

Psychotherapy Meets the Twelve Steps: An Integrative Approach

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Outline

1. Previous failures of traditional psychodynamic psychotherapy with addicts and alcoholics
2. Reasons for renewed interest in psychotherapy for addiction
3. Indications for psychotherapy
4. Integrative Approach: Recovery-Focused Psychotherapy
5. Self-Medication Model



Psychotherapy for SUDs

Failure of Traditional Approaches

- ◆ Focused on underlying causes, not behavior change
- ◆ Substance use seen as a symptom, not as a primary disorder
- ◆ Assumed that substance use will stop when underlying issues are sufficiently resolved
- ◆ Therapist takes a passive, nondirective stance
- ◆ The therapy itself is anxiety-provoking



Psychotherapy for SUDs

Reasons for Renewed Interest

- ◆ Modifications in techniques and timing
- ◆ Development of new strategies
- ◆ Increasing demand for more individualized approaches
- ◆ Increasing recognition that psychological factors contribute importantly to addiction and relapse



Step Four: "Character defects"

- ◆ "Character defects based upon shortsighted or unworthy desires are the obstacles that block our path toward the achievement of AA's objectives."
- ◆ "How reluctantly we alcoholics come to grips with those character flaws that make problem drinkers of us in the first place, flaws which must be dealt with to prevent a retreat into alcoholism once again."



Psychotherapy for SUDs

Reasons for Renewed Interest

- ◆ Increasing demand for office-based treatment
- ◆ Influx of higher-functioning patients
- ◆ Influx of mental health professionals
- ◆ Synergy with new pharmacotherapies
- ◆ Empirical evidence of effectiveness



Psychotherapy vs. Counseling

- ◆ Psychotherapy focuses not only on the addictive behavior, but also on related psychological and psychiatric issues that may be intertwined with the addiction
- ◆ Self-esteem, affect regulation, interpersonal relationships, sexuality, defensive structure, other personality problems, dependency issues, impact of previous trauma, separation-individuation, Axis I and Axis II disorders, etc.



Newer Approaches

- ◆ Cognitive-Behavioral (relapse prevention)
- ◆ Motivational (client-centered)
- ◆ Brief Interventions (Stages of Change)
- ◆ Modified Psychodynamic (self-medication)
- ◆ Integrative (Recovery-Focused Psychotherapy)



Indications for Psychotherapy

- ◆ To engage patients who are actively using
- ◆ To help patients develop the motivation and resolve to stop using
- ◆ To supplement the patient's involvement other treatment modalities



Indications for Psychotherapy

- ◆ As aftercare following the patient's completion of other treatment modalities
- ◆ For patients who have already achieved stable recovery
- ◆ To centralize and coordinate the patient's involvement in multiple treatment modalities
"Primary Care Therapist"



Indications for Psychotherapy

- ◆ Many patients require individual therapy to remain with other treatments
- ◆ Many cannot or will not make use of other modalities



Integrative Approach

Recovery-Focused Psychotherapy



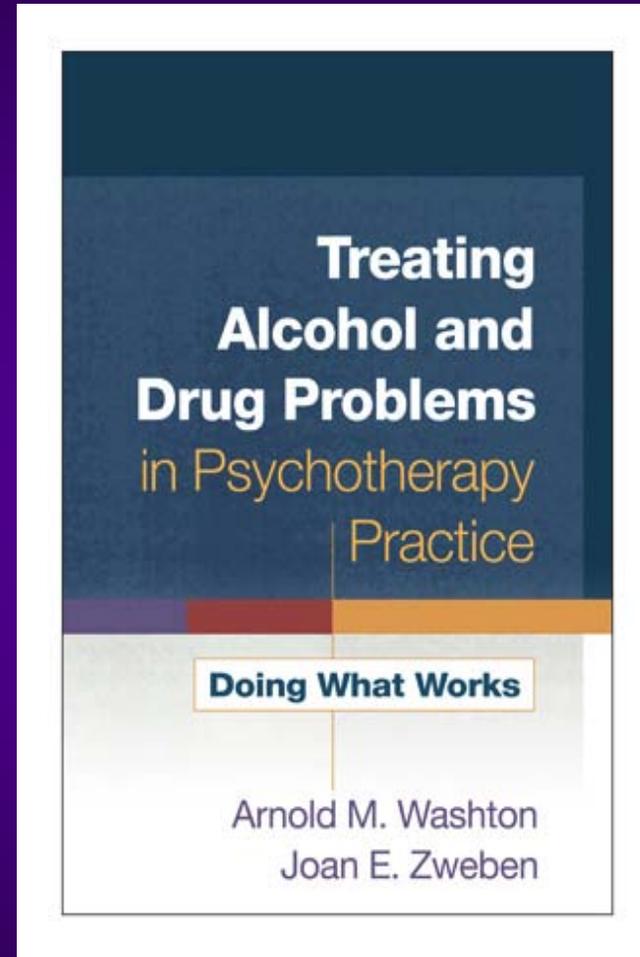
Integrative Approach

- ◆ Integrates recovery-oriented psychotherapy, abstinence-based addiction counseling, AA involvement, and pharmacotherapy (when indicated), while maintaining a perspective on the unique psychology and psychodynamics of each patient



