DYNAMIC THERAPIES FOR PSYCHIATRIC DISORDERS

Supportive-Expressive *Therapy* of Cocaine *Abuse*

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HISTORY AND DEVELOPMENT

In June 1884, Sigmund Freud wrote to Martha Bernays, his fiancée, playfully warning her of his upcoming visit, when he would arrive "a big wild man who has cocaine in his body" (Jones, 1953, p. 84). He had begun experimenting with the drug earlier that year and found it "a magical substance" that counteracted his tendency toward depressive moods, increased his energy and concentration, and suppressed his appetite, leaving him feeling "that there is nothing at all one need bother about" (p. 84). These properties of cocaine have been attested to by many subsequent users. It is interesting that, given the conflicted role cocaine came to play in Freud's personal and professional life (not the least, the painful involvement he had with his friend Fleischl von Marxow's cocaine addiction), little subsequent psychoanalytic literature on substance addiction focused specifically on cocaine. Although Freud used the drug for 10 years, he denied being addicted to it. He did recognize its addictive potential for certain individuals but hypothesized that it was attributable to a personality predisposition, not to any direct physiological effects.

Since these initial speculations, the psychoanalytic understanding of all types of substance abuse has emphasized predisposing personality factors. At the same time, the way in which these personality factors have been viewed exemplifies the shifting lens of metapsychology that has characterized the development of psychoanalytic thought in this century. Early psychoanalytic writers, following Freud's lead, were mainly interested in states of intoxication and emphasized the libidinal significance of drug taking, casting its dynamics in terms of unconscious pleasure seeking, psychosexual development, and constitutional factors. (A comprehensive review of the early literature is provided by Yorke, 1970.) Thus, Abraham (1908/1979) wrote of the regressive release of infantile component instincts involved in alcohol abuse and compared its dynamics to those of the perversions, with their attendant substitute sexual gratifications. Freud (1897/1950) linked addiction to masturbatory activity. Freud had not ignored the object relational significance of drug use—for example, comparing what alcoholics say about wine to a model of a "happy marriage"—but this attachment was always cast in intrapsychic, libidinal terms. Likewise, Freud and other early theorists were not oblivious to the defensive function of substance use as a buffer against painful experience, but they tended to highlight its wish-fulfilling function. Finally, much of the early focus tended to be on alcoholism. Rado (1926) was one of the only early theorists who expressed an interest in the differential effects of drugs and their progressive interaction with

psychological experience and development.

Glover (1932) was the first to explicitly state that the unconscious mental content evident in addiction involved not just regressive processes but "reparative" activity. While his focus remained on unconscious fantasy according to the dominant "lens" of the time, he nevertheless anticipated what recent authors have termed the "prosthetic" or "self-medicating" function of drugs. With the advent of ego psychology, a view of substance abuse as a faulty effort at adaptation began to be emphasized and articulated more clearly. As Krystal and Raskin (1970) described it, substance abuse is an attempt at self-help that fails. Attention shifted to the various components of ego functioning—affect, cognition, memory, and so on—and their respective vulnerabilities in the development of substance abuse. While ego psychology may have initially tended to give equal weight to the various components, the impact of recent developmental research has begun to give primacy to components such as affectivity or object relations, and this new focus is reflected in numerous current theories—some of which we allude to later.

History of Our Own Approach to Treatment

Supportive-expressive (SE) psychotherapy was originally developed at the Menninger Foundation in the 1940s and 1950s. Luborsky (1984) defined and operationalized its core principles. The specific approach we describe in

this chapter, a time-limited SE treatment for cocaine patients, has evolved over the course of the last 14 years. In 1978 a study with opiate-addicted patients was begun (see Woody et al., 1983, for details) in which the typical time frame for treatment has been six months of weekly or twice-weekly sessions. Since that time, two additional projects have been undertaken, another with opiate addicts and one with cocaine-dependent patients. For the latter project, a treatment manual was developed (Mark & Luborsky, 1992). This chapter revises and amplifies that treatment manual.

One of our major assumptions has been that it is useful to understand the phenomenon of drug addiction, whatever the causes, in the context of a person's life, including an understanding of the person's personality or character structure. When the therapist sees and understands the patient as a person who abuses drugs rather than primarily as a drug addict, the basis for establishing a sound therapeutic alliance is enhanced. Viewing the patient as a person with a problem rather than as a stigmatized category of being (a drug addict) allows the therapist to be more responsive to the entire person and therefore able to take a more flexible approach to the patient. This is important because it has repeatedly been demonstrated that psychotherapeutic outcome is correlated with the therapeutic alliance.

We have also assumed that the core conflictual relationship theme (CCRT) (Luborsky, 1984) provides a useful framework for understanding a

person's personality or character structure.

As we worked with substance abuse patients, it became clear that certain aspects of SE psychotherapy treatment would have to be modified with this population. The therapist often has to take a more active role than is usually practiced in SE therapy. In addition, we believe the use of drugs has another very serious implication for psychodynamic therapy. The ordinary assumption in dynamic therapy is that the experiences that occur in the sessions generate interest, curiosity, and concern for the patient. Eventually, these experiences are recast as interpretations that are offered back to the patient. This often new experience of having interpretations offered in the context of a supportive relationship is regarded as therapeutic. However, cocaine, like any abused drug, substitutes a chemical reaction for experience. Actual reactivity to external events, including the impact of another person, is frequently obliterated by the chemically generated hyper-excitability, tension, irritability, and paranoia induced by cocaine. Whether high or not, the cocaine-dependent individual usually has a tremendously impoverished and impaired capacity to experience. Therefore, the traditional methods of support and interpretation are insufficient. Techniques that cultivate such a capacity to experience and that generate curiosity and concern for the patient become particularly vital with this population. Such techniques and shifts in emphases will be discussed in detail below.

INCLUSION/EXCLUSION CRITERIA

Naturally, the patients chosen for this treatment will meet the criteria for cocaine abuse or dependence. In our experience, it is rare to find an individual who abuses only cocaine; most patients will also meet the criteria for other *DSM-IV* substance abuse disorders, particularly alcohol abuse and dependence. Although we view our approach as flexible enough to be effective for differing degrees of severity, some contraindications should be mentioned. A patient should have achieved a reasonable degree of stability related to his or her drug use at the beginning of SE treatment. We do not expect total abstinence. Relapsing is typical, and the advantage of our approach is that it offers a means for understanding the meanings of these "slips" in the context of the person's relationships. However, if a patient is actively binging, is in need of hospitalization for detoxification, or has been hospitalized within the last 30 days, we believe more stability needs to be demonstrated before he or she can effectively utilize our method. Similarly, other conditions that may serve to limit a person's ability to actively engage with our method include dementia or other irreversible organic brain syndrome, schizophrenia or other psychotic disorders, bipolar disorder, current suicide or homicide risk, or a life-threatening or unstable medical condition that can create marked changes in mental status.

DYNAMIC ISSUES IN SUBSTANCE ABUSE

In this section, we discuss some of the psychodynamic issues presented by substance-abusing patients that have informed our treatment strategies. Because our approach is grounded in the core conflictual relationship theme method (Luborsky, 1984), we will describe the principles and components of this method, as well as how recent theories of substance abuse relate to these principles. We will then turn to a discussion of particular aspects of cocaine abuse in light of these considerations.

Core Conflictual Relationship Theme

We have borrowed freely from Luborsky's descriptions of the CCRT but altered the meaning of the terms in some respects. The CCRT consists of three basic components. The core response from others (RO) is the component that refers to the person's predominant expectations or experiences of others' internal and external reactions to them. By the terms *predominant* and *core* we mean those expectations or experiences that are most causally related to the person's difficulties in living. The RO could include any of the following: other's actual responses to the person, the person's anticipations of others' responses, and the person's fantasies of others' responses.

The second component, the core response of the self (RS), refers to a more or less coherent combination of the following: somatic experiences, affects, actions, cognitive style, self-esteem, and self-representations.[1]

The final component, the wish, refers to what a person desires or yearns for. By definition, the wish includes an RS and an RO. That is, wishes cannot exist apart from the person who has them; wishes originate from a self, and therefore include an RS. (Imagine a wish without a bodily experience, an affect, or a self-representation.) Furthermore, a person cannot wish without wishing *for* something, and therefore a wish necessarily includes an object. Usually, but not always, that "object" is another person. We want to emphasize that these "wishful" ROs and RSs are different from the person's core ROs and RSs discussed previously. The wishful RS and RO are part and parcel of the wish; they are related by definition, as it were. In contrast, the core RS and RO are related contingently to the wish.

