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Psychotherapeutic Experiences with Methadone Maintained Patients in the Framework of Multidisciplinary Clinical Institution

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Summary

This communication presents a number of theoretical and clinical formulations that belong to a psychodynamic framework specifically constructed to foster the understanding and treatment of drug addiction. I find this framework useful not merely for the purpose of conceptualizing drug addiction as a clinical category, but also in explaining the complex experiences involved in the therapeutic process to people suffering from that condition. Contemporary psychoanalytic tradition sees drug addiction as an unsuccessful attempt to ward off the unbearable and unmanageable effects through self-medication, but also, more importantly, as a massive disorder originating in early interactions with significant others, resulting in a fragmentation of the self that prompts the individual to self-injury, constant traumatic experiences and a paradoxical fear/pain/pleasure relationship with the drug via addictive fantasies. All of this, enacted in everyday life and in therapeutic sessions, evokes complex emotional experiences on the part of patients, therapists and whole institutions. Relieving, bearing, getting to understand and, crucially, modifying these experiences is seen to be the task at stake in the therapeutic encounter. The final part of the article reflects on some of the advantages for the psychotherapeutic work that derive from methadone maintenance treatment and well-organized team work within a specialized clinic.

Key Words: Methadone Treatment; Psychotherapy.

From a psychotherapeutic point of view, experience can be seen as a combination of affective states, perceptions, representations and memories organized as mental events. We now know, from a variety of developmental studies, that the modification and gradual integration of affects into emotional experiences that can be known and used are determined by complex genetic dispositions, as well as by human relationships, notably by those held with the figures who provided care early in life [7, 9, 18, 20]. This datum testifies to the significant relation between affect representations and internal representations of human relationships which are conceptualized as images of the self and the other in interactions reinforced by affective links or emotional tones. Thus, from a representational point of view, subjective experience includes intersubjective elements. For example, the urge to gain feelings of well-being, which are so important for the develop-

ment of the self, is experimentally proven to be related to the setting up of a background of safety, connected with the internal models of secure representation of the attachment figure [5]. Any lack of such representations leads to emotional disorganization, and of feelings of fragmentation, or even chaos.

In short, the human ability to tolerate and make use of emotional experience cannot be taken for granted. It is a developmental achievement connected with the capacity for accurate representations of affect - states which are gained through interactions with parental objects capable of empathic mirroring and reflective containment of the infant's affective expressions [8]

Implicit or unconscious functions of the mind, called defence mechanisms, play an important role, too. They are set to perform adaptive manoeuvres, which have the power to rearrange the representational world. Primitive

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mechanisms, such as the splitting of the self and its object, projection, idealization and others, intervene in shaping the representations of the object, modifying them so that they end up resembling the unconscious self-representations. This prevents a more mature establishment of self and object boundaries, and affects the overall integration of internal and external reality. The quality of the emotional interplay with parental responses which provide secure emotional containment, such as the adequate representation of a child's thoughts and feelings, allows the individual to internalize those very capacities that are seen as prerequisites for symbolic representations of one's own mental states in terms of wishes, thoughts and beliefs of any kind, not only as devastating and overwhelming expressions of affect. So the mirroring and containing capacities of the caregiver, which are seen as two interwoven processes of replication and acceptance of outward expressions of subjective internal experience – expressions founded on an underlying empathic attitude – provide the infant with representations of its internal state. That state is manageable, while remaining different from the caregivers' own emotion – features that allow it to be internalized as a self-state and be used for self-regulation [1].

These day-to-day interactive processes play crucial role in establishing a sense of identity and an awareness of oneself as a feeling and thinking being capable of introspection. Alternatively, early parental failures connected with emotional unavailability or disorganized and abusive care-giving may result in serious impairments of self-perception and self-control, affecting the entire personality structure, and leading to an exhausting use of pathological defence mechanisms. Such inabilities in parents, due to their own emotional difficulties, make them react to their children's negative affect with expressions that may be overwhelming, threatening and even alien in nature and content. Instead of reflecting their children, such parents are likely to defensively push them back, because of a real incapacity to tolerate them; in this way they fail to represent those feelings as belonging to the child, but mark them to be felt as their own states of intolerance. The outcome is that no secondary or symbolic representation of an infant's affective state can be established. The child will unconsciously attribute the affect to the parent, alienating his/her own emotional experience and, instead of regulating it, the interaction with the caregiver will escalate the negative state, so leading to a kind of traumatization.

