusted clinical attitude, a psychoanalyst could help many kinds of formerly-believed-to-be-inappropriate-for-treatment people, including those who use substances.

Leo Stone, cont.

- Therapist is active, not silent.
- Therapist is a real person.
- Interpretation of the transference can wait.
- Early treatment focuses on supporting and containing the patient.
- Sometimes the patient's inside world can't be explored until his safety and difficulties in the outside world are addressed.

Debra Rothschild, 2007

- Relational theory/therapy + harm reduction!
  - The unit of inquiry in relational treatment is the relationship between the client and the therapist.
  - Emotionally charged, unconsciously motivated moments (enactments) happen during treatment, and they are explored to promote understanding and change.
  - This exploration of enactments is a great strategy with people who are prone to action – like compulsive drug users. Actions have meanings.
  - Exploring the meanings around the client's drug use, the therapist and client can learn about other meanings and other courses of action available to the client. This is harm reduction.

Four ways to work with substance users:

- Four major points of view around psychoanalytic therapies with compulsive substance users:

1. Psychoanalysis can proceed as usual if patient is able to give up use for the duration of the treatment (Rosenfeld).
2. Psychoanalytic technique may be modified and enhanced to meet the particular needs of the compulsive user (Stone).
3. Modified psychoanalytic technique should be augmented by specialized addiction approaches (Yalisove).
4. 4. A new model integrating psychoanalytic theory and harm reduction psychotherapy should be developed (Rothschild).

Clinical attitude today

- Therapist's own self is her best tool.
- Therapist is warm, empathic, authentic . . .
- She is aware of herself and the client, their relationship, and of the transferences and countertransferences that arise during the treatment.
- Therapist maintains, as much as possible, a neutral, abstinent (meaning she doesn't intrude on the patient with her own needs) attitude. But she is always a real person.
- Therapist creates and maintains a safe environment for the client.
- Therapist gets good support (from supervisors, experts, collaterals) in the service of the treatment.

In sessions we pay attention to:

- Information about the client's **unconscious** as presented through free association and through the reporting of dreams.
- **Defenses** used by the client.
- The relationship/interactions between the client and the therapist (**transference and countertransference**).
- **Conflicts** or **deficits**.
- **Resistances**.
- **Preoccupations**.
- Ways in which the **developmental history** impacts present day-to-day life.
- Important **events** in and outside of therapy.

How I do this:

- I assume there is **more going on than meets the eye.**
- I ask (myself)**, "What's the meaning of this?"**
- I don't ask direct questions. **I encourage the client to direct the conversation**.
- Themes, preoccupations, conflicts, deficits, defenses used, as well as predominant transferences come to light through the client's words. My countertransferences will also come to light. These all contain useful information!
- **I interpret what I think is going on** based on what I've come to know about the client through our interactions.
- Over time, through our conversation (hopefully) the **client develops new ways to think and feel about themselves.**
- Hopefully, this leads to **greater freedom and more choices** about how to live.

Safety I want my clients to be safe so we can work together!

- This is where harm reduction comes in:
  - I pay attention to myself. I make sure to put the client's needs first.
  - I listen for clues about the client's environment, relationships and behavior.
  - I maintain an attitude of openness, honesty, trustworthiness and hope enables my clients to tell me about traumatic or dangerous situations in their lives and about unsafe behaviors/situations that may be multiply determined (ie – that make the client feel simultaneously filled with and relieved of suffering), like substance use.
  - I try to facilitate an environment in which clients can look at their behaviors/situations and think about what they could do to be more safe.
  - If necessary, I engage directly in a conversation about safety, offering concrete suggestions and providing structure.
  - If absolutely necessary, I will directly intervene, weighing the risks to the client's safety against the risks to the therapeutic alliance that direct intervention could bring,

Ways that psychoanalysis can positively influence harm reduction strategies:

- The whole point of psychoanalytic therapy is for the patient to discover in themselves how they have come to be the way they are. In so doing, they can understand their motivations, desires, drives, their love and aggression, the choices they've made, the defenses they've deployed, the solutions they've developed, and the lenses through which they understand the world and the other people in it. With understanding, they can make choices about all these things.