For example, the core RS of Mr. Block (to be discussed in the case example) includes the sense of himself as incompetent, foolish inter-personally, and unlikable; his core RO includes "others don't like me," "others exploit me," and "others ridicule me." His core wish, to be loved, often took the specific form of a wish to be admired and appreciated. The associated wishful RO was, not surprisingly, an admiring, grateful audience, while the associated wishful RS was of a young boy with great promise and talent.

The Core RO Component

We have found that cocaine patients typically expect or experience a

whole range of negative responses from others. These include being criticized, rejected, misunderstood, controlled, and/or humiliated. Typical responses of the self that go hand in hand with these include feelings of extreme shame and guilt that can defensively flip into a sense of omnipotent entitlement and devaluation of the other, as well as feelings of helplessness, neediness, and despair that can vacillate with a withdrawn self-isolation and disavowal of needs.

It is in this context that substance abusers may seek to find solace in a relationship with a drug that seems a more reliable companion and friend than other people. Interestingly, Greenspan (1979) has speculated that the choice of a particular substance may be related to its ability to reevoke pleasurable experiences in the original attachment to a caregiver.

Feelings of victimization and entitlement can fuel the rather remarkable interpersonal violations substance abusers are capable of committing to acquire their drug. At the same time, this behavior begins a cycle of destruction in their potentially meaningful relationships that again amplifies their predisposing problems. Substance abusers breed tremendous anger, distrust, and rejection in those close to them and endure social contempt from the general culture—the very reactions they inherently fear most.

These reactions from others, in turn, can evoke overwhelming shame,

guilt, and self-loathing in the substance abuser, who may then attempt to cope with these painful states by "enacting" them. For example, it is very difficult for anyone, the therapist included, not to take a parental position in relation to the substance abuser; for example, it is difficult to avoid saying, in effect, "You shouldn't be doing that!" The point here is that once someone else takes such a position, the substance abuser is often thereby relieved of feeling that way toward himself or herself and is further liberated by the righteous sense of having been misunderstood and mistreated.

The Core RS Component

The compelling need to externalize painful affective states, as discussed in the previous paragraph, points to one of the most conspicuous and consistently observed features presented by substance-abusing individuals—their difficulty identifying, tolerating, modulating, and/or expressing their emotional experiences. In Greenspan's (1977) terminology, they function at primitive levels of *representational elaboration.* As a consequence, their emotional experiences can remain amorphous, threatening, and frequently somatized, reinforcing their sense of being a victim—here, of their own bodies, not just of others. Wurmser (1978) has referred to this problem as "hypo-symbolization," and Krystal (1987) similarly describes a "dedifferentiation" of affect and a form of alexithymia among many substance abusers. In this context, the use of substances can be seen as a kind of self-

medication for treating overwhelming and painful affective and related disruptive self-states (see Wilson, Passik, Faude, Abrams, & Gordon, 1989).

To use a drug like cocaine in order to cope with poorly integrated and painful affect states not only serves to confound the predisposing dynamics but powerfully perpetuates the use. In this process of "symptom substitution," the original painful effect of anxiety or anger, itself poorly integrated and diffuse, becomes replaced by an urge or craving—"I need a drug" (e.g., to feel physically better, to exorcise this feeling of being a bad person, to get back at a family member who's wronged me). This is an example of how an initial core RS can be transformed into a wish. In turn, the subsequent pharmacological effects and withdrawal effects (as well as the guilt and shame attendant to using the drug) can either mask or resonate with the original painful feelings. In the process, attention is further directed away from the original emotional and psychological contexts and meanings of the drug use toward physiological factors and drug effects. We have found that taking this "psychopharmacogenic" perspective (Wieder & Kaplan, 1969), in which we remain cognizant of the physiological and psychological effects of a drug as they interact with a patient's dynamic issues, is often critical when we attempt to tease apart the presenting experience of a patient. The therapist must be knowledgeable about the biochemical profile of specific drugs and their likely impact. This dynamic confound on the frontier between biology and subjectivity is part of what makes work with substance abuse so

challenging and interesting.

Finally, therapists working in the substance abuse field often refer to the "manipulativeness" of substance abusers. Some studies have suggested that a large percentage of substance abusers meet the criteria for antisocial personality disorder (Rounsaville, Weissman, Kleber, & Wilber, 1982; Khantzian & Khantzian, 1984). This has not been our experience with cocaine patients. In any case, we would note that, whether the individual was pre-morbidly psychopathic or not, the "lifestyle" of substance abuse often requires the use of conning, deception, and other sociopathic behaviors in relation to others.

The Wish Component

Certain wishes can be expected from any cocaine patient. With regard to the substance itself, there is typically a conflict between the wish to stop using cocaine and the wish to continue to use, albeit without suffering the consequences. (This latter wish takes the form in most patients of hoping to control their use). In addition, the wish to continue using is, at least initially, either denied—whether to oneself or others—or relegated to the status of a craving devoid of any psychological context, or invoked as an explanation after the patient uses in order to give the illusion of control. This nonreflective, reassuring explanation does not involve an *experience* of

intention, thus differing from a true awareness of the wish to use cocaine prior to a potential drug-taking episode.

Of course, the cocaine abuse itself inevitably damages the person's interpersonal relationships and thereby generates certain wishes that typically are prominent for cocaine patients. For example, many of them wish to be understood. (The precise associated wishful RO and RS differ with the personality of the patient, though the RS, of course, includes a representation of oneself as "good" and presents others as "kind and understanding.")

Personality style: Related to the wish component, we have found that a general presenting feature that typifies many substance abusers is what Shapiro (1965) has termed a "passive-impulsive," narcissistic style. A defining element of this style involves an extreme vacillation in the ordinary experience of deliberateness and intention—in particular, a striking absence of this experience around activities that, to the outsider, would seem to require a great deal of planning and intent. This style is most obvious when drug users say that they "don't know how" they ended up in a situation where drugs were available, or "don't know why" they keep taking drugs—"It's not me."

Defenses: The defenses typically associated with substance abusers, denial and externalization of responsibility, can be seen to follow from this

particular intentional style. Statements like, "I just ended up at the crack house," "I didn't mean to do it, but someone gave it to me," and, "I guess I just wasn't myself," reflect an underlying experience of passivity, of *disclaimed action,* to use Schafer's (1983) term. A therapist must be especially attentive to the ways in which the currently prevalent disease model of addiction can be used by the patient as a clever foil for such externalizations. This is not to suggest that there is no merit in the disease model or that drugs do not exert genuine detrimental effects. Nevertheless, the "progression" of the illness is neither predictable nor inevitable and is characterized by choice and necessity all along the way.

Narratives or relationship episodes: The narratives of substance abusers often reflect this experience of themselves as "disclaimed" or passive agents, with the fabric of meaning appearing thin, tattered, and disconnected (Mark & Luborsky, 1992). Therefore, it is particularly critical that intervention techniques serve to enrich and extend meaningful narrative data with these patients.

The Dynamics of Cocaine Abuse

Although once a source of debate, it is now clear that cocaine can be both physiologically and psychologically addictive and that tolerance and withdrawal do develop. The specific pharmacological effects of cocaine may

partially explain the tremendous craving it induces. Cocaine is a highly powerful central nervous system stimulant. It alters circulating levels of dopamine, norepinephrine, and epinephrine, as well as hypothalamic-pituitary-adrenal axis hormones. Most important, its effects are experienced rapidly and diminish just as quickly (the drug is metabolized by the liver in five to fifteen minutes). When cocaine is smoked or injected rather than snorted, these effects are amplified tremendously. Cocaine provides what many users report as a rush of self-confidence (if not feelings of omnipotence), boundless energy, enhanced concentration, a sense of wellbeing, and a lack of inhibition (recall Freud's "wild man"). These effects are followed by experiences of lethargy, fatigue, irritability, and depression when the drug action diminishes, representing in part a biochemical "rebound" effect. This sequence of effects, when repeated, becomes one of quick and labile cyclings of highs and lows in which the user searches for the initial peak but never quite gets there again and the low seems to fall deeper and deeper. It is intriguing to note how much the form and content of these effects parallel and reinforce many of the predisposing personality conflicts and vulnerabilities we have reviewed: feelings of impotence, emptiness, and poor self-esteem, which may be defended against through narcissistic and omnipotent disavowal of need; labile and disorganized emotional experience; and an impulsive cognitive style characterized by speed, abruptness, and discontinuity.

