Psychotherapy Meets the Twelve Steps: An Integrative Approach

Arnold M. Washton, Ph.D.
Clinical Director, The Retreat at Princeton
Princeton House Behavioral Health
and
Executive Director, Recovery Options
A Private Practice of Addiction Psychology
New York, NY and Princeton, NJ
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.
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 Khantizian)

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.
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