The Top 3 Psychological Issues That Drive Addiction
A Psychotherapist’s Role in Treating Substance Abuse

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Substance abuse is a complex, multidimensional disorder. While it is traditionally characterized as a "biopsychosocial" disease, the role of psychotherapy in treating addiction is paradoxically given short shrift or ignored completely in traditional treatment approaches based on the disease model.

In this White Paper we discuss an integrated approach to treating addiction that goes beyond the addiction itself to address multiple areas of an individual's psychological and emotional functioning, as in any psychotherapy.

Our discussion centers on psychological issues that are often intertwined with substance abuse and the importance of addressing these issues in ongoing psychotherapy. These include:

The functional role and significance of substance use and the top 3 issues driving addiction:
1. Relationship and intimacy issues
2. Separation and individuation issues
3. Childhood trauma and PTSD issues

We also discuss the clinical value of helping patients identify positive byproducts of their struggle with addiction, above and beyond whatever negative impact it may have had on their lives.

In our view, the goal of psychotherapy for addiction is not merely the acquisition of self-knowledge and insight, but fundamental change in an individual's habitually maladaptive ways of thinking, feeling, behaving, and interacting. Because people with long histories of substance abuse often lack the ability to identify, modulate, tolerate, and appropriately express
feelings (especially negative ones), psychotherapy can play an important role in raising a person’s awareness of these difficulties and in developing affect management skills to improve their functioning and to help prevent relapse over long-term. Ongoing therapy can also address, where indicated, couple’s issues and long-standing problems that may stem from parental alcoholism, physical and psychological abuse, and other developmental and life traumas. Each patient’s treatment requires a focus on different sets of issues and themes as these arise in the course of the treatment. An important caution is that whenever such highly charged issues are being addressed, the therapist must be especially mindful of the patient’s heightened potential for returning to alcohol and drug use. Even when exploration of these issues appears well-tolerated, patients and therapists should always be alerted to the possibility that focusing on these issues can and sometimes does reignite the person’s desire to medicate emotional discomfort with alcohol and drugs. Thus, psychotherapy with these patients should never lose sight of the potential for relapse, no matter how motivated and stable they appear to be.

It is frequently said that psychological issues cannot be meaningfully addressed and psychotherapy is not likely to be beneficial while patients continue to use intoxicants at any level (even if the patient is not intoxicated during therapy sessions) and not until a period of at least three to six months of uninterrupted abstinence has been achieved. This view is based on the assumption that use of intoxicants at any level poses an obstacle to making therapeutic progress. It is seen as preventing patients from developing a realistic perspective on their behavior, from getting in touch with internal feelings, and from acquiring non-chemical coping and affect management skills. Also, there is concern that while patients are focusing on the challenging task of changing their substance use behavior, they cannot channel sufficient energy into addressing and working through other issues.

However, we think it important to recognize that many patients come to treatment with personal crises and other problems that beg for immediate attention. Some patients insist on addressing relationship problems or negative mood states (e.g., anxiety or depression) as their first priority rather than substance use. Although continued substance use can and often does hamper efforts to address other problems, the patient’s immediate concerns and priorities must not be overridden or ignored by a therapist who insists on unilaterally setting the treatment agenda. A balance must be struck in ongoing therapy sessions between addressing substance
abuse on the one hand and giving sufficient attention to problems that are of greater concern to the patient, on the other.

The need for ongoing psychotherapy as part of an overall recovery plan that extends beyond dealing with the substance abuse itself, depends primarily on the person's desire, readiness, and felt need for this type of treatment. Not all individuals want or need ongoing psychotherapy to maintain recovery. Some patients have little or no interest in engaging in ongoing psychotherapy, including those who are satisfied with having achieved their initial substance use treatment goals (whether reduction or abstinence), those who see their participation in 12-step programs rather than therapy as the mainstay of their recovery plan, those who are not actively distressed or emotionally unstable, and those who do not feel at high or imminent risk of returning to their former pattern of substance use.

Inevitably, however, many individuals reach a point where they are disappointed to find that while remaining abstinent from alcohol and drugs has brought substantial relief from problems caused by the substance use itself, it has not resolved other emotional difficulties that surface more clearly in the absence of the substance use. Others become receptive to engaging in ongoing psychotherapy after relapsing repeatedly in prior to attempts to maintain abstinence despite their conscious intentions to remain alcohol and drug free. They may develop a sense that perhaps there are unconscious conflicts and other forces operating beneath the surface that lead them back to using substances over and over again. Still others arrive at a point in recovery where they feel a need to find out why they developed a serious alcohol or drug problem in the first place, seeing identification and resolution of these issues as important to sustaining recovery over the long term.