The traumatic consequences of the affect produced in these cases can be recognized in various deficits of the personality structure, such as fragmentation of the self, lack of empathic or mentalizing capacities, tendencies to somatize instead of verbalizing emotional experiences; these are none other than some of the typical features of the way the borderline personality is organized [1, 11].

In line with these formulations I now wish to present a summary of the basic psychoanalytical understanding

of addiction.

Many recent views on addiction have emphasized that substances are used for the purpose of managing intolerable affective states [3, 6]. Some authors speak of a defect in the stimulus barrier, resulting in incapacity of the self to ward off repeated painful experiences; they have seen substance use as augmenting this defective barrier, or else as a substitute for it. This also suggests that what is normally a developmental process of differentiation, desomatization, and verbalization of affects may turn out to be strongly impaired in addicts. There are specific affective states, including aggressive feelings, anxiety, depression, rage, and shame, that addicts attempt to manage through the use of drugs [14, 22].

Khantzian, for example, focused attention on a self-medication hypothesis in which an individual's choice of drug is the result of the pharmacological action of the drug in alleviating the individual's principal painful affect. He and coworkers have observed that addicts seem to have a deficit in a group of ego functions involved in the anticipation of danger and in self-protection, which they have called "self-care" functions. They have emphasized the importance of this deficit psychology in substance abusers, a finding that helps to explain the self-destructive nature of drug abuse. Khantzian has also considered a view that addictive behaviour serves as an unconscious attempt at mastery over poorly understood and passively experienced suffering, by creating a dysphoria which is controllable and understandable. Accordingly, some authors have viewed the choice of a drug as dependent on its influence over the most troubling of affect: narcotics are used to reduce or eliminate rage, shame, and feelings of abandonment; amphetamines and cocaine to give a sense of grandeur, or to provide a line of defence against underlying depression, and so on.

From a different perspective, many analysts have described the use of drugs as an object functioning as a substitute for a yearned-for parental figure or object relations. Kernberg [12] saw addictive behaviour as a gratification of primitive, oral instinctual needs; as an enacted wish for reunion with an idealized parental object through an activation of "all-good" self and object images. Similarly, Kohut referred to addictions as "narcissistic behaviour disorders". He viewed the disturbance in addicts as due to the mother's failure to function as an adequate idealized self-object, but he saw drugs serving "not as a substitute for loved or loving objects, but as a replacement for a defect in the psychological structure [15]". Others have also emphasized a "narcissistic crisis" in drug abusers, in which the collapse of a grandiose self, or an idealized object leads to feelings for which drug use is an attempt to respond.

Contemporary with the strong interest being shown in the psychoanalytic literature for borderline states are current views of drug addiction as a traumatic disorder of early relationships where the vulnerabilities of the self are related to neglectful, abusive and chaotic emotional

environment, only to be intensified later by the repeated traumatization of a fragile self. The trauma is attached to an emotional chaos where the affect becomes a thing that should be acted upon and manipulated in a very concrete way. Thus the sheer repetition of addictive suffering, inseparable from addictive relief, is a ritual of “repetition enactment” designed to inflict psychophysiological torment, perhaps in the hope that psyche will be able to master unmanageable past and current traumas by structuring and controlling this “event” according to the premeditated ceremony acted out by addicts. Addicts unconsciously prefer to inflict trauma upon themselves rather than finding themselves in a “shock trauma” that leaves them helplessly victimized. In this precise connection, Dodes [6] stresses the role of the drug as a defence against helplessness made possible by creating the paradox of being in control while losing it. Speaking from the perspective of this early trauma, the difficulty of working with the most severe cases of this pathology is related to an internal situation that is imbued with great excitement, because pleasure and pain are perceived in mixed forms once a state of emotional chaos looms nearer, and the bond with the chaotic primary object borders on an experience of mutual destruction involved in what Bollas calls borderline craving [2].

