Squalls on an Already Rough Sea: Negotiating Countertransference While Treating Addicted Patients

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Patients often lose the ability to connect and relate through the compulsive use of mind-altering substances. Treating such patients can feel like a Sisyphean task and there are unique challenges to consider. Significant treatment obstacles arise from our negative countertransference, which can be quite intense with such patients. One unique source of this negativity towards addiction is that it may exist even prior to consultation with patients. We may unconsciously experience long held and unacknowledged social biases about those who misuse alcohol and drugs. These biases may have followed us from childhood, ingrained from traumatic personal or family history with substance abuse. These unformulated feelings become triggered in the course of treating addicted patients, along with adverse feelings that emerge with the treatment challenges themselves.

Addictions may stem from failures in the attachment system at critical times in a person's development. When addicted people then seek to become sober, their main source of self-regulation is no longer available. They must now manage life stressors with a fragile self-system. There is also the overwhelming sense of shame associated with having needed drugs and/or alcohol to feel normal (Gill, 2014). Then comes a dawning realization that becoming sober is only the beginning. The newly sober addict can have unrealistic expectations of therapy – that it will act like a drug. There is disappointment and confusion when it does not do so. It is not surprising that the therapist could develop a multitude of negative responses to treating an addicted person, despite one's best efforts. One must be especially mindful and monitor one's countertransference with addicted patients and alert to the potential for enactment.

Bromberg (2006) suggests that the difficult patient needs that which is nearly impossible to provide – a relationship based upon "affective honesty and safety" (p.108). What could be more difficult an undertaking than for an analyst (with potentially dissociated fears, anxieties, unacknowledged contempt and perhaps some doubts about their own substance use) endeavoring to connect in an authentic way to a patient for whom authenticity has all but been neutralized? Thus, the focus of the treatment must include: a willingness to explore attachment patterns in a specific way, as well an unpacking of those unique patterns that set the foundation for the introduction of the thrall of substance abuse. At the same time, the analyst must counterbalance the inevitable misgivings inherent in working with an addicted patient. The analyst will vacillate between feeling like the most important person to the patient and feeling like a worthless, powerless and punitive withholding scold.

The myriad of negative counter-responses to addicted patients does not solely rest within the patient's overt behavior. Hirsh (2008) suggested that the analyst's current life status has an influence over the development of our negative countertransference. This can often be combined with our own possible anxiety about substance use and users, ambivalence about our desire to sustain a workable alliance in the face of potential eventual sociopathy, acting out, lying, resistance, and relapse. Hence the task can become immense, maybe even insurmountable. The temptation to become more passive is great, if only to protect oneself from the eventual failures (Slochower, 2006). Recently, a

newly sober patient told me how disappointed she was that I too was not “sober.” She proceeded to contemptuously question what I could possibly know about her suffering and that I had deceived her. Minutes later, she apologized but it was evident that I had let her down and could not sufficiently make that up to her.

Adding to the pull to be protectively passive (or actively hostile and confrontational) is the reality (in the case of the recovering addict) of the 12-Step Program. And with that comes the reality of the sponsor. We may struggle to effectively proceed in an insight-focused treatment (asking the patient to collaborate with us) when the rest of the patient’s time is spent in an action-oriented approach with another to whom they “report” and who more sufficiently understands their experience. Does the analyst through enactment set herself up as the good object thus making the sponsor or the program the bad object? Or must the analyst tolerate being the bad object at times, as she does not gratify the patient the way the Fellowship can, with applause and encouragement? As analysts we must set aside our own need for omnipotence in such patients’ lives and share the spotlight with an unknown other that can perform important functions we cannot (Read, 2002). There is a potential for an unspoken rivalry. The patient could also split the analyst from the sponsor, playing one against the other. The sponsor is not likely a trained mental health professional, thus we are charged with being mindful of all the landmines in our shared field. We must bear the loss of our omnipotence in the treatment. The patient may feel a need to privilege the sponsor’s wisdom over our contribution. As relapse is always on the horizon, we may also vacillate between feeling comfortably authoritative and utterly powerless in the face of the addiction itself.

Patients in early recovery may employ projective identification during treatment. The patient will project into the analyst (in the best times) a part of oneself inaccessible to verbal expression. In the worst sense, the patient will do so to rid herself of unwanted parts of self, including cravings, shame and extreme neediness. The analyst will hold these parts, thus becoming an object easily rejected and regarded with contempt, until they can be repurposed and reintroduced to the patient.