Some of the key psychological themes and issues addressed in ongoing addiction psychotherapy include: (a) working through grief and loss centered around giving up alcohol and drugs and the lifestyle associated with using as well as other losses resulting from death, divorce, and wasted time; (b) addressing childhood traumas including abuse (both physical and psychological), neglect, and abandonment; (c) addressing transference and countertransference reactions; (d) relinquishing narcissistic vulnerabilities; (e) overcoming residual dysfunctional affects including chronic depression and anxiety; and, (f) establishing healthy self-care.

**The "Self-Medication" Value of Substance Use**
An essential theme in ongoing psychotherapy for substance abuse is examining the meaning and role of alcohol and drug use in the person’s life. Typically, this involves focusing in detail on how substances may have been used to self-medicate intolerable affects and escape conflict. Exploration of these issues is valuable because it provides a basis for understanding that for individuals who develop chemical addictions, substance use is initially an attempt to cope and to resolve human problems. Consistent with this view, it seems that individuals develop addictions only to those substances that work well for them in the early stages of use. They become victims of expecting that they can derive the beneficial self-medicating effects of alcohol and drugs without suffering the adverse consequences. In this context, it is not surprising that many patients experience intense grief reactions and considerable anxiety when they attempt to give up alcohol and drugs.

Some authors contend that without addressing and working through certain core issues, unique to each person, the prognosis for long-term recovery may be substantially diminished. Psychodynamic theories of addiction have emphasized that in addition to the role of internal (unconscious) conflict and the object meaning of alcohol and drugs for an individual, deficits in ego and self functioning are important contributors to reliance on psychoactive substances. There are certain types of self-regulatory impairments that require attention in ongoing psychotherapy with addicted patients. These are: deficits in affect management, self-esteem maintenance, the capacity for self-care, and interpersonal relations. Problems in these areas may be evident during active addiction, but usually reveal themselves more clearly during periods of sustained abstinence. Similarly, therapy from a self-psychology perspective defines pathological narcissism as a core issue for people in recovery, and defines the primary goals of psychotherapy in later-stage recovery as internalization of sobriety, remediation of structural deficits in the self, resolving intrapsychic conflicts, and building genuine self-esteem.

1. RELATIONSHIP ISSUES

Some authors contend that achieving healthy intimate relationships is the single most important objective of recovery. Healthy intimate relationships can be defined as having certain defining features, including:
1. The partners are meaningfully connected, but not fused or enmeshed with one another. Each retains appropriate autonomy from the other and boundaries are respected and kept clear.

2. The partners are able to freely express both positive and negative thoughts and feelings to one another without fearing reprisal, recrimination, or hostility from the other. Communication is respectful and well-intentioned. The partners work hard on the difficult task of tolerating and processing anger appropriately with one another.

3. The partners are able to use their communication with one another to define and maintain boundaries of the relationship; to express caring, concern, and commitment; to negotiate rules and roles; and, to resolve conflicts.

4. Sexual experience, which is not synonymous with intimacy but only one way of expressing it, is caring, nurturing, and affectionate, and mutually satisfying for both partners. There is a balanced perspective about sex- it is neither made too important or neglected. Sex between the partners is free of shame and guilt.

Married couples and others in intimate relationships are affected not only by a partner’s active addiction, but also by profound changes that occur during recovery. Once active alcohol and drug use are no longer clouding the picture and serving as the primary focus or preoccupation of the relationship, other difficulties emerge more clearly, often revealing serious deficits in communication and intimacy. The partner in recovery may be at a disadvantage in not feeling that he has the right to voice dissatisfactions with certain aspects of the relationship, and it may become clearer that previous substance use was a way to avoid facing these problems. Sustained abstinence often brings destabilization in relationships as the power dynamics shift. Alcohol and other drug use also may have promoted an abusive dynamic, in which anger and irritability were used to intimidate the non-addicted partner into submission. Once the substances are removed, communication and conflict resolution skills are needed as tools to renegotiate the interpersonal dynamics of the relationship.