Clinical vignette

Evi

(Even though I have disguised this person, please do not talk about her case outside of this room.)


HARM
REDUCTION

Isn’t harm reduction…

- In favor of drug use?
- Tacit consent to use drugs?
- “Don’t ask, don’t tell”?
- Simply a masked bid for drug legalization?
- “Anything goes”?
- Anti-abstinence?

Harm reduction

- Is a set of practical strategies that reduce negative consequences of drug use and other high-risk behaviors
- Incorporates strategies that range from safer use to managed use to abstinence
- Meets and accepts drug users on their own terms

– Harm Reduction Coalition

The spirit of our work

(Miller & Rollnick, 2002)

Harm Reduction

- Collaboration
- Evocation
- Autonomy
- Dancing

Opposite Approach

- Confrontation
- Education
- Authority
- Wrestling

Principles of harm reduction

- Drug addiction is a biopsychosocial phenomenon
- Drug use is initially adaptive
- *Drug*, *set*, and *setting* are central to understanding an individual's drug use
- There is no inevitable progression from use to dependence

(Denning, 2000)

Principles of harm reduction

- Users have the right to sensitive treatment, and to not be expelled for the very behavior that brings them to treatment
- Treatment should be based on the development of a needs hierarchy
- Active drug users can and do participate in treatment
- Success is related to self-efficacy
- Any reduction in drug-related harm is a step in the right direction

(Denning, 2000)

Principles of harm reduction

- Clients have a voice and are treated with dignity.
- Clients define their own goals.
- Clients' decisions to engage in risky behavior are accepted (pragmatism).
- Clients are expected to take responsibility for those decisions.
- Therapist focuses on reducing harm, and not necessarily on reducing the behavior itself.

Principles of harm reduction

- Harm reduction offers a creative, individualized menu of options.
- We celebrate small steps.
- We continually redefine success.
- Progress is a collaborative process.
- Building motivation is key to change.

Recovery = Any positive change

- Harm reduction values the development and maintenance of a nonjudgmental partnership that enables the client to make well-informed, empowered choices
- Recovery is envisioned as a process—the client sets the pace and parameters of that process, and any steps forward are valued

Harm reduction values

- See small changes as successes
- Recognize ambivalence as normal
- Emphasize the individual's strengths
- Emphasize personal responsibility for outcomes

Harm reduction values

We promote the human rights of all clients, including those who engage in risky behaviors.

Harm reduction and abstinence

- Harm reduction and abstinence are congruent goals
- Harm reduction expands the therapeutic conversation, allowing staff to intervene with active users who are not yet contemplating abstinence
- Harm reduction strategies can be used at any phase in the change process

Harm reduction applications

- **Safer sex** – education about condom use to prevent disease and contraception, avoiding risky sexual practices, abstinence….
- **Safer driving** – speed limits, seat belts, intoxication limits, air bags, defensive driving, abstinence….
- **Safer drug use** – reduced use, avoiding risky routes of administration, drug substitution, safe using partners (designated driver), abstinence….
- Other examples?

Hierarchy of harm reducing goals

- Staying alive
- Maintaining health, housing, employment, resources, etc…
- Improving quality life, choices and resources

(Some) Goals of harm reduction

- Save lives
- Safer drug use
- Reducing drug use
- Getting off drugs
- Improved emotional state
- Improved health and better nutrition
- Improved living situation
- Stable income
- Improved social relationships
- Reducing stigma
- Reduced social isolation
- Increasing validation and normalization
- Reducing risky or harmful behaviors
- Intact and better functioning families
- Reducing violence and aggression
- Higher self-esteem
- Greater ability to love and be loved

Harm Reduction and High-risk Behaviors

- Many of the same strategies can be applied to individuals who engage in high-risk behavior like sex work or remaining in domestic violence situations
- Harm reduction is consumer-centered, taking into account the needs articulated by the client and avoiding labels

Best Practices

- Balance the practice of harm reduction between the needs of individual, family, community and organization.
- Offer objective, factual information, both positive and negative, in the context of educating regarding choices and decision-making.
- Clarify consequences of choices, both positive and negative.