TREATMENT GOALS

Goals at the Beginning of Treatment

The first in a series of goals has typically been referred to as, for example, "establishing a collaborative relationship," or, "building a therapeutic alliance." Such phrases must be understood as an ideal description of what ought to occur, not as a prescription to the therapist as to what to do. (See Greenberg, 1981, for a discussion of the distinction between description and prescription in the context of the theory of therapy.) The problem with regarding "establishing a collaborative relationship" or "building a therapeutic alliance" as a goal that the therapist self-consciously sets out to achieve is that such a goal almost inevitably comes across to the patient as artificial or manipulative. This impression is a particularly serious liability with substance abuse patients, who frequently carry out, suffer from, and anticipate such artifice or manipulation.

It is more useful if the therapist attempts to (1) instill a sense of curiosity in the patient regarding his or her psychological functioning (see the case example), (2) encourage a sense of hope in the patient, and (3) establish a sense of purpose and relevance for the therapeutic sessions early in the therapy. To facilitate the latter two tasks, it is recommended that the therapist inquire about the patient's goals at the beginning of treatment. Luborsky (1984) notes that "the most common goals for many patients are

the control of anxiety, depression, and problems of personal functioning" (p. 62).

Cocaine patients, however, tend to create certain "technical" difficulties with regard to goals early in treatment. If the therapist is to create a sense of purpose and relevance to the therapeutic sessions, it is very important that the agreed-upon goals are within the therapist's realm of competence. For a number of reasons (e.g., the devastating impairment in functioning due to the drug abuse, previous experience with drug counselors, ignorance about psychotherapy, narcissism, hopelessness, defiant hostility), cocaine patients frequently state goals that are more appropriate to present to an employment or housing agency than to a therapist (e.g., "I need a job," or, "I need a place to live away from my mother"). A more subtle example of this difficulty occurs when the patient says something like, "I need someone to talk to about my problems. I have no one to talk to." In all of these examples, the therapist cannot provide what is missing in the patient's life. It is therefore crucial that the therapist help frame the patient's goals in terms that are within the therapist's realm of competence. For example, the patient and therapist could agree to pursue the question, "Why is there no one in your life you can speak with?"

It is assumed that a collaborative therapeutic relationship in the context of a secure therapeutic frame creates the necessary conditions of safety and

trust to permit patients to be as open as possible, to be able to convey and absorb their most significant experiences. With cocaine patients, however, the issues of abstinence and attendance complicate the establishment of a secure frame as well as a collaborative relationship. Patient attendance is often poor; a primary reason, of course, is that the patient often uses during the course of treatment. When patients use during the course of treatment, their motivation for continued treatment decreases and they are often too ashamed even to make appointments for—much less attend—future sessions. (Therefore, the therapist should, in most instances, call the patient after a missed session rather than wait for the patient to make contact.)

Generally speaking, the therapeutic atmosphere ought to be one of warm naturalness. It does not seem to be a good idea with substance abuse patients to rigidly adhere to a "role," particularly that of the anonymous, neutral analyst. Within a generally flexible frame, certain aspects of the treatment ought to be carefully established and attended to, such as drug use, the patient's attendance in individual sessions, groups, and CA/NA/AA meetings, as well as lateness to sessions.

No discussion of goals in the treatment of cocaine patients would be complete without broaching the issue of abstinence. It seems to us that insisting on abstinence unnecessarily generates an adversarial relationship between therapist and patient. Typically, the patient wants to continue to use,

but without the negative consequences of the use. This wish is often expressed in such phrases as, "I want to control my use of cocaine." It is not useful to enter into an argument on the virtues of abstinence. Instead, the therapist must stress that, while he or she would recommend abstinence from all drugs, including marijuana and alcohol, such a goal is for the patient to decide on. Sometimes demonstrating to the patient the severity of the addiction and the untenability of "controlled use" can be accomplished by proposing an experiment in which the patient is asked to abstain from any drugs for a mutually agreed amount of time. The amount of time should obviously be longer than the usual nonuse period for the patient. Cocaine patients in particular often wait between paychecks before binging.

It is useful, however, to allow patients to experience and express how vital they feel drugs to be in their lives. Such a communication is most likely to experientially come alive in the context of a relapse, a dream about a relapse, or an experience of craving, rather than in response to a simple question from the therapist. Once such a deeply felt acknowledgment of the significance of drugs in the patient's life occurs, a problem-solving attitude may be set in motion. That is, the patient begins to wonder, "Why is cocaine so essential?" and, "What can begin to take its place?"

Finally, it is recommended that the therapist advise the patient to attend CA/NA/AA meetings. The goal in the early phase of treatment is simply to get

the patient to try out these self-help groups.

Goals in the Middle Phase of Treatment

The central goal for the middle phase of treatment is to frame the patient's goals in a core relationship theme context while proceeding to work on them. The hope is that consistent demonstration of the pervasive functioning and significance of the CCRT will encourage a problem-solving attitude. The issues discussed in therapy become shaped by and focused on the CCRT. This focus permits the therapy to be time-limited. Specifically, the CCRT is used to establish a focus in the following three areas:

1. The meanings, functions, and consequences of the patient's cocaine use are drawn out in terms of the CCRT.

2. The CCRT is used to illuminate the roadblocks encountered during the patient's attempts to become drug-free. Even when the patient genuinely wishes to discontinue using drugs, the process is never as simple as "Just say no." For example, a person who intensely derogates self and others will have great difficulty getting help from a sponsor, as well as from the therapist.

3. The patient's difficulties in living without drugs are framed within the CCRT.

Goals Related to the Patient's Participation in Self-help Groups

Patients frequently relapse after a month or so of abstinence. In such cases, it is particularly useful to investigate the nature of the patient's difficulties participating in CA/NA/AA groups or obtaining and using a sponsor. Often the patient has attended only a few meetings, or has not really "engaged," or is still waiting to find the "right" sponsor. By the middle phase of treatment, it should be possible to frame such difficulties in terms of the patient's CCRT. Such understanding often renews the patient's interest and involvement. For example, Mr. Brown felt enormously uncomfortable not being the center of attention at the meetings. He was certain he was not liked. Describing his predicament in terms of the CCRT enabled him to suggest that perhaps he should try to listen to others at the meetings and that, if he did, he might find that others liked him for being a good listener.

Goals for the Last Phase of Treatment

It is important to keep in mind that the conclusion of time-limited treatment does not mean the end of the process of recovery. Such knowledge may help the therapist refrain from assuming excessive responsibility for the patient or from pressuring the patient to do more than is realistic. If the therapy has been useful, the therapist ought not to be the only positive and therapeutic agent in the patient's life—the patient should be engaged in some form of ongoing group. Thus, one of the central goals for the end of individual treatment is for the patient to have invested in a social network that will

sustain the patient, help him or her avoid isolation, and provide practical help in minimizing or circumventing a relapse. The therapist has done a good job if he or she has been a reasonably helpful, benevolent person at a potentially crucial time in the patient's life, if central problems associated with cocaine use and its cessation have been worked through, and if the patient's core relationship patterns have been identified in an experientially meaningful fashion. Accomplishing these goals can provide the patient with the hope and courage to continue the process of recovery. More than that the therapist cannot do.

THEORY OF CHANGE

There are three components of change during the course of a successful SE time-limited treatment of cocaine abuse: (1) the use of drugs, (2) changes in interpersonal patterns and relationships, and (3) intrapsychic changes.

It goes without saying that there will be no stable changes in the intrapsychic or interpersonal realms if the patient continues the use of cocaine. Nothing is so corrosive to the patient's interpersonal and intrapsychic functioning as the continued use of cocaine. This basic fact necessitates the dynamic therapist's careful attention to, and continuous monitoring of, many of the patient's behavioral routines: Who is the patient socializing with? and when? What do they do? Is the patient still hanging out

in bars, even if "only" to imbibe nonalcoholic beverages? What is the patient doing with his or her paycheck? *The dynamic therapist must focus on behavioral matters as much as the traditional drug counselor or cognitive-behavioral therapist does.* The difference lies in the particular skills the dynamic therapist uses in dealing with these behavioral matters, including:

1. A capacity for comprehending the meaning of the patient's cocaine use within a CCRT framework, thus often providing greater understanding for both therapist and patient. Such understanding ought to permit the patient's shame, guilt, tendency to devalue others, and so on, to be expressed and worked through even as it increases the therapist's capacity to tolerate and work through his or her own reactions to being caught up in this complex web.

2. Sensitivity to indications the patient is concerned about relapsing. Frequently, such indications are communicated subtly and indirectly. For example, a patient may tell of an incident in which he helped a drug supplier fix his stereo. The dynamically oriented clinician, attuned to the subtleties of communication, may wonder with the patient why the patient chose to bring this incident up with the therapist. The patient can then reveal his doubts about his potential actions.