In the context of drug addiction, the concept of “transitional objects” has its place, too. It connotes the infant’s first grasp of the “not-me possession marked by something inanimate and cherished (a soft blanket, toy, teddy bear, etc.), which must have an affective tie to the mother in the course of emotional and physical separation from her”. According to Winnicott, transitional objects are used with the purpose of ameliorating and helping the processes of separation and differentiation from the primary object, but they can also have their pathological function. For the heroin addict, the concept of a transitional object is transformed into a pathological process, while the drug and the equipment used, such as needles, become fetish-like transitional objects, dysfunctional and lacking the most important adaptive cognitive and affective expressions. In this way, transitional objects become available for use with the precise role of inanimate but omnipotent objects; this is one of numerous dysfunctional ways suffering addict has to cope with separation, extreme anxiety and fragmentation [17].

Of course each summary of psychological insights into the meaning and use of drugs is bound to remain incomplete and related to individual cases only, but it will come as no surprise that psychotherapy with drug addicts raises the same issues that arise in any seriously damaged and maladaptively defended patients (for this category, patients with borderline personality disorder are exemplary).

As already suggested by my choice of topic, the aim of psychotherapy is bound up with the possibility of gradually changing the system of self-regulation by rendering the affects containable and thus providing new

opportunities for the organization of self-experience. In Bion’s terms, every psychotherapeutic experience can be seen as a series of transformations that bring together a factual situation, emotional states and representations in hope of discovering the meaning of their links and interdependence. The psychodynamic therapeutic situation invites and allows the patient to actualize or enact feelings, representations and defences in the presence of the therapist in a specially designed setting where transference - countertransference dynamics are found to take centre stage in the process. The term ‘transference’ implies that patients bring to life old models of interaction between self and other, where the mental world of the therapist becomes part of their emotional state. According to Sandler [19], the therapist becomes an embodiment of a wish, a figure offering safety, a victim or a persecutor, depending on the affect that unconsciously prompts the patient to assign roles to the therapist. The open attitude or ‘role responsiveness’ argued for by Sandler allows the therapist to identify the assigned role without fully enacting it; to perform a containing mental function that could later lead to interpretation of the transference and an internalization of new meaning. This is not an easy task, bearing in mind the specific transference manifestations of patients with addictions. Their basic characteristics, following Langs [16], could be presented as direct expressions of affects and inner fantasies maintained with a strong belief in their validity. They are often enacted impulsively in a poorly disguised manner, with their unbearable qualities projected into the therapist. Such transferences usually bring into the open very strong aggressive feelings, which patients with addictions tend to act out in abusive relationships.

Early in her therapy with me a young woman with heroin addiction had left twice in the middle of her previous sessions; later, she went on to tell me that she had gone to a party after she felt so lost and abandoned in her therapy, and had taken a needle from a person with AIDS. Only after a few sessions did she add that she hadn’t used the needle on that occasion, because she was held back by the thought that I might be the only person still capable of believing there was something good left inside her.

Another type is the narcissistic transference in which patients press their need to actualize omnipotent idealizations both of themselves and the therapist, vigorously defending their inner world against feelings of helplessness, uncertainty and dependence. One case of this type is that of Mr. B, who for months came very late to his sessions, just to tell me that he was doing perfectly well, hanging out with his dealer, and having access to free drugs, but not using them, because he was simply enjoying his position of superiority over other users. At the same time, he was constantly saying how grateful he felt for being able to work with me, because he knew that I was the best professional in the clinic.

The term ‘countertransference’, on the other hand,

signifies the emotions which the patient induces in the therapist. More precisely, we speak of 'countertransference reactions' where the active conflicts in the therapist are in specific interaction with the projected parts of the patient's self. That is the reason why most common countertransference reactions in the field of addictions are of the same order as the transference manifestations just mentioned; they inflict feelings of helplessness, frustration, anger and even rage on the therapist, combined with defensive manoeuvres, such as rescue fantasies, withdrawal or rationalized superiority.