Best Practices

- Build policies and practices around safety issues and client functioning – focus on expectations and responsibilities rather than rules.
- Acknowledge change is hard, ambivalence is normal, and look for opportunities to build motivation to change.
- Celebrate collaboratively defined successes and identify lessons learned from setbacks.

Why do people use drugs?

- Mood
- Perception
- Socialization
- Religion
- Culture: mood-altering substances used in all cultures

Why use drugs?

The desire to alter one's experience of consciousness is universal, a basic human activity

Drug use and getting high

- Usually not pathological
- No inevitable progression
- On a continuum, but not linear
- Experimentation
- Regular recreational use
- Use for a purpose
- Problematic or chaotic use
- Addiction

Defining Terms

Drug: A common definition of the word ‘drug’ is any substance that in small amounts produces significant changes in the body, mind or both.

Psychoactive Drug: Psychoactive drugs target the Central Nervous System (CNS) and can affect mood, perception and/or thought, producing changes in both mind and body.

Substance: Any liquid, solid, or gas consumed for the purpose of changing a persons feeling, mood, or consciousness. Typically limited to those substance considered “drugs of abuse”.

Defining Terms

Substance Use: The consumption of any liquid, solid, or gas consumed for the purpose of changing a persons feeling, mood or consciousness. Typically limited to those substance considered “drugs of abuse” and those not prescribed by a person’s health care provider.

Defining Terms

Substance Misuse: Consuming any substance in larger quantities or more often, by different routes of administration, or for a different purpose than intended by prescribing health care provider.

For example:

1. Taking four doses of a prescribed “pain killer” at one time for the purpose of “getting a buzz” or taking this same pain killer more frequently than prescribed.
2. Injecting alcohol to get a fast and powerful high or snorting pain killers.
3. Taking four doses of Benadryl™ for the purpose of “catching a nod”.

Drug, Set, and Setting

- **Drug**: the drug itself, its effects and the consequences of its use
- **Set**: the individual's unique self – his or her physiology, experience, culture, and mental or emotional state
- **Setting**: the context of use – stress, support network, those with whom one uses, and one's cultural or community standards

(Zinberg, 1984)

Characteristics of a good relationship with drugs

- You recognize that the substance is a drug, and know how it affects your body.
- You maximize the pleasure you get from a drug by using it sparingly and strategically.
- You are using it with no adverse physical or social effects.
- You can take it or leave it.

Prohibitionism

- The drug is associated with the corruption of children, particularly their sexual corruption.
- User and supplier are defined as fiends always searching for new victims; use is considered contagious.
- People who resist prohibitionism (abstinence) are seen as part of the problem.

Harm Reduction Therapy

- Is grounded in Public Heath
- Low-threshold access (Marlatt & Tapert, 1993)
- Services are offered with the least amount of requirements or restrictions

Stages of Change

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse
- Termination

(Prochaska et al., 1992; Prochaska, Norcross & DiClemente 1994)

Harm Reduction Resources:

Kenneth Anderson, *How to Change Your Drinking.*

Patt Denning and Jeannie Little, *Practicing Harm Reduction Psychotherapy.*

Andrew Tatarsky, *Harm Reduction Psychotherapy.*

Antoine Douaihy and Daley Dennis, *Substance Use Disorders.*

Patt Denning et al , *Over The Influence.*

Richard Pates, *Harm Reduction in Substance Use and High-Risk Behaviour.*

Kim Mueser et al, *Integrated Treatment for Dual Disorders.*

William Miller and Stephen Rollnick, *Motivational Interviewing.*

SMART Recovery Handbook.