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Drug and Alcohol Counselling from a Psychodynamic Perspective

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Abstract

What is Psychodynamic Therapy and how this work is accomplished? Psychodynamic psychotherapy encompasses a range of different therapies which focus on understanding the unique internal dynamics within a person which impact on their feelings, behaviour and relationships.

The paper illustrates how to work with drug and alcohol clients using a combined social learning theory and psychodynamic approach.

The work is in two parts: (i) an introduction to Alcohol and Drug counselling methodologies (ii) a brief overview of working from a Psychodynamic perspective

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Introduction

Have you ever wondered how to engage and work at a deeper level with your alcohol and drug using clients?

From this author's perspective a prerequisite of working with clients is to see the client as a unique individual. The counsellor is not an expert on the life of the client and time needs to be spent in understanding the world as seen through the prism of the client's experience.

To that end in working with alcohol and drug using clients a mixture of Social Learning theory and Psychodynamic theory is used to enable the client to see where s/he has come from and where the future could be.

Approaches to drug and alcohol clients

Most people in our community use drugs to some extent and the majority will experience few if any problems associated with this use. However some people will develop problems associated with their drug use and will be in need of support and care. Others will seek support due to the use of drugs and alcohol by a spouse or other family member.

A number of theories have developed over time to engage why people engage in illicit or detrimental drug using behaviours. These models have shaped the way legislators and differing societies have responded.

Within the drug and alcohol area treatment and counselling approaches vary from organisation to organisation. Historically there have been a number of approaches. The two predominant models upon which all the other approaches are based are Harm Minimisation and the Disease/Medical Model. These variances can move from a total abstinence approach (typically using a 12 Step model) to that of an approach whereby the client decides for himself/herself what is appropriate.

The approaches as outlined in this paper would fit more comfortably into a harm minimisation approach.

Social Learning Theory

Social Learning theory is not really one theory, but rather a compendium of approaches. These models all have a common belief that we are responsible for our own actions. In working with clients who use drugs and alcohol it is essential to understand what it is about the substance that is attractive for that client. To that end there are three attributes that are taken as being essential to understand the client and then the client have ability to undertake the required work.

All drug use is functional. In all societies there are activities and substances that are used for the enjoyment of the individual. We use these substances because they are functional

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in that there are real and expected consequences. The use of alcohol and other drugs has an expected consequence for the user. These consequences may include feeling 'high', feeling relaxed, feeling sociable, the avoidance of withdrawal discomfort and so on. We learn how to respond to so much of our life by modelling ourselves on others. Drug use is a learned behaviour. This learning is taken from parents, the various forms of media, our peers and from observing others. Modelling, which can be vicarious or observational learning, is a key factor in the adoption of alcohol and other drug use behaviours.

Drug use is complex and this complexity is acknowledged in this theory. There is an interaction of various factors; an individual is not driven by internal factors alone nor responds passively to external or environmental factors. The factors are interdependent and behaviour is a function of these. This complexity indicates the different reasons for use and the different responses required.

Of the many approaches encapsulated by the generic title of Social Learning Theory, the following three are highlighted as being pertinent in working concurrently with a clinician coming from a Psychodynamic Perspective.

Stages of Change

In this model developed by Prochaska and DiClemente, we are provided with an approach for understanding how people change. They found that people's readiness to change is not constant and that people move through stages of change. They introduced the concept that behaviour change as a process.

A key factor in this movement through stages is that people go back and forth. Prochaska and DiClemente referred to the changes as a cycle and they found that people often went through the cycle a number of times. The length of time in each stage in the cycle also varied. Throughout the movements of the cycle lapse and relapse are possible and are planned for and discussed.

Pre-contemplation
Contemplation
Preparation
Action
Maintenance

Motivational Interviewing

A traditional view of motivation is that it is something a person either has or doesn't have. There is a belief that many drug users do not give up on drug use because they do not have the willpower or motivation. They may be perceived as unmotivated, difficult or denying their problems.

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However a more accurate view of motivation is that everyone is motivated. It is more a question about the nature of the motivation. Are they motivated to continue using, reducing or stopping?

Motivational Interviewing is a counselling approach designed by Miller & Rollnick to help people with decisions about their behaviour. Its aim is to work through ambivalence about changing and consider the possibility of change. Motivation to change occurs when the positives of doing something are outweighed by the negative of doing it. In explaining how behaviour is maintained, despite what may be perceived as negative consequences, it is important to realise that the consequences occurring closest in time to a particular behaviour have the greatest effect on behaviour.