3. Careful attention to the patient's anxiety, resistance, and transference, as well as to the therapist's own anxiety, may permit a more thorough inquiry into the specifics of the patient's behavior surrounding drug use, the handling of

money, friends, and so forth. Considerable skill is often required to elicit these details, which are often crucial to obtain because patients can almost always rationalize their behavior if the details are not on the table between patient and therapist. It becomes harder to dismiss the significance of critical actions and experiences once both patient and therapist are in possession of the relevant data.

Interpersonal Changes

What follows is a "typical scenario" of the changes in interpersonal relationships during the course of time-limited SE therapy with cocaine patients. Such a scenario, needless to say, does not describe the experience of every patient—it merely occurs, in more or less this fashion, frequently enough to be considered typical. The purpose of such a description is to help the therapist understand, accompany, and, when more active measures are called for (e.g., when the patient is in a state of despair over his or her relationships), guide the patient through these changes.

At the beginning of treatment, cocaine-dependent patients are usually profoundly isolated from the majority of their significant others. These relationships are frequently characterized by mutual suspicion, dishonesty, hostility, hurt, and alienation. The cocaine-dependent patient's sense of isolation is relieved, if at all, only by involvement in the drug subculture, namely, in relationships with other cocaine users. Given the essential

destruction of whatever positive qualities existed in their previous (i.e., prior to their addiction) relationships, it is not surprising that cocaine users frequently form intense relationships within the cocaine subculture. However intense, and whatever love and sacrifice for each other is manifested, such "cocaine relationships" are, in a very basic sense, poisoned by the dependence on the drug. Not only are such relationships inevitably unstable, but a mutually exploitative quality to the relationship is inescapable. Not only do they subordinate all sorts of relational qualities like trust, honesty, and reliability to the cocaine, but cocaine users need to keep each other down, to keep the other(s) dependent on the drug—or else the one who continues to use will fully experience the isolation that has been staved off by the cocaine relationship.

In our typical scenario, the cocaine patient has achieved a certain amount of "clean time" early in treatment. The patient now frequently "anticipates," or acts as if he or she anticipates, that all will be forgiven and forgotten by his or her family. (It should be mentioned that this anticipation is often not overtly stated by the patient. Indeed, the patient often says quite the opposite, e.g., "I know it will take time to mend my relationships." Cocaine patients are neither as narcissistic nor as stupid as they are often considered—they know the culture's, and therefore the therapist's, likely response to such an open acknowledgment of an "expectation" of familial forgiveness.) The evidence that the patient shelters such hopeful anticipations is usually

forthcoming once these hopes are dashed, as in, "I haven't used for two months, but do you think they'll ever forget!" Indeed, such hopes usually are dashed when family members, especially those exposed to any previous failed attempts by the patient at recovery, are quite dubious about the degree of change, the stability of the recovery, and even the truthfulness of the patient's assertion regarding clean time. The patient, who has been in a near-manic state, denying any difficulties ahead, becomes crushingly disillusioned. This disillusionment is often covered over with a standard piece of cultural advice, such as, "It doesn't matter what they think, I know what I've accomplished. I've got to do this for myself." Unfortunately, such advice rarely sustains the patient. The therapist has a crucial stabilizing role to play during all of this: interpreting the hopes and anxieties that lurk beneath the manic assertions of smooth sailing, and providing encouragement and support during the periods of disillusionment.

One might think the ideal end point of this scenario is reached when the patient truly believes that "it doesn't matter what anyone else thinks but me." Perhaps it is, but we have the impression that before such an ideal of independence is achieved, family members become convinced about the security of the patient's sobriety, i.e., improvement in family relationships is largely secondary to the patient's clean time (although the lag time before family members trust the patient again is, as stated above, often intolerable to the patient). The changes in family relationships—for those successful

patients who achieve a substantial amount of clean time—are often considerable. Nevertheless, certain basic "structural" aspects of these relationships do not change, or at any rate change far less than the therapist might wish. For example, a patient may come to find himself treated in a friendly, trusting manner by his father, but the patient's basic wish—to strike just the right note with his narcissistic father—is still unchanged.

The patient's relationship to group (therapy group and/or self-help group) frequently follows a path similar to the one traveled in family relationships: the path travels from isolation, alienation, and a defensive superiority to the patient experiencing himself or herself as a genuine member of the group. Once again, the therapist may be distressed by the character of the patient's involvement with others, for example the patient's involvement with a self-help group may seem rigid, mechanical, or dogmatic. We can only remind the therapist of the not insignificant changes that have occurred and caution him or her against forcing an ideal standard upon the patient.

Before discussing the changes in the therapeutic relationship, one point needs to be made. With many other kinds of patients, the therapist need not become actively embroiled in the patient's interpersonal patterns in short-term therapy. In effect, the treatment ends before the therapist gets caught up in the interpersonal field between patient and therapist. In such treatments, it

might be reasonably appropriate to consider the transference relationship one that is primarily subject to intrapsychic changes. With cocaine abuse patients, however, therapists ought to become more or less dramatically embroiled in the patient's core relationship patterns. Indeed, the therapist who does not become at all embroiled has probably not done his or her job, such as those therapists who are able to maintain a steady therapeutic posture and remain outside the patient's core relationship patterns by avoiding careful inquiry into the particulars of the patient's life (such inquiry inevitably generates resistance and countertransference).

What, then, are the typical changes in the therapeutic relationship over the course of the six months of treatment? Consider the aspect of the therapeutic relationship involving the patient's hope or cynicism about the potential helpfulness of the therapist. Obviously, cocaine abuse patients differ in the proportion of hope or cynicism they manifest at the beginning of treatment. (What distinguishes cocaine abuse patients as a group from many other kinds of patients is the relative ease with which profound cynicism may inject itself into the therapeutic relationship.) From the therapist's side at the beginning of treatment, the therapist (if not too cynical himself or herself) wants to be helpful, benign, and understanding. In addition, naturalness and warmth are advantages in working with substance abuse patients, as contrasted with a concern for maintaining the "role" of therapist.

Sooner or later, often very soon indeed, the therapist's initial therapeutic spirit is sorely tested. We intend no implication of intent, either conscious or unconscious, on the part of the patient in using the term *tested.* It may all be more impersonal than that. The patient does what the patient does: coming late, missing sessions and not calling, getting high, lying, acting contemptuously, and obscuring critical realities in his or her life. And the therapist does what the therapist does: making a strenuous effort to maintain "sympathetic understanding" without becoming a fool or a phony. The therapist attempts to avoid feeling furious or disgusted and to avoid moralizing, acting parental, or coming across as a disciplinarian. Because the therapist usually is unable to do this—he or she withdraws and makes no demands on the patient—the therapist typically becomes anxious and guilty. The therapist then becomes still more angry with the patient, who is experienced as forcing the therapist to feel and act in ways not considered in keeping with the therapeutic ideal.

Cocaine patients, like all substance abusers, are enormously sensitive to being treated with derogation, contempt, withdrawal, moralizing, authoritarianism, or, by way of reaction formation, the inauthentic opposite of these attitudes, on the part of the therapist. Such sensitivity in the patient increases the therapist's guilt and anxiety about leaking out any such characteristics. One can see how a destructive therapeutic crisis could easily ensue.

If the therapist is not oppressed by unrealistically high ideals regarding acceptable therapeutic attitudes, several positive consequences follow. Because they are not handled defensively (e.g., by repression, reaction formation, or blaming the patient), these attitudes are registered by the therapist earlier in treatment than they otherwise would be. This makes it possible for the therapist to "metabolize" these attitudes. For example, the therapist may discover an authoritarian or moral streak in himself or herself. Such a discovery moderates the intensity of the therapist's reaction. Furthermore, it is very possible that it is not merely the above-mentioned attitudes themselves but the therapist's denial, either overtly or more usually implicitly, of these attitudes that is particularly noxious for the patient.

Thus, the patient hits a point fairly early in treatment when the therapist is experienced as being much like many other people in his or her life, for the very good reason that the therapist is reacting much like many other people in the patient's life. This experience can elicit many different reactions from the patient: disappointment, resignation, rage, cynical confirmation of the uselessness of others. Ideally, the therapist, sometimes with the patient's help, finds a way to continue a therapeutic inquiry while not continuing to enact aspects of the core relationship pattern.

Intrapsychic Changes

The following areas of intrapsychic change during the course of a successful time-limited SE treatment of cocaine abuse obviously overlap a great deal. In addition, we do not claim that the following list is complete.

Hope. Perhaps no other population is so thoroughly demoralized as substance abuse patients, and cocaine patients are no exception. A central aspect of change is the patient's increased sense of hope that a life can be lived without drugs, and lived happily and productively.