The following are two clinical vignettes that illustrate how transference/countertransference patterns go on to define the contours of treatment with addicted patients.

Josie

Both of Josie’s parents abused alcohol. Her mother was placed in rehab and relapsed multiple times. Josie reported being under the care of several “nannies” that were but random housekeepers with no childcare experience. She talked of episodes of sexual abuse that were ignored, and teachers abusing her in Spanish class. She began using drugs and drinking early, with the teenaged son of one of her “nannies.” Josie learned early that authority figures could not be relied upon – except for cruelty, humiliation and neglect. A therapist could not be expected to provide much more than that, and AA was a haven for judgment and restrictions. Working with someone who was at once desperate for connection and fought it at every turn was some balancing act. Josie envied and hated me for allowing her to pay a lower fee while she was still unemployed. She envied the life she fantasized I led. She dared me to fire her from treatment, to scold and humiliate her so that she could return to her familiar isolation and abyss of neglect. Her attendance was inconsistent, and her absences were usually preceded by lengthy voicemails. When she did come to session, she flooded it with an anxious and apologetic yet defiant affect.

One day she nonchalantly told me how her daughter took a gulp of iced tea from the refrigerator. It was an iced tea laced with vodka. I was shocked by this news and her associated affect. This was my test: would I finally reject her, as she dreaded/wished for? I replied with something to the effect of “I’m

afraid that you're going to do something finally that you can't come back from." Although Josie is now in AA, the hiding, lying, overpromising and under-delivering have continued. I complicated an already complicated attachment pattern, setting me up as not only an authority to elude and rebel against, but a caring, yet frightened maternal figure to be soothed and reassured in whatever way is available. Josie complied. She got sober. But the other associated behaviors and attachment patterns remain.

Dieter

Dieter represents an opposite attachment pattern. When Dieter was nine, his parents were warned by his teachers that he was too hard on himself. By age 14, he practiced the saxophone so intensely (so as to gain early admission into a music academy) that he developed a huge blister on his lip. He then could not play for weeks. A year later, Dieter stopped his father from taking his own life with a pistol. He concluded from this experience that he needed to be perfect and eternally happy. As neither was possible, Dieter eventually drank and used drugs. It was the only way he could manage to at least create the façade of that perfect boy with not a care in the world. The details of his "bottoming out" were virtually cinematic. At his birthday party, he literally tried to drink himself to death – and all on the edge of his wife leaving him. He collapsed on the street, managed to get home, and begged for her forgiveness. Dieter then took himself to his first AA meeting the next day. He began therapy with me two weeks later. Dieter stated that he "always thought about therapy," but managed to talk himself out of it. He stated that now he "had no choice."

On the surface, Dieter is a model patient. He is never late, pays on time, always compliant and cheerful. He never tired of reporting how "great" sobriety was and how "grateful" he was – even with the challenges. I knew something was amiss. At times, I would observe him in the waiting room. He sat with his head bowed and body slack. The look on his face was that of dejection, hopelessness and defeat. Finally, I decided to address it. He was taken aback, the potential for a hostile reprisal hung in the air. On the contrary, he admitted to feeling obliged to put on the best face possible even in therapy, in order to protect our connection, to preserve my good appraisal of him – to preserve us. That is when I learned of his previously noted history. He found a way to navigate in the world and brought it to bear in therapy, as well and in AA meetings. "I can't let you…I can't let anyone see the Beast," he finally said. But, in a way, Dieter valued this Beast state. He relied on him to drive his musical ambitions. Though he feared his "Beast self" would separate him from those he loved (and thus had to be hidden), it also required nurturance. Dieter found drinking and drugs would satisfy this impossible internal bargain. The challenge with Dieter is to be mindful that he will resist and detest an environment where he has permission, where he is required in a sense to be vulnerable, to share those demons. The temptation lies in allowing Dieter to take care of me in session, by allowing him to remain compliant and "easy." Nevertheless, we need to confront "the Beast."

Treating those who are chemically addicted often raises more questions than answers. Not only must we keep the patient's sobriety in mind but also how we are going to keep it in mind. Holding these patients in mind (as individuals and not just their symptoms) in ways that had been denied to them before, seems like a reasonable first step. However, we are also charged with a greater responsibility: to manage our own anxieties, fears, frustrations, rage and loss of omnipotence all while remaining authentic and available. It is to say the least a delicate balancing act.

References

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