For hours and hours on end I felt angry, useless and abandoned by Mr. N, a patient in his third year of treatment, who, after achieving a steady remission from heroin, would come to his sessions well after the agreed time, only to tell me that he did not find any purpose in coming, because with the help of methadone his was doing just fine. Instead of working through these difficult feelings of emptiness and abandonment, I often enacted the active position of a powerful, knowledgeable therapist, who, in the very few minutes left at the end of each session, would make complex, often confusing interpretations of his unconscious wish to put me in his situation of being someone helpless and left alone. Only after I was able to take in seriously the role of being a helpless and abused child and to mourn my own omnipotent saviour fantasies, was I able to become more in touch with my patient. Not words and interpretations, but my acceptance of the role of someone who, even if benevolent, still didn't know exactly how he could help this patient, prompted Mr. N to make a move, resume his therapy and tell me that what had stopped him for so long was the idea that I would be so triumphantly happy to tell him one day that I had cured him. Now he sees the cure as his own task and at most I can play a role in it.

Several main roles, according to Burian, oscillate in various combinations, between the patient and the therapist through the transference-countertransference dynamics. The idealized, omnipotent saviour, the victim, the perpetrator and the cold mother are a few instances among others [4, 10].

Almost every psychotherapy starts with idealizations which unconsciously bring to life the relationship with all good objects, providing wished-for relationships and states of well-being. These representations are inevitably split off from the bad parts of the self, those imbued with aggression, hate and contempt of oneself, which are easily externalized and disowned by the patient. Patients often expect therapy to work like a drug, producing rapid gratification and predictable responses, and they can feel let down and betrayed when it does not work out in that way. There is a constant swing between goodness and badness, which makes the patient and therapist move between feelings of self-importance and uselessness through projective and introjective mechanisms. Besides feeling unskilled and incompetent, the therapist who takes in patient's aggressive projections could feel persecuted

(a victim) and, at a later stage, a persecutor who does not understand the patient, but only re-enacts his or her internal traumatization. A typical enactment on the part of the therapist in such cases is to give up his benevolent neutrality and become very rigid in his/her thinking and use of technique, building a wall between himself and the patient by applying rules and theories. Or, alternatively, by performing certain boundary violations, he may constantly try to reassure himself and his patient that he will not stop being a good object, even while suffering a constant rejection and disempowerment.

As the therapy progresses, the early relationship patterns are brought into the transference in a very concrete manner. The ambivalence, shame and guilt are no longer tolerated, but totally disowned and externalized to the point where the therapist is perceived as cold, rejecting mother, abandoning its child to internal chaos and unable to protect it from any real or imaginary injury. Once such externalization is achieved, a patient no longer has any interest in his/her relationship with the therapy, which is perceived as undermining their attempts to separate themselves from their disowned parts. They seek to maintain the weak balance in themselves through outside relationships (acting outs), such as marriage, finding a job, or, in the worst scenarios, drug dealing, which often lead to heavy relapses. Survival of the therapist and therapy in these cases proves very difficult, since the therapist feels as if he/she is taking part in the destruction. One case in point is that of Mr. P (of whom I am hearing much in staff supervision); he stopped attending his groups after he took to drug dealing directed at other patients, then locked himself in his home for weeks, and suffered a breakdown while demanding that his parents supply him with money and drugs, while saying he would allow his therapist to see him if only she visited his home. It needed a serious team effort and an even bigger effort from the therapist, who refused to succumb to his demands, but stayed in touch with his suffering through phone calls, to bring this patient back into therapy, in which he now starting his 4th year.