Meaningfulness. The patient begins to develop a sense of purpose that involves a set of values, beliefs, and goals. As the patient maintains sobriety, the idea that it is actually possible to live up to something of these values, beliefs, and goals begins to take root. Subsequently, occurrences in life begin to make sense. Drug taking and the urge to use cocaine no longer seem to strike the patient at random—a sense of coherence develops.

Self-esteem. As cocaine use decreases, patients are able to pursue their interests more steadily and consistently. All this enhances their sense of effectiveness. They also experience a genuine increase in self-respect, rather than swings from self-contempt to grandiosity.

Alienation. Cocaine patients begin to appreciate that their problems are ordinary, human problems. This perspective contrasts with their previous swings between intense states of despair—affected by a belief that their

problems are extraordinary, almost demonic in nature—and a manic state in which they deny all difficulties.

Experience. The patient's experience becomes more refined and articulated. With regard to both internal and external stimuli, more is registered, felt, and considered than when cocaine substituted for experience.

Defenses. The use of frequently employed defenses, such as denial and grandiosity, decreases.

The "Curative Factors"

In the dynamic therapy literature, it is often debated whether "relationship" or "insight" is responsible for change. It seems to us that such a debate is fruitless—surely, interpretations that generate insight inevitably affect the therapist-patient relationship, and the quality of the relationship places constraints on the efficacy and resonance of interpretations. A third factor ought to be mentioned: namely, the therapist's ability to foster an environment, even cultivate events (e.g., through "extending enactments" or developing more coherent, concrete narratives, as discussed below), in which the patient can absorb and integrate experience.

TECHNIQUES

As the name implies, SE therapy includes both supportive and expressive methods. Because these techniques have been described elsewhere (Luborsky, 1984; Luborsky & Mark, 1991), we concentrate here on those techniques emphasized and/or modified for cocaine abuse patients. First, however, we will describe the principles involved in choosing an expressive technique over a purely supportive one.

Two principles help the therapist decide when support, compassion, and encouragement are called for and when more expressive methods are required. (For a review of the major supportive components of therapy, the reader is referred to Luborsky, 1984, chap. 6.) The first principle is that supportiveness generally decreases anxiety, while expressive techniques tend to increase anxiety. The second principle is that progress in therapy is most likely to occur when the patient feels mild to moderate degrees of anxiety.

The particular techniques emphasized and/or modified for cocaine-dependent patients are: (1) the interpretation of "collective" wishes; (2) the development of relatively coherent and complete narratives; (3) interpretations of drug taking or craving and of drug-taking narratives; (4) modifying the "basic" rule"; (5) extending enactments; (6) staying close to the patient's immediate experience; and (7) the short-term time limit.

The Interpretation of Collective Wishes

The interpretation of wishes has been regarded as an expressive technique that tends to increase anxiety (especially when the wishes focused on were considered to be almost exclusively of a forbidden sexual or aggressive nature). Yet one of the very significant supportive approaches with cocaine patients is the interpretation of collective wishes. Strictly speaking, the term *collective* does not refer to a discrete category but rather to an aspect of divers wishes. We define *collective* as a reference to what is consensually understood as the culture's definition of what constitutes humanity, of what allows a person to feel he or she partakes in the human community. Addiction almost inevitably involves violations of interpersonal commitments and cultural norms; the most damaging consequence is that the addicted person feels less than fully human and excommunicated (accounting perhaps for the creation of a drug subculture, including its specialized argot). Thus, interpretations that identify the addicted person's lost or disowned desire to reconnect with the human community are uniquely powerful.

For example, a patient started a session by talking for 10 minutes about how careful he was to make sure his children were safe and taken care of whenever he left to get high during a period of time when he had been left with the sole responsibility for them. The therapist has a very delicate path to travel when such assertions are made by a patient in an effort to seek reassurance from the therapist. On the one hand, the patient's self-esteem is far too vulnerable for the therapist to lead off with an interpretation of the

CCRT like, "I wonder if you are telling me at such great length about how you, unlike some other people you know, made sure your children were always left in a protected environment whenever you left to get high, in order to get some reassurance from me that you really are a good, caring person and parent?" On the other hand, to simply respond supportively ("So even in your addiction, you, unlike many others, really went to great lengths to protect and care for your children") is to collude with the patient in minimizing the traumatic consequences of his cocaine abuse.

The therapist will need to make certain points, as demonstrated in the following examples:

1. "You have the wish to be a good, caring responsible parent" (the collective wish).

2. "As one of the terrible consequences of the cocaine abuse, it has been impossible to fulfill that wish on a steady, consistent basis."

3. "This damages the way you regard yourself."

4. "You attempt to bolster your self-esteem in a way that cannot succeed in the long run—by obtaining reassurance from others, perhaps especially from others who are in a position of authority."

5. "The only way to truly reassure yourself in this regard is to stay off

cocaine so you can fulfill your wish to be a good parent."

While the interpretation of the wish component is an expressive technique, the interpretation of the collective wish is also very likely to be experienced supportively by the patient. For it conveys that in spite of the failures that have occurred in the patient's life as a result of the drug abuse, the patient's wishes are ordinary, human ones. Hence, the underlying fear of being less than fully human ("What sort of parent would be so irresponsible?") is addressed. The interpretation also provides hope, suggests a solution, and allows the patient to think, "If I stay off drugs, I can give myself a chance to fulfill my wish of being a good parent."

A Review of the Logic of the CCRT Method

The formulation and interpretation of the central relationship pattern has been considered "the most vital expressive technique" (Luborsky & Mark, 1991). Because many of the modifications for the treatment of cocaine patients have to do with developing useful data upon which CCRT formulations are made, it might be useful to first review the logic of the CCRT method. The CCRT formulation is derived either from enactments between the patient and therapist or, more frequently, from narratives, called relationship episodes (REs), told by the patient (Luborsky, 1984). The narratives from which the CCRT is derived are very different from the narratives of Spence (1982) and Schafer (1983). According to them, the

narrative is not the raw data of the therapy session but what is constructed from the raw data—the interpretive scheme into which the raw data are cast. On the other hand, with the CCRT method, the narratives are the raw data and the CCRT is constructed from these data. Most of the relationship episodes in a psychotherapy session—including psychoanalysis, psychodynamic psychotherapy, and cognitive-behavioral therapy—are explicit narrations of the patient's relationships with others (Luborsky & Crits-Christoph, 1990).

Patient narratives as such have received scant attention in the psychodynamic literature, in part because the original psychoanalytic model advocated minimal verbal activity on the part of the therapist. Therapist interventions were thought to contaminate the transference. The therapist was not to interrupt the flow of the patient's associations except to interpret resistance or content. Short-term psychodynamic approaches advocate a more active therapeutic role, but primarily to accomplish the same goal as in psychoanalysis—to interpret the transference and make reconstructions (Malan, 1963, 1976), only sooner and more vigorously. Not surprisingly, this quicker, more vigorous activity on the part of the therapist often results in a highly confrontational and adversarial style (Davanloo, 1980; Sifneos, 1972). Even since supportive interventions have become an accepted part of the psychodynamic armamentarium, scant attention has been paid to the development of data in the psychoanalytical approach to psychotherapy.

The Development of Relatively Complete and Coherent Narratives

Because the narratives provide the bulk of the raw material for the CCRT formulation, it is particularly important that these narratives be relatively coherent and complete. The problem of narratives that are scattered, highly condensed, and virtually without psychological significance is especially acute with cocaine abuse patients. Their attention is frequently scattered, and they often talk a great deal about symptoms, such as anxiety, entirely isolated from psychologically meaningful contexts. This lack of "representational elaboration" (Greenspan, 1977) is striking.

It takes a great deal of skill for a therapist to know when and how to intervene with questions and comments that help develop the patient's narratives. No manual can teach such a skill. Acquiring it takes supervision; therapist and supervisor listen to tapes of sessions together to hear, evaluate, and discuss how to develop narratives. However, within the context of this manual, we can suggest some questions that may be helpful to the therapist.

1. Does the narrative appear to engage the patient, concern the patient, or matter to the patient in some way? Does the narrative raise a question for the patient about what the patient or another person in his or her life felt, thought, or did? Does the narrative have the quality of search (Zucker, 1967)?

2. Does the narrative have a graphic, vivid quality (Zucker, 1967)? Can

the therapist picture what is being narrated? Are some aspects unexpectedly missing (Cooper & Witenberg, 1983)?