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Integrative Approach

- ◆ Flexible, pragmatic, non-dogmatic
- ◆ Neither requires nor recommends adherence to one theoretical model or treatment approach
- ◆ Encourages creativity, flexibility, and open-mindedness
- ◆ Blends together many different and seemingly conflicting treatment approaches
- ◆ Priority #1: the therapeutic relationship



Guiding principles

- ◆ Start “where the patient is”
- ◆ Do what works
- ◆ Above all, do no harm !



Integrative Approach

- ◆ A truly individualized approach, adjusted to meet the clinical needs of each patient
- ◆ Emphasizes the centrality of the patient-therapist relationship as a vehicle for facilitating change
- ◆ Respects timing and sequencing of issues to be addressed at each stage of treatment



Phases of Treatment

- ◆ Phase 1: Engaging the actively-using client
- ◆ Phase 2: Negotiating treatment goals
- ◆ Phase 3: Helping the client to stop using
- ◆ Phase 4: Teaching relapse prevention skills
- ◆ Phase 5: Addressing psychological issues



Integrative Approach

Distinguishing Features

- ◆ **Nondogmatic, Individualized**- no single treatment method, philosophy, or pathway to recovery is best for everyone with an alcohol/drug problem
- ◆ **Flexible**- treatment adjusts to accommodate the changing needs of patients as they move through successive phases of treatment



Integrative Approach

Distinguishing Features

- ◆ **Client-Centered-** must meet patients “where they are”; positive therapeutic alliance is important to facilitate positive change
- ◆ **Empirically-Supported-** incorporates some of the field’s “best practices” supported by recent research



Integrative Approach

Distinguishing Features

- ◆ **Stages of Change Model** to guide the timing, choice, and sequencing of treatment interventions
- ◆ **Disease Model** to justify the need for total abstinence and induct patients into a recovery-oriented framework



Integrative Approach

Distinguishing Features

- ◆ **Harm Reduction Model** (when needed) as initial engagement strategy for patients unwilling to start with abstinence
- ◆ **Self-Medication Model** to identify and address psychological issues intertwined with the addiction



Integrative Approach

Distinguishing Features

- ◆ **Motivational therapy** to facilitate patient engagement and enhance patient motivation readiness for change
- ◆ **Cognitive-behavioral therapy** to help patients establish abstinence, prevent relapse, manage cravings/urges, manage negative emotions/moods



Integrative Approach

Distinguishing Features

- ◆ **12-step facilitation therapy** to enhance involvement in AA and other 12-step programs
- ◆ **Modified psychodynamic therapy** to address “self-medication” aspects of substance use and other core psychological issues



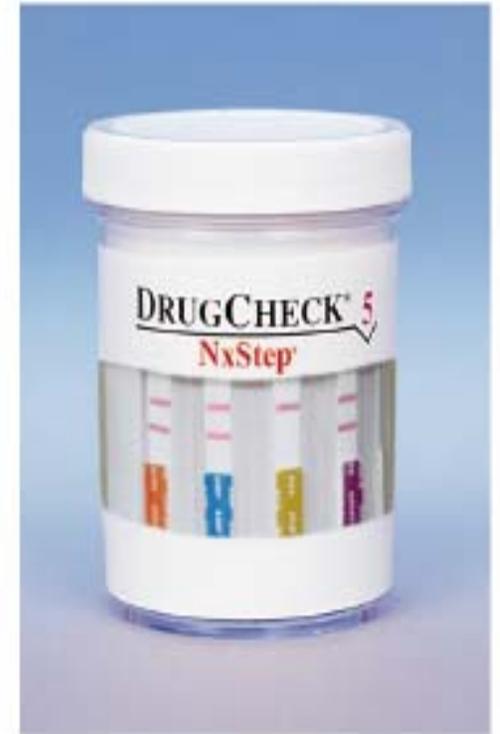
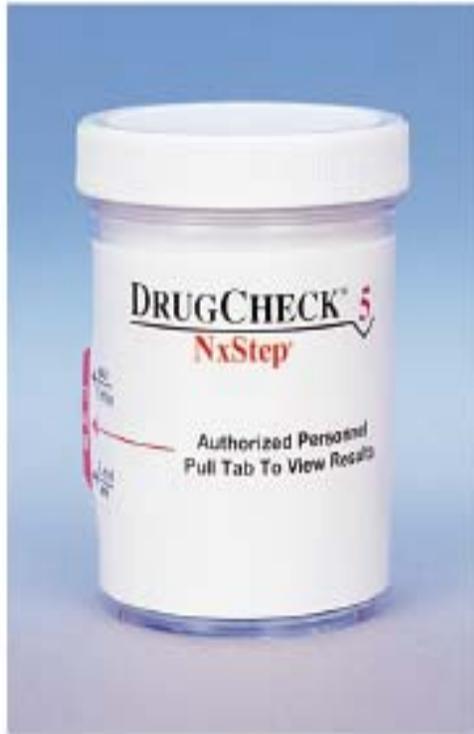
Integrative Approach