Having made these observations, which cover an inseparable part of the psychotherapeutic experience with addicted patients, one inevitably ends up by asking what actually brings about change in these patients. Of course, there is no mechanical, straightforward answer to that question. It has already been suggested that an empathic mirroring and consistent containment of emotions of the kind implied in the therapeutic setting and attitude, combined with interpretation of here-and-now transference, could lead to minimization of splitting, and bring about a gradual integration of representations and affects [13]. This could be achieved only by constant transformations within the therapist's mind that require him/her to endure the destruction of, and attacks on his or her good objects, by maintaining the hope that, even in the most severe states of distress and chaos, the patient could go on experiencing the presence of the therapist, who

remains alive and thinking, and so capable of becoming a new part of the mental economy of the affect. This calls for a constant and careful observation of the therapist's countertransference reactions and regressed profile, the steady application of self-analysis of one's own vulnerability and inner conflicts, allowing parts of his or her personality to become a home for patients' experiences without losing the capacity to reflect and symbolize.

In conclusion, I wish to briefly put forward some ideas on the advantages brought to the psychotherapy of heroin addiction by two factors: methadone maintenance treatment and working in a multidisciplinary institution.

We have an abundant evidence of the stabilizing effects of methadone on the brain. We also know the great advantages of the medically prescribed doses and the beneficial effects of changing the vicious cycle of illicit drug use. Bearing in mind that methadone is a long-acting agonist, we recognize its potential not only as a means of minimizing the tormenting effects of painful affects, but also as enabling the therapist to act on perception and other cognitive functions. Well known is the fact that drug dependence consists not only of taking drugs, but also of withdrawal from them. The loss of the omnipotent state of fusion with the drug during withdrawal periods promotes strong narcissistic crises, which are experienced as real traumatic events. Thus the lack of withdrawal symptoms, along with the behavioural change consequent on taking methadone, open up the way to become free of the great amounts of shame, guilt and helplessness involved in the cycle of illicit use. These are two of the immediate advantages of methadone maintenance. In short, when medically prescribed methadone stabilizes numerous brain functions, the task performed is no less than making long-term psychotherapy with heroin addicts feasible. And by that I don't mean only the possibility of retaining patients who are notorious for their acting outs and their breaking of relationships in long-term psychological treatment, but also the ability of this medication to ensure a new dimension of psychological functioning by alleviating severe depressive and even psychotic anxieties. It is a matter of level, really, as methadone treatment cannot by itself cure the psychological problems of affect regulation or of integration of personality. Patients' feelings of dependence on methadone, their rage against the regulated admission of the medication, the hardships of enduring the process of being in treatment as opposed to the omnipotent fantasy of grandeur and the periods of regressive helplessness burdened by feelings of failure are real conflicts that are brought into the open during the therapy. But they are part and parcel of every significant restructuring effort and therapeutic support, which, in the best practice, includes a complex system of care including the efforts of many practitioners, doctors, psychologists and social workers; that is what allows these contradictory and confusing emotions to be endured and made productive in the psychotherapeutic process.

It is difficult, almost impossible, to work psycho-

therapeutically with addictions outside an institutional framework. The institution, with its overall organization of treatment, providing different levels of interaction, various figures and multiple functions could be seen as a form of mental organization, which communicates and interacts with the patients' mental organization [4]. A therapeutic team which shares a clear and consistent clinical policy and philosophy allows the patient to enter various relationships and to experience different parallel transferences which make possible a gradual and steady integration in the patient's mind, through the perception of a whole new object, located within a new social structure, that works as a facilitating environment. The institution itself, with its rules and functions, may play various transference roles like that of powerful mother or forbidding father, but, most importantly, it offers an opportunity to help patients to integrate their otherwise split projections by linking them with their representation of the clinic as a mental and social space, which tolerates triangulation and hierarchy, and behaves like a stable social structure. Of course, like methadone itself, a clinic can always be made the object of fearful attacks. Abusive interactions with members of the staff or perverse relationships with other patients are not rare events in our practice. These acting outs usually serve the purpose of redirecting angry and violent feelings from the often entangled situations that arise in psychotherapy and vis-à-vis the therapist towards other more experience-distant objects, so saving the enfeebled link or threatened therapeutic alliance with the therapist. Certainly, a different movement could also take place: while working in seriously regressed mode in the therapy, a patient who finds difficulty in making progress within the strongly ambivalent situation may use the clinic as a whole, or other staff members, as objects for reparation, in this way strengthening his healthier and more mature parts, via parallel psychic route.