As recovery proceeds, many relationship issues and dynamics rise to the surface that are not unique to people recovering from addiction. The tendency of addicted people to become fused and/or enmeshed with their partners requires a focus on clarifying personal boundaries, so that neither partner consumes or dominates the other. Some patients have an intense need for fusion
in order to feel safe and they need help to develop the capacity to comfortably be alone, even when not attached to a significant other. Developing intimacy while retaining healthy autonomy is a challenge, especially if there is a long history of using alcohol and other drugs to feel connected or to escape feeling engulfed and smothered.

Sexual problems may emerge particularly in individuals who have used drugs to enhance their sexual experiences. Sex can be a trigger for renewed drug cravings and a powerful relapse trigger. Many patients come to believe that they cannot function sexually or genuinely enjoy sex without intoxicants. They cannot imagine getting through feelings of awkwardness and self-consciousness, particularly with a new partner. Past infidelities can pose a formidable challenge to the viability of the relationship and may be an insurmountable obstacle for some couples. Under the influence of alcohol and drugs, many individuals (particularly those who use stimulant drugs) engage in sexual behaviors and indiscretions that are uncharacteristic of them, but the partner’s sense of betrayal is often profound and persists well into recovery. The partner’s pent up anger, disappointment, resentment, and pain can be overwhelming and create a formidable barrier to re-engaging in sex and intimacy.

As the recovering partner continues to remain sober, the power balance in the couple’s relationship inevitably shifts. During active addiction, addicted partners do not want to call attention to themselves and their mates typically assume major responsibilities and control, particularly where children are involved. Then, in early recovery, shame and guilt often prevents the now abstinent person from challenging the mate. With extended recovery, however, other relationship problems emerge and the role of “identified patient” becomes increasingly unacceptable to the person in now good recovery. Recovering partners becomes better able to stand up for their legitimate needs and opinions, and they begin to insist on more equality. This is particularly likely to play out over money and parenting issues. The anxieties and resistances of the mate must be handled sensitively, particularly if there has been a long period of irresponsibility during active use.

Will the relationship survive recovery? The complex challenges of couples in recovery have been described in a developmental model that examines the tasks in the active addiction cycle, transition to abstinence, and ongoing recovery. Certainly the couple’s chances improve if the partner is willing to learn about addiction and recovery and use the opportunity to make appropriate changes in the service of enhancing their own lives. Couples may benefit from
working with a skilled couple’s therapist who has in-depth knowledge and understanding of recovery-related issues. In our clinical experience, poor prognostic signs for relationships surviving recovery include: (1) the relationship was formed while the addiction was active; (2) the mate has unrelenting hostility and resentment; (3) the mate refuses to self-examine and take any responsibility whatsoever for contributing to problems in the relationship; (4) the mate is unable to see the need for personal change; and, (5) the mate is unwilling to engage in individual therapy, couple’s therapy or self-help. However, it essential to avoid premature conclusions and predictions of failure based on these considerations, as some couples are able to overcome immense obstacles and emerge with a healthier and stronger relationship.

2. SELF-ESTEEM ISSUES

Self-esteem problems are nearly universal among people who develop addictions. In some cases, this is evident in an individual’s self-deprecating posture and passive reluctance to ask for what he or she needs. In others, problems of low self esteem may be covered over by a hostile demanding attitude fueled by arrogance and grandiosity. These dynamics are likely to show up in the patient’s transference reactions to the therapist, providing an opportunity to address them therapeutically. Typically, self-esteem problems are rooted in developmental insults including the remnants of unattuned parenting as well as psychological abuse and neglect.

Also contributing to self-esteem problems are lingering feelings of shame, guilt, and self-recrimination stemming from the individual’s behavior while actively addicted. These may include acts of dishonesty, irresponsibility, and infidelity. Many patients also lament wasted time, energy, and money associated with their alcohol and drug use. While it is important to support your patient’s willingness to accept personal responsibility for regretted behaviors, it is just as important to help them achieve self-forgiveness, realizing that many of things they did while addicted were part of the insanity of addiction and not characteristic of how they normally behave. It can be very difficult for individuals to achieve greater self-acceptance and make peace with the past while others adversely affected by the addiction (e.g., spouses) continue to express anger, hostility, distrust, and deep-seated resentment toward them. A helpful edict espoused in AA is that greater self-esteem results from performing estimable acts such as being rigorously
and unfailingly honest as well as humble and non-defensive about previous acts that have adversely affected others.