Distinguishing Features

- ◆ On-Site Urine Testing
 - ◆ Supports and reinforces impulse control
 - ◆ Objective marker of progress
 - ◆ Enhances credibility with significant others
 - ◆ Not intended to catch patients in lies
 - ◆ Should never be used to impose consequences



Onsite Drug Test





Advantages of Office-Based Treatment

- ◆ Private, totally confidential
- ◆ Alternative to traditional treatment programs
- ◆ Lower entry threshold, less stigmatizing
- ◆ No institutional control over treatment



Advantages of Office-Based Treatment

- ◆ Fosters rapid development of therapeutic alliance
- ◆ Opportunity for early identification and intervention
- ◆ Flexible, individualized approach rather than “one size fits all”



Office-based treatment is especially attractive to patients who...

- ◆ Do not meet criteria for Dependence
- ◆ Want alternatives to mainstream programs
- ◆ Want personalized attention
- ◆ Want to choose their own therapist
- ◆ Want treatment delivered by a licensed MH professional
- ◆ Are executives, professionals, and others with strong confidentiality concerns



Especially attractive to patients who...

- ◆ Are in the early stages of coming to grips with an alcohol or drug problem
- ◆ Want an approach that is motivational, not confrontational
- ◆ Have maintained abstinence and want psychotherapy to address related psychological issues



Especially attractive to patients who...

- ◆ Are currently receiving group therapy in an outpatient program and want concurrent individual therapy
- ◆ Have completed an outpatient or inpatient program and want aftercare individual and/or group therapy
- ◆ Are in AA or other self-help programs and want professional therapy to deal with issues that self-help alone cannot adequately address



Limitations of Office-Based Treatment

- ◆ Higher cost
- ◆ May not be covered sufficiently if at all by insurance
- ◆ Limited intensity



Therapist Qualifications

Clinicians with professional (graduate) training and expertise in both psychotherapy and addiction treatment:

- ◆ Addiction Psychologist (Ph.D., Psy.D.)
- ◆ Addiction Psychiatrist (M.D., D.O.)
- ◆ Master's level mental health therapist (e.g., LCSW, MFT)



Practical Aspects

- ◆ Individual therapy alone or in combination with small group therapy
- ◆ Office-based private practice setting



Practical Aspects

- ◆ Geared toward functional adults
- ◆ May have co-existing mood or anxiety disorders, but no severe psychiatric illness
- ◆ Close collaboration with prescribing physicians and other caregivers/program



Synergy between Psychotherapy and Pharmacotherapy

- ◆ Mutually enhancing
- ◆ Better patient retention and compliance
- ◆ Lower dropout and relapse rates



Synergy between Psychotherapy and Pharmacotherapy

- ◆ Relapse prevention
 - ◆ Naltrexone, Acamprosate
- ◆ Opioid substitution
 - ◆ Methadone, Buprenorphine
- ◆ Co-occurring psychiatric disorders
 - ◆ Antidepressants, Mood Stabilizers



Addressing Psychological Issues



Self-Medication Model

- ◆ Substance use is initially adaptive, an attempt to cope.... with stress, negative emotions, lack of assertiveness, social anxiety, etc...
- ◆ Because substances instantly reduce negative emotions and enhance functioning, they become extremely potent reinforcers



Self-Medication Model (EJ Khantzian)

Addiction vulnerability is due to deficits in four specific areas of psychological functioning:

- ◆ Affect (emotional) regulation
- ◆ Self-esteem regulation
- ◆ Self-care functions
- ◆ Managing interpersonal relationships



Self-Medication Model

- ◆ Substances are used initially as attempt to cope
- ◆ Addiction develops when substances are used repeatedly and habitually as coping strategies



Self-Medication Model

- ◆ Addiction-prone people often lack the ability to reliably identify, modulate, tolerate, and appropriately utilize/express feelings
- ◆ Addiction develops only to those substances that actually work to alleviate problems and/or enhance functioning