3. Is the narrative relatively coherent, with an intelligible sequence, or is it fragmented?

The Use of Cocaine

What to Interpret

Where does drug taking fit in with regard to the components of the CCRT? As originally conceptualized in the CCRT, the response from self includes symptoms such as anxiety or depression. The CCRT also views cocaine dependency, or any form of drug dependence, as a response from self, but drug use has a complex, often ambiguous and evolving status with regard to the CCRT. Early in the development of the addiction—though not necessarily at the very beginning—the use of drugs may have been regarded as a symptomatic response from self, usually as a consequence of the frustration of a wish that resulted from a negative response from other. Eventually, however, the drug use became more than merely a symptom and a response from self. Drug use became something actually wished for, unlike anxiety, depression, or obsessions. Therefore, in terms of the CCRT, as drug use evolves it is not just a negative response from self but also a wish. Sooner or later, the wish for the drug becomes dissociated, so that the drug-dependent patient experiences the drug use as compulsive. And somewhat

more than other compulsions, drug dependence becomes a way of life, with a relatively established subculture to sustain it. Drug addiction thus eventually becomes a central determinant of a person's physiological state, identity, and relationships with others. It is only well into the recovery process that a "slip" may once again be regarded merely as a symptomatic negative response from self. In addition, once the drug becomes a significant aspect of the patient's life, it occasionally makes sense to think of the cocaine as the "other" whose negative response (NRO) is often "to harm, humiliate, protect, or enhance me."

When to Interpret

How does the therapist decide whether to interpret the cocaine use as a wish or as a response of the self? As a general rule, very early in treatment the drug use will tend to be interpreted as a response of the self. Such an interpretation is usually experienced supportively; it decreases anxiety because it decreases responsibility for the drug taking. As soon as possible, the therapist begins to interpret the cocaine as a wish. This increases responsibility and anxiety. Still later in treatment, the wish for cocaine is seen as a derivative wish rather than a primary wish.

CCRT Patterns with Cocaine as the Central Wish

What are some typical CCRT patterns involving cocaine as the central

wish?

1. When the wish to use cocaine is defended against with an NRS of either helplessness ("I had no idea he [a drug-using acquaintance] would be there, and he just offered it to me. It was in my face. There was nothing I could do") or disavowal (the patient drove around and around just to relax and "happened" to arrive in his old drug-using neighborhood).

2. When the wish to use cocaine brings into (typically fleeting or intermittent) awareness the consequences, such as NRO-anger, hurt, disappointment in self, getting fired (often accompanied by the NRS of shame). In turn, these consequences are defended against with an NRS of devaluation of others, grandiosity, and so forth.

3. When the wish to use cocaine brings into awareness (again, fleeting or intermittent) the NRS of guilt. In turn, this guilt is often defended against by justifying the use, usually by an NRO in response to which the patient accuses and blames others ("My wife doesn't understand me, so I went out and found someone [a coke-using prostitute] who does"). In other instances, the NRS of guilt is alleviated by an enactment involving an NRO of "Blame me, punish me." This is often observed in the transference.

The purpose to establishing the patient's wish to use cocaine is not to humiliate him or her (though it may do so). Clearly, patients are not in a position to take relatively simple steps (such as avoiding "people, places, and

things") if they have not yet convinced themselves they do not want to use. Therapists are often reluctant to interpret the patient's wish to use for fear that such an interpretation will exacerbate the patient's shame and guilt. Several points need to be made: It's a sign of progress if the patient can experience shame and guilt rather than the defenses against them of reproach, grandiosity, devaluation, and so on. The therapist's capacity to draw out these affects, rather than nervously shy away from acknowledging their existence, and to hold the patient to the experience is an important aspect of SE therapy with cocaine patients. To put it another way, the patient's experience of shame or guilt in the presence of another person (the therapist) who is neither anxiously reassuring nor punishing or humiliating ought to be useful. Furthermore, there are positive aspects to both shame and guilt in and of themselves. The presence of these affects may signal the existence of a desire (a collective wish) to rectify relations with others, a concern for others, or personal standards and values. Pointing this out to the patient ought to provide motivation for sobriety. Finally, drawing out the patient's wish to use cocaine increases the patient's responsibility for his or her actions. While a sense of responsibility may exacerbate shame and guilt, it ought also to provide hope for the patient. After all, feeling helpless about your addiction can be a terribly despairing state; responsibility implies that you can do things to improve your condition.

We do not want to give the one-sided impression that we advocate only

interpreting the wish to use cocaine. The CCRT ought also to be used at moments when the wish to not use cocaine comes into the foreground. For example, substance abuse patients receive some standard pieces of advice, such as, "Avoid people, places, and things," "Call your sponsor if you're experiencing a craving," and, Don't let yourself overwork, get too lonely," and so on. As discussed earlier, the patient's inability or unwillingness to follow such advice should not always be regarded merely as the wish to use. Rather, his or her inability or unwillingness ought to be placed in the context of the CCRT.

Drug-taking Narratives

It is often useful to obtain a relationship episode around which an incident of drug use or a craving to use occurred. Sometimes it is possible to discover a core conflictual theme that stimulates the craving for the use of drugs. Inferences regarding a CCRT are far more sound when the patient has not used drugs for quite a while than when the patient has been using compulsively or steadily (e.g., after each paycheck). If the patient is using drugs compulsively or routinely, it is not sound practice to infer the underlying dynamics motivating the drug use episode.

Even under these latter conditions, however, it is useful for the therapist to carefully obtain the drug-taking relationship episode. A relatively complete

RE often permits the patient and therapist to identify some of the immediate triggers of the drug-taking episode. In addition, the joint effort to identify such triggers by obtaining relatively complete drug-taking REs is frequently experienced supportively by the patient. The patient experiences this effort as a collaborative undertaking that may also reduce anxiety by attempting to make sense out of the obviously destructive and often incomprehensible behavior of drug taking.

Modification of the "Basic Rule"

In dynamic therapy, some variation of the "basic rule"—"You can talk about the things you want to talk about"— is typically suggested. For cocaine patients, particularly in a short-term format, such an opening is too vague. We recommend a direct invitation to the patient to bring up a significant narrative. In addition, we indicate to the patient that we expect them to discuss any craving or cocaine use experience. Thus, instead of the basic rule, we might begin several of the early sessions as follows: "What has occurred since we last met that concerned you, raised a question for you, made you anxious? If you've used or felt tempted to, naturally that would be useful to bring up in here."

Extending Enactments

To briefly review, the CCRT is formulated on the basis of patient narratives and enactments between patient and therapist. Because cocaine patients have learned to scatter, divert, and short-circuit experience so effectively, special therapeutic attention must be given to the development of meaningful data—both patient narratives and enactments. Enactments are behaviorally expressed events between patient and therapist. Particularly for cocaine patients, spontaneously occurring enactments often need to be drawn out or extended before their meanings are clear or can be absorbed by the patient.

Mr. Block provided an example of extending enactments. He often refused to talk about certain matters once they became uncomfortable for him. To draw out this form of oppositionality, which blocked every effort to enter into an exploration of the problems in his life, the therapist would say to him, "Okay, you don't want to discuss going back to work. What do you want to talk about?" The patient would then bring up something else, for example, "my depression." Before long, he would find a way to block further discussion of his depression, insisting that nothing more needed to be said about it. Again, the therapist would ask the patient what he wished to discuss. After several rounds like this, the structure of his responses had been revealed sufficiently to make it virtually unavoidable for him to acknowledge it. Thus, by allowing the behavior to occur a number of times *without* interpretation, the ground can be prepared by the therapist for the patient to more readily

acknowledge and absorb an interpretation when it's offered, in this case about how he blocked every attempt to enter into a discussion of something troubling in his life.

Staying Close to the Patient's Immediate Experience

Although an event may have been extended sufficiently to generate a meaningful experience, the therapist may recognize that the material is no longer in the patient's awareness, or perhaps is somewhat unacceptable to the patient. Interpretation will only create defensiveness on the part of the patient and thus be premature. In these instances, it is useful to stay as close to the patient's immediate experience as possible. Doing so involves much more than merely reflecting back what the patient is saying, especially when the patient is discussing something entirely removed from the therapeutic relationship.

For example, a patient, a rather macho, 43-year-old cocaine abuser, was talking to the therapist about how he would get his old job back. His words communicated utter certainty about his course of action. He conveyed equal confidence that his reception at his old workplace would be positive, even grateful. Nevertheless, he went on at great length, and he frequently cast a hungry look at the therapist, as if he were really quite unsure of himself and needed the therapist to affirm what he was saying.

The therapist decided to stop the patient shortly after the patient had shot him that quick, hungry look, saying, "Sam, I have a sense that you are looking at me very carefully. Do you have a sense of that?" Thus, rather than simply asking, "What are you feeling now?" the therapist tried to stay as close to the experience as possible by making direct reference to something that was concretely occurring. Particularly with drug abuse patients, who are apt to convert affective experience into drug deficiencies ("I don't have enough benzos"), it is important to keep the level of abstraction to an absolute minimum whenever possible.