The 4 L's Model

The third approach taken from social learning theoretical bracket that is often conducive to a client deepening their understanding of their drug and alcohol use is known as the 4 L's. This model describes drug related problems in relation to four key areas of a person's life.

Liver: the physical, psychological, emotional health affects of the substance use

Lover: relationship issues with partners, family, friends and peers

Livelihood: study, work, money, recreation and lifestyle problems

Law: legal implications (criminal & family law) cultural law

Working with AOD Clients

The standard assessment interview asks for a client perspective on what is happening in their life and a drug and alcohol history. The initial session is about making an assessment as to the drug and alcohol use and any other factors impinging upon the client at this time. The building of a rapport and developing an open relationship at this beginning stage is vital to the ongoing treatment.

Using the Stages of Change Model, an assessment is made as to whether the client is ready to begin looking at their maladaptive pattern of behaviour. A pre-contemplator and an individual in contemplation stage are not ready to begin investigating into the reason why they use their substance of choice the way they do. Education and the possibility of other options is the primary role of the therapist at this point.

The client who is ready to make a change or for a client who is ambivalent about whether the time is right or not to change their drug using behaviour we would have a discussion around their feelings and the use of the motivational interviewing technique would be used.

A standard way of progressing from this point is to look at the clients' life and the how and when of their drug and/or alcohol use. This approach is very cognitive and focuses upon the thinking that leads to the substance use. Strategies and options are then

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discussed to help the client alleviate the symptoms and occasions of their drug using behaviour.

Psychodynamic Therapy

Psychodynamic psychotherapy is a form of depth psychology, the primary focus of which is to reveal the unconscious content of a client's psyche in an effort to alleviate psychic tension. Within all analytic approaches to therapy the major underlying principle is that behaviour is determined by unconscious, as well as conscious motivations. It is these unconscious motivations that need to be explored that are at the heart of psychodynamic therapy.

In this way, it is similar to psychoanalysis, however, psychodynamic therapy tends to be briefer and less intensive than psychoanalysis, and also relies more on the interpersonal relationship between client and therapist than do other forms of depth psychology. In terms of approach, this form of therapy also tends to be more eclectic than others, taking techniques from a variety of sources, rather than relying on a single system of intervention. It is a focus that has been used in individual psychotherapy, group psychotherapy, family therapy, and to understand and work with institutional and organizational contexts.

Psychodynamic psychotherapy encompasses a range of different therapies which focus on understanding the unique internal dynamics within a person which impact on their feelings, behaviour and relationships.

Psychodynamic psychotherapy adopts the view that insight or self-knowledge is an essential condition for lasting recovery and change. A trusting, consistent relationship with the therapist allows the individual to gradually reveal the patterns in their emotional and behavioural reactions that are causing problems. The therapist helps the client to explore and understand these problems.

Unlike strict Social Learning Theory and other CBT type techniques, that perceives the individual as a consequence of many stimuli from the environment; psychodynamic psychotherapy perceives the individual as an agent in his or her own behaviour and seeks to help the individual understand the unconscious meaning—that is, the dynamics—of troubling symptoms. Thus, insight into the symptoms is valued as a far more helpful and lasting cure than merely “getting rid” of the symptoms.

Psychodynamic therapy involves a great deal of introspection and reflection from the client. Speaking to this is also the client's ability to dive into their past; they must possess enough resilience and ego-strength to deal with/use the onslaught of feeling which a new perspective brings on.

Three essential concepts need to be understood to work within a psychodynamic modality. Transference can be understood as the process by which a person's current pattern of relating is unconsciously shaped by past experience. Transference refers to all impulses (wishes, fantasies and feelings) experienced by the client in relation to the

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therapist that are not generated by the objective situation. Most often these feelings have their origin in the client's early childhood.

Countertransference is commonly considered to encompass all of the therapist's feelings, and attitudes toward the client. Countertransference refers to therapist reactions to the client rather than in the clinical situation per se. Often this response has its origin in the early life of the therapist. This may be expressed as the therapist's unconscious response to the client's transference.

The use of psychological defence mechanisms as a response to external stimuli. The defences, e.g. denial, avoidance, intellectualisation, are unconscious and keep unacceptable desires and impulses from becoming conscious. This may take the form of the blocking or repression of such impulses, or by distorting them into acceptable forms, e.g. by projecting them onto someone else, thus seeing them as if existing in the other person, rather than in oneself.