Self-Medication Model

- ◆ Addiction prone individuals use substances as a way to cope with inner difficulties that they are unable to resolve in other more adaptive ways
- ◆ Using substances to manage negative emotions and moods is maladaptive because it disables and nullifies the “signal value” of emotions
- ◆ Without emotional “radar” painful collision with reality is inevitable



Self-Medication Model

- ◆ The particular substance that ultimately becomes an individual's drug of choice is neither random nor accidental
- ◆ Specific substances are chosen because an individual discovers (often out of conscious awareness) that a specific pharmacological action helps to alleviate their emotional discomfort and suffering



Deficits in Emotional (Affect) Regulation

- ◆ Feelings often are vague, ill-defined, confusing, or totally obscured
- ◆ Feelings are poorly regulated and poorly tolerated
- ◆ Feelings are usually acted out (expressed through action), rather than worked out (processed adaptively)



Deficits in Affect Tolerance

- ◆ Some people are overwhelmed and traumatized by intolerable emotions (“affective flooding”)
- ◆ They have an inadequate stimulus barrier and lack sufficient affect management and self-soothing abilities



Deficits in Affect Tolerance

- ◆ Lack ability to differentiate, verbalize, and contain emotions and thus use them adaptively as signals
- ◆ Substances that anesthetize feelings may be especially appealing- alcohol, sedatives, opioids,
- ◆ May be developmentally rooted in childhood abuse, trauma, neglect, chaos, and “unattuned” parenting



Deficits in Affect Recognition

- ◆ Other people feel too little, have an overactive stimulus barrier, are emotionally numb, lack signal anxiety, and have impaired affect recognition skills ("Alexithymia")
- ◆ This lack of emotional "radar" leads to maladaptive behavior because problems do not set off the appropriate emotional warning signals to get their attention and mobilize adaptive problem-solving behaviors



Deficits in Affect Recognition

- ◆ Stimulant drugs such as cocaine or methamphetamine may be especially appealing because they induce rather than anesthetize feelings
- ◆ These drugs induce feelings of sexuality, being alive, and create an illusory sense of being more emotionally present



Drug of Choice Phenomenon

◆ ***Opioids***

- ◆ Provide extraordinary relief of emotional pain that helps to modulate disturbing feelings of anger, rage, and disappointment that are the source of much suffering

◆ ***Alcohol and Sedative-Hypnotics***

- ◆ Help tense, emotionally-constricted individuals experience walled-off affects and overcome fears related to closeness, dependency, and intimacy



Drug of Choice Phenomenon

◆ ***Cocaine, MA, and other stimulants***

- ◆ Highly activating drugs that can help to overcome feelings of fatigue, boredom, depletion, depression, and inhibition (particularly sexual inhibition in males)
- ◆ High-energy individuals may be attracted to stimulants because it increases feelings of self-esteem and self-sufficiency and amplifies a preferred hyperactive style
- ◆ Paradoxically stimulants can calm the restlessness and hyperactivity of individuals who suffer with ADD or ADHD



Deficits in Self-Esteem Regulation

- ◆ Hypercritical inner voice
- ◆ Hyper-reactive easily injured sense of self that generates emotional pain and profound dysphoria which can be disorganizing and/or paralyzing
- ◆ Self-esteem may be like a “candle blowing in the wind”
- ◆ “Imposter Syndrome”



Deficits in Self-Esteem Regulation

- ◆ May develop an entitled “grandiose self” that masks poor self-esteem and places unreasonable demands on others to gratify narcissistic needs (“splitting” defenses)
- ◆ When limitations are inevitably encountered in others’ giving, painful affects of shame, rage, and feelings of abandonment are elicited



Deficits in self-care

- ◆ Inability to anticipate problems and use emotional signals to activate defenses and/or avoidance maneuvers
- ◆ Inability to soothe and calm oneself when stressed or overwhelmed



Deficits in Relationship Functioning

- ◆ Dependency
- ◆ Counter-dependency (pseudo-autonomy)
- ◆ Passivity & lack of assertiveness
- ◆ Poor boundaries
- ◆ Parent-child dynamic



Clinical Implications of the Self-Medication Model

- ◆ Treatment must address the “self-medication” aspects of a person’s substance use
- ◆ Create atmosphere of behavioral and emotional safety (“holding” environment)
- ◆ Utilize cognitive-behavioral and DBT techniques to teach patients how to recognize, label, and manage internal affects and contain acting-out impulses



Clinical Implications of the Self-Medication Model

- ◆ Utilize psychotropic medication, where indicated, to cushion emotional extremes and thereby facilitate learning of affect regulation skills
- ◆ Use insight-oriented techniques, when appropriate, to address ongoing and unresolved psychodynamic issues