The Time Limit

In a certain sense, the short-term time limit (we are currently using a six-month treatment for an ongoing National Institute of Drug Addiction study of cocaine abuse) is far more acceptable to this population than to many others. It has been our experience that patients whose primary symptoms have been anxiety and depression are often very uncomfortable with the short-term nature of the treatment, frequently wondering how anything will be accomplished in so short a period of time. Not so with the cocaine patients. There are many reasons for the cocaine patient's relative lack of expressed anxiety over the short-term nature of the therapy, not the least of which is that the dynamically oriented therapist, who has typically spent years and years in school and is used to treatments lasting for years, regards six months

as a considerably shorter period of time than does the cocaine patient, who may not have had too many relationships, projects, or goals last for six months.

The six-month limit on the treatment, which is clearly discussed with the patient at the beginning of treatment, can be used to provide the therapist with a certain leverage when it comes to the frequent complaint by the patient that attending all of the sessions is an impossible burden. The therapist can remind the patient that whatever burdens are anticipated will be for a limited period of time. The patient is, in effect, asked to make a commitment with a definite limit on it; this is more palatable than if the commitment were open-ended.

CASE EXAMPLE

The following case was a time-limited (six months) SE treatment for cocaine abuse in which the patient was seen twice weekly. The major purpose of this case example is to illustrate how the CCRT can be used to help understand the meanings and functions of a person's drug use and the difficulties involved in becoming drug-free, as well as the difficulties that exist for the person facing life without drugs.

Mr. Block was an unmarried, 26-year-old lower-level manager of a midsized factory. He had owned his own home and allowed a male friend to

live in his house rent-free. Mr. Block had used a variety of substances recreationally for 10 years, but his drug use had increased dramatically in the two years prior to treatment. Mr. Block had been depressed since high school. In fact, he certainly would have met the criteria for dysthymic disorder since high school, and that of major depression since shortly before his first cocaine use two years before. Clearly, the self-medication hypothesis of drug abuse (Glover, 1932; Khantzian & Khantzian, 1984) is very relevant in this case.

Some cocaine abuse patients come to therapy stating that cocaine is their only problem and nothing else concerns them. Other patients come to therapy insisting that cocaine is not a problem, that it is strictly subsidiary to some other difficulty, often a troublesome parent or spouse. Mr. Block began the therapy with a variation of the latter presentation. With an extraordinary sense of shame, he "confessed" that he had never had a girlfriend—more specifically, he had never had sex with a woman without "paying for it." He insisted that the cocaine itself was not a problem and that if the therapist were to make an issue of it he would bolt the treatment.

The beginning of treatment with Mr. Block illustrates two other aspects of therapy with cocaine abuse patients mentioned earlier in this chapter. First, the goals need to be shaped into something within the therapist's realm of competence. For example, the patient's "presenting complaint," of never having had sex without paying, was experienced with such intense shame that

it was impossible for him to consider the meanings and significance of the issues involved; rather, he remained enveloped in a vague, yet acute, distress he simply wanted eradicated (illustrating Shapiro's passive-impulsive style). The therapist needed to propose a viable working arrangement, and since he was neither in the business of procuring dates nor capable of magically and instantaneously eradicating Mr. Block's agony, he attempted to get Mr. Block curious about certain questions (one of the early goals of treatment): Why *such* shame? How did Mr. Block relate to others?

The beginning of treatment with Mr. Block also illustrates how quickly the therapist is placed in the middle of a transference-countertransference bind. Almost instantly, the therapist was feeling controlled and threatened while simultaneously being appealed to as a source of pity. As the therapist struggled with this, the interpersonal field itself became a focus for the therapy. The patient acknowledged that he had placed his parents and certain friends in a very similar position. The consequences of doing so were elaborated. For example, getting what he wanted from others by way of pity, threat, and intimidation left him very uneasy about where he stood in relation to others. In addition, his threat to bolt the treatment and explode with rage if pushed had consequences for him apart from its effects on others, and his tendency to explode and flee whenever he encountered a difficulty in living became a problem in its own right in the therapy. His subjective experience of cocaine—as a means of obliterating his distress—shows how cocaine

functioned as a ready vehicle for flight for him.

Mr. Block's cocaine use (as well as the above issues) grew out of a variety of core relationship problems. For example, even before his cocaine use became unmanageable, his self-esteem was artificially, and therefore precariously, maintained. More specifically, his central response of the self, in addition to the cocaine abuse and depressive symptoms, included: a self-image of being a fool, interpersonally incompetent, and unlikable; central affect states of shame and humiliation; actions that would be described by most members of the culture as foolish, incompetent in the interpersonal realm, explosive, and threatening; and a tendency to flee in the face of perceived difficulties and humiliations.

The core RSs serve as the impetus for the patient's wishes, which in turn either reinforce existing RSs or generate new ones. For example, the precariousness of Mr. Block's self-esteem and sense of security was perpetuated by the nature of the relationships he created. He repeatedly resorted to two modes of living. One was to strive to be the center of attention (a wish derivative of wanting to be loved and appreciated) via a special achievement or by acting the clown. He exhibited this mode in his behavior and in his dreams. In one dream he was to perform in an international competition and was accompanied there by his entire family—a much larger entourage than his actual family. When he went out to a party to meet

someone, he regularly took along pictures, souvenirs, or joke items and left them in his car. He then retrieved them when he struck up a conversation with someone, using them for their attention-getting value. This practice had inevitable consequences for his core RS—it exacerbated his sense of himself as interpersonally incompetent and added to this self-image a sense of being a sham. Mr. Block was so focused on being the center of attention that other aspects of his experience atrophied. Personal meanings of events and relationships, outside of considerations regarding the limelight, were relatively undeveloped. This deficit contributed to his inability to create meaningful relationships and intensified his need to become the center of attention.

The other mode of living in which Mr. Block demonstrated a desire for love and appreciation from others (but evidenced no idea of how to build such a relationship) was his pattern of offering a quick commodity—often drugs or money—to "buy" friendship (recall the presenting complaint). Not surprisingly, he often ended up feeling exploited by others—the central negative response from others. Examples of the above pattern included providing cocaine for his group of friends, having a male friend living in his house rent-free, and frequently paying for groups of friends at restaurants and bars. His success at work provided him with the money for these often lavish expenditures and gestures. It also provided another substitute for relatedness: praise and attention from his superiors. Indeed, at least early in

his cocaine addiction, he believed the cocaine enhanced his work performance.

His increasing cocaine abuse, while at first improving his work performance, inevitably began to impair it. He began to miss workdays more frequently, and his motivation at work diminished. When this lost him the respect of his superiors, he turned his efforts to impressing his coworkers with his ability to "get away with murder" at work—namely, to use cocaine heavily yet remain on the job.

Eventually, however, he lost his job and then his house. These losses can be more deeply understood in terms of the CCRT: he not only lost his job and his house, even his self-esteem, but the very means by which he had created the illusion of relatedness.

Thus, we can see how his cocaine use was intricately interwoven with his core relationship problems. At first, the cocaine served as one manifestation of his tendency to flee when confronted with a difficulty (an RS), while it also provided him with the means to both excel at work, thereby impressing his superiors, and literally buy the friendship of others (satisfying the wish to be loved and appreciated). Even after his cocaine use severely impaired his work performance, it still functioned to capture the limelight with his coworkers.

As discussed earlier, the desire to use cocaine and the desire not to use cocaine occupy the foreground at different times in the treatment. It was only after Mr. Block underwent a particularly severe binge two months into the therapy that he was able to profoundly acknowledge his desire to use cocaine. Concurrently, this acknowledgment provided the opportunity to nondefensively experience the desire to stay off drugs. Many patients experience a slip or even a severe binge during the course of treatment. This need not be a cause for dismay, despair, or panic on the part of the therapist; as in Mr. Block's case, the drug use often can be turned to therapeutic advantage.

Once Mr. Block acknowledged his desire to stay off drugs, the problem became how to achieve sobriety. This desire is complicated by a number of factors. The CCRT provides a means not only of appreciating the gravity of the losses involved but also of instilling the hope that alternative means of achieving the desire exist.

The man living at his house rent-free was heavily involved in drug dealing. Thus, getting off and staying drug-free while his friend was in his house was virtually impossible. Until Mr. Block comprehended his pattern of relatedness—being repeatedly exploited by others, an exploitation he invited by his need to buy friendship (his central RO)—he did not feel able or willing to do whatever was necessary to get his friend out of the house.