In a nutshell, these observations are consistent and in total accord with the conclusions made by the best known empirical research, conducted in the field by Woody, McLellan, Luborsky and O'Brien [21], stating clearly that psychotherapy is useful and efficient for the treatment of opiate addiction, but only if it is successfully integrated with other important services, drug counselling, methadone treatment and an overall institutional structure. The moral and scientific value of their findings is something that still lays a foundation for adequate practice with addicted patients. The practice of integrated multidisciplinary treatment in cases where patients would not have been available for treatment without methadone, the latter together with the concrete services provided and with drug-focused counselling, are helping them manage addiction and the related social problems, while psychotherapy helps them to achieve significant changes in their internal models and personality structures.

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Conflict of Interest

The author has no relevant conflict of interest to report in relation to the present paper.

References

1. BATEMANA., FONAGYP. (2004): Psychotherapy for Borderline Personality Disorder: Mentalization-based treatment. Oxford University Press, Oxford.
2. BOLLAS C. (1999): The Mystery of Things. Routledge, London.
3. BRICKMAN B. (1988): Psychoanalysis and Substance Abuse: Toward a More Effective Approach. *J Am Acad Psychoanal.* 16 359-379.
4. BURIAN W. (2002): Addiction and Trauma. In: STEINER-POPOVIC T. (Ed.) *Upheaval: Psychoanalytic perspectives on trauma.* IAN, Belgrade.
5. CASSIDY J., SHAVER P. (1999): Handbook of Attachment: Theory, Research, Clinical Applications. Guilford, New York.
6. DODES L. M. (1990): Addiction, Helplessness and Narcissistic Rage. *Psychoanal Q.* 59 398-419.
7. EMDER. (1999): Integrating influences of affective processes. *Int J Psychoanal.* 80:(2).
8. FONAGYP., TARGETM. (2002): Early intervention and the development of self-regulation. *Psychoanal Inq.* 22 307-335.
9. FONAGY P., TARGET M. (2003): Psychoanalytic theories: Perspectives from Developmental Psychopathology. Whurr Publishers, London.
10. GABBARD G., WILKINSON S. (1994): Management of Counter-transference with Borderline Patients. American Psychiatric Press, Washington, D.C.
11. KERNBERG O. F. (1967): Borderline personality organization. *J Am Psychoanal Assoc.* 15 641-685.
12. KERNBERG O. F. (1975): Borderline Conditions and Pathological Narcissism. Aronson, New York.
13. KERNBERG O. F., YEOMANS F., CLARKIN J. F., LEVY K. N. (2008): Transference focused psychotherapy: Overview and update. *Int J Psychoanal.* 89 601-620.
14. KHANTIANE J. (1978): The ego, the self and opiate addiction: theoretical and treatment considerations. *Int J Psychoanal.* 5 189-198.
15. KOHUT H. (1971): The Analysis of the Self. A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorders. Int. Univ. Press, New York.
16. LANGSR. (1974): The Technique of Psychoanalytic Psychotherapy. Jason Aronson, New York.
17. MILLER J. (2002): Heroin Addiction: The Needle as Transitional Object. *J Am Acad Psychoanal.* 30 293-304.
18. REDDY V. (1991): Playing with others' expectations. In: WHITEN (Ed.) *Natural Theories of Mind.* Blackwell, Oxford
19. SANDLER J. (1976): Counter-transference and role responsiveness. *Int Rev Psychoanal.* 3 43-47.
20. STERN D. N. (1985): The interpersonal world of the child. Basic Books, New York.
21. WOODY G., MCLELLAN A. T., LUBORSKY L., O'BRIEN C. (1990): Psycho-therapy and Counselling for Methadone-Maintained Opiate Addicts: Results of Research Studies. NIDA Research Monographs,
22. WURMSER L. (1974): Psychoanalytic considerations of the aetiology of compulsive drug use. *J Am Psychoanal Assoc.* 22 820-843.

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