3. CHILDHOOD TRAUMA and PTSD

One of the most significant unacknowledged contributors to alcohol and drug relapse is the failure to identify and treat underlying childhood abuse issues. Addictive behaviors are not only manifestations of the underlying self-impairment caused by trauma, but they also mask the impairment and damaged sense of self. In many if not most cases, only after the addictive behavior has ceased for a while does recognition and repair of the original trauma become possible. Sustained abstinence from alcohol and drugs often leads to emergence of repressed sexual abuse memories that rekindle a person’s desire to self-medicate. Sexual trauma survivors in addiction recovery are at risk for relapse in four major areas that need to be addressed as recovery proceeds:

1. Memories of the abuse are unknown, but begin to surface
2. Affects associated with the abuse as well as feelings in general begin to emerge
3. Life experiences and problems are encountered without the aid of addictive behaviors
4. Addictive behaviors surface other than alcohol and drug addiction, such as sex and love addiction and compulsive eating.

Trauma issues related to early abuse or suffering other types of traumatic events (e.g., medical illness and disability, parental death, violent crime, financial ruination, acrimonious divorce and child custody disputes, etc.) can surface at any point in the recovery process, but the manner of handling them varies with stage of recovery. In the early stages, the task is to help the patient express or contain feelings and memories without drinking or using, and to work on creating safety in their current life circumstances. As patients gain a more solid foothold in recovery, more intensive efforts towards trauma resolution can be undertaken and may be more effective.

THE IMPORTANCE OF IDENTIFYING POSITIVE BYPRODUCTS OF RECOVERY

As patients move through the later stages of recovery they often become increasingly aware of how much their lives have improved along the way. It is not unusual to hear patients refer to
their addiction and its consequences as a “wake up call” that gave them the impetus not only to come to grips with the addiction, but also to make a variety of meaningful changes in their lives. Many believe that without this “wake up call” these changes probably never would have occurred. This is exactly what people in recovery mean when they refer to themselves as “grateful addicts and alcoholics”.

Research has shown that individuals who are able to find benefit from weathering various types of traumatic life events generally show better post-traumatic adjustment and clinical outcomes than individuals who remain stuck in feeling helpless and victimized. These studies provide empirical support for the notions that “what doesn’t kill you often makes you stronger” and “there is a silver lining in every cloud.” Two recent studies found that the types of positive byproducts reported by patients recovering from addiction were very similar to those commonly reported by people who have struggled with other kinds of adversities such as near fatal illnesses, catastrophic physical and psychological events (fires, tornados, rape), and various traumas (e.g., military combat, death of a loved one). The particular benefits reported most frequently by recovering patients included: (1) greater appreciation for the simpler things in life; (2) positive reordering of life priorities; (3) greater acceptance of things that cannot be controlled or changed; (4) greater compassion, tolerance, and empathy for others; (5) greater honesty with oneself and others; and, (6) enhanced self-knowledge. Moreover, the degree of perceived benefit was positively correlated with patients’ length of time in recovery and level of involvement in AA. The most positive changes were reported by individuals who were farther along in recovery and more meaningfully involved in AA.

Identifying positive benefits is important for patients in all stages of recovery because it can help to bolster their motivation to remain abstinent and continue to improve their lives. Thus, you should make a point of encouraging patients to compare their overall happiness, life satisfaction, and priorities during recovery versus prior periods of active addiction. You should also help them periodically re-assess positive benefits at various points along the way in recovery since some benefits become apparent at later points in the process than others.

**FINAL COMMENT**

Ongoing individual psychotherapy is a valuable tool for addressing a variety of important problem areas, including intimacy, separation/individuation, self-esteem, childhood traumas, and
relationships. It is crucial for the therapist to be continuously mindful of recovery issues and be prepared to shift the focus of therapy, as needed, to behaviors that support abstinence when the patient is tackling particularly painful issues, or shows signs of letting up on practices that support recovery. It is also important to help patients identify and periodically re-assess specific ways they have benefited from facing their addiction and channeling their energies into recovery. Patients in recovery can potentially benefit as much from ongoing psychotherapy as any other patients, and often make rather striking and meaningful changes.

*Portions of this paper were excerpted from the book "Treating Alcohol and Drug Problems in Psychotherapy Practice: Doing What Works" by Arnold Washton and Joan Zweben, Guilford Publications, 2006

The full publication and Author’s page can be found here:
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