Early in treatment, Mr. Block would touch only very lightly on his pattern of being exploited by others. That is, his exploitation by others was not always unconscious, but he would quickly lose awareness of it by getting high or getting so enraged in such a diffuse way that he lost touch with what it was that had hurt or upset him. Sometimes he would claim that he "had" depression, owing to "bad genes." Thus, more was involved than simply cutting off contact with a drug-using friend (i.e., "people, places, and things"); an entire system of relatedness had to be challenged.

We now turn to how the CCRT provides a useful lens for appreciating the problems associated with facing and sustaining a drug-free life. One of Mr. Block's central difficulties was a lifelong tendency to resort to destructive extremes when confronted with conflicts or disappointments with others and, more generally, when things did not go according to his wishes. Evidence of this tendency, one aspect of his central response from self, was revealed in several of his relationship episodes. As a youngster he had wanted to go to a school play with his friends unaccompanied by a parent. It was a safe, suburban neighborhood, and all the other children were going without their parents. However, Mr. Block's father insisted on going with his son, maintaining that it would be too dangerous for his son to go without an adult. Mr. Block's response was to lock himself in his room. His parents begged him to come out and offered to modify their position, but to no avail. Much later, when he had grown up, two friends accused Mr. Block of mistreating another

friend. Even though Mr. Block was able to defend his position in a way that made his two friends understand, he was so upset that they initially had sided with the other friend that he disappeared for a week, flying to another city without telling anyone. In therapy, when the therapist asked when Mr. Block intended to attempt to return to work—he had been drug-free for about three months but still had made no effort to return to work—Mr. Block began the next session by saying he had decided it was time to terminate therapy. He also made suicide threats during anxiety-provoking moments during treatment. The cocaine abuse itself was another form of going to dire and self-destructive extremes.

Awareness of and work on this lifelong tendency to threaten to engage in such extreme behavior when things did not go as he wanted them to, or when others disappointed him, was delayed while he abused cocaine. Looking at his tendency another way, the inevitable anxiety a person faces after emerging from a long period of abusing drugs was, in Mr. Block's case, compounded by his characteristic response to flee from, avoid, or deny difficulties, conflicts, and disappointments.

Again, the therapist's appreciation of this tendency allowed him both to empathically convey an understanding of Mr. Block's predicament and to keep the issue clearly "on the table," despite the patient's often desperate efforts to obfuscate matters with dramatic threats such as quitting therapy or

even committing suicide. For instance, when Mr. Block threatened to quit therapy following the session in which the therapist raised the issue about his plans to return to work, the therapist at first sidestepped the termination issue altogether. He felt that he must first demonstrate that Mr. Block was avoiding the conflict, difficulties, and humiliation generated in the previous session. Only after this demonstration would the therapist have leverage to engage the patient around the defensive meanings he associated with the issue of termination. Otherwise, the exchange would very likely have degenerated into an involved and circuitous debate on termination and would never really have dealt with his pattern of avoidance. Here is how it went:

Therapist: Can you recall what we talked about last time?

Patient: No.

The therapist was not surprised. It reflected the degree to which the patient had banished a troubling topic. However, after the topic was exhumed, the therapist attempted to interest Mr. Block in looking at his skill at burying difficulties and disappointments. The discussion of his fleeing in the face of challenges had a good chance of proceeding meaningfully because Mr. Block had recently experienced a demonstration of that tendency right there with the therapist. A little later in the session, the dialogue continued:

Patient: This talk about work is going nowhere. I don't really care about work. Let's just leave it at that.

Therapist: You want to drop the topic?

Patient: I would be more depressed if I worked.

Therapist: Could you say more about that?

Mr. Block's last remark offered a ray of light. Now it became not simply a matter of not wanting to talk about work, or considering work irrelevant to his life, but feeling that he would be "more depressed" if he worked. The therapist hoped to open this topic up and so asked for an elaboration. A little later in the session, after Mr. Block said he "dreaded" work, the dialogue continued:

Therapist: Should we try and understand what this fear is about? Is there another way, other than dropping the matter altogether?

Patient: I've never done that before.

Therapist: Well, let's see if we can get a hold of it. What about your dread about this situation, of returning to work?

At this point, the beginning of a meaningful discussion of his relationships at work began. Aspects of the CCRT had been re-created in the session—in this case, a tendency to create a storm, to resort to extremes, to enter a kind of oblivion (reminiscent of cocaine intoxication) when faced with a difficulty or disappointment, as seen in Mr. Block's threats to quit therapy or his insistence that "this is going nowhere." This reaction pattern showed itself with particular intensity once he stopped abusing cocaine. In that same session he said he was afraid to return to work in part because he had only "one more chance," given his performance during the time he was heavily using cocaine at work.

At termination, Mr. Block had been drug-free since the ninth week of treatment and had begun to work. He had connected with a sponsor and was

regularly attending NA meetings. He believed he was far less explosive with others (one of his goals of treatment) but did not feel that his ability to form a meaningful relationship with a woman was substantially improved. It was agreed that this was a serious problem that would require therapeutic attention, but that it was a problem that had a better chance of being improved as long as he stayed drug-free.

TRAINING

Substance abuse patients are never easy to treat, and our experience has been no different in this respect from that of others in the field. After a careful selection process in which more than 50% of the applicants for learning the SE treatment were rejected before the pilot phase of the study (all of whom had at least five years' experience after obtaining their M.D., PH.D., or M.S.W. degree) and a careful training process in which the therapists received frequent supervision on three different cases (approximately one hour for every two sessions), we would estimate that only about 70% of the remaining therapists deliver the treatment at an acceptable level of competence.

We believe it is important to select therapists who have experience with both dynamic therapy and substance abuse patients. Ideally, the therapists are the kind of person who is able to maintain a reasonably consistent

background sense of warmth, concern, and interest while keeping the significant issues meaningfully present between the patient and therapist. Our experience was that some therapists became hostile or moralistic, or withdrew from the patient; most, however, maintained a surface warmth and concern, but they often did so by failing to engage the patient around the significant areas that might have provided therapeutic traction.

Exploration of the transference tends to be banal and frequently occurs in the absence of a relationship episode, thereby giving the investigation of transference an excessively abstract and general character (e.g., "How does it feel in here with me?" or, "Do you feel that way with me?"). The issue of excessive generality can be solved if the therapist is reminded that investigation of the transference ought to occur in the context of an RE. In addition, the investigation of the transference ought to provoke anxiety for the therapist as well. If the transference implicates the therapist as well as the patient, then an inquiry that suggests a struggle for only the patient ought to be looked on with great suspicion; the odds are that such an inquiry is serving more to make the therapist comfortable than to draw out the central areas of feeling, tension, and difficulty between patient and therapist.

Our experience has been that supervisors must begin the supervisory sessions by reviewing with the therapist matters such as the patient's drug use, attendance at the sessions and groups, and lateness. Even our relatively

experienced sample of therapists often does not give sufficient attention to such matters. Supervision has occurred with the aid of tapes of the sessions to be reviewed by supervisor and therapist. We believe that this is essential. After the supervisor has listened to the session, certain issues ought to be routinely reviewed with the therapist:

1. Identify the various REs.

2. Ask the therapist to attempt to envision the event the patient has described. Are central aspects of the event, either internal or external, missing? If so, the RE has been insufficiently elaborated.

3. Ask the therapist his or her reaction to the RE described. In effect, ask the therapist to react to the event narrated as if he or she were a friend hearing about the incident, rather than a therapist. We have found that therapists are often afraid to react to the patient's material for fear of being judgmental, a reaction that would be considered an indication that the therapist has left the patient's subjective frame of reference. Yet such a reaction is the very basis of interpretations.

4. Identify the relationship components manifested in the REs. We have found that therapists have difficulty maintaining a consistent focus. Therefore, every few sessions we ask the therapists to formulate the CCRT in writing.

EMPIRICAL EVIDENCE FOR THE APPROACH

The efficacy of applying SE therapy to cocaine-dependent individuals is currently being tested in an ongoing NIDA-funded, multisite, controlled study —the Cocaine Addiction Collaborative Study. Studies researching the effectiveness of SE treatment for methadone-maintained patients with a primary diagnosis of opiate dependence have been completed (see Chapter 5 on opiate addition).

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Notes

1 These terms, *affects, somatic experiences, self-esteem,* and so on, do not represent discrete categories,

nor are they at the same level of abstraction. Furthermore, these terms differ in that some represent immediate "first-person" experience (e.g., a particular affect state or somatic experience), but others are inferred and in clinical practice tend to come from the "third person" (i.e., the therapist). We believe these distinctions have important implications for clinical practice, but we do not have space here to elaborate. See our forthcoming book (Mark & Faude, in press).