How does the Therapist work?

In psychodynamic therapy awareness of the relationship is an indispensable tool. Key concepts for the therapist to be aware of and to be continually self monitoring are the need to be genuine and transparent; non-defensive and to be open to learn from the client; to be oneself and allow spontaneity; always view the client with utmost respect.

Psychodynamically, we learn the most about clients by allowing ourselves to feel what they are feeling, to enter their world as if it were our own. The therapist normally takes an attitude of unconditional acceptance. This basically means that the therapist holds the person in high regard because the client is seen first and foremost as a person, no matter what your problem is.

Careful exploration of the client's experience without judgement produces a lowering of defences. As the person feels listened to, understood and responded to by the therapist, s/he begins to feel safe enough to allow unacknowledged needs, fears and vulnerabilities to emerge.

The therapist tries to develop a relationship, to help discover what is going on in the unconscious mind. The therapist often uses how they feel in the room with the client, as a guide to how the client is feeling. The therapist, for lack of a better way of putting it, is testing the relationship to help the client to discover more about themselves than s/he is aware of. The therapist uses interpretations, which are a way of making sense about what is going on, in order to help the client become aware of their unconscious feelings.

So, in every session, the therapist is trying to judge, how much the client is in touch with his/her feelings, what feelings the client is not aware of, how close is the client to knowing the unconscious feelings, how painful these feelings are, and how well the client can tolerate the pain that becoming aware of these feelings will bring. In working with

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clients who abuse drugs and alcohol it can often be the case that the behaviour can be linked with some conscious or unconscious part of the self.

Working in this manner, the therapist is looking for patterns of feeling, thought and behaviour. The model of the 4 L's, as described above, may be of benefit to the client as s/he looks at their life as it is lived in the present as well as in the past.

Most psychodynamic approaches are centred on the idea of a maladaptive function developed early in life (usually childhood) which is at least in part unconscious. This maladapted function does not do well as it formed instead of a normal/healthy one. Later on the client will feel discomfort when they notice (or do not notice) that this function causes problems day to day. In working with drug and alcohol using clients it is always of interest to see where, how and why the client began their drug use and what function this behaviour fulfilled for the client. Does it still fulfil and/or maintain the same function?

The psychodynamic therapist will first treat the discomfort associated with the poorly formed function, reveal to the client that such a function exists, then change, remove or replace it with a more adaptive function.

Basic premises of psychodynamic work:

Client can work with an interpersonal therapy for problems stemming from interpersonal relationships

Dysfunctional styles are learned in the past

Dysfunctional styles are maintained in the present

The client re-enacts interpersonal difficulties with the therapist

Therapist as a participant observer

There is one identifiable, problematic relationship pattern

A Psychodynamic interviewing style

Building rapport with the client and focussing on what the client is bringing to each session is a first step. To that end it is important to notice, and comment on as appropriate, the use of language, idiom and pay attention to what is not said as much as the actual words used.

Being Person – Centred and being in tune with the words and meanings attributed by the client are hallmarks of the therapist working in a psychodynamic manner. Use of open ended questions and evidence of listening respectively throughout the treatment is also in

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evidence by a therapist working in this manner. The treatment is dynamic in nature as it is responding to the client not a pre-planned form of attack.

Encouragement is given to the client to experience and express affect in the session and with the client allow expression and exploration of feelings in relation to significant others. From these feelings come the thoughts and beliefs and behaviours in relation the people and situations in life. In working in the AOD (alcohol and other drug) arena, the place of the substance and the people and places associated with use and the feelings that this discussion arouses are to be encouraged and explored.

The therapist has an important role in the therapy and needs to be aware of his/her role as a participant observer. How is the client relating to me as therapist (transference issues)? How am I relating to the client (counter-transference)? Responses therefore need to be made in an accepting and understanding manner.

It is common, and even expected, for the client to experience strong feelings within the counselling session. Some examples of this transference could be, a feeling that can resemble the mixed feelings (i.e., love and hate) that the client had in childhood for a parent or parents, and a client can begin to treat the psychotherapist according to these feelings, all out of proportion to what is actually happening in the psychotherapy. In such a case, the therapist works with the client to realise that the counsellor is only bringing these feelings to light; it's the client's feelings, not the person of the psychotherapist, that are important.

Working in a dynamic manner as being discussed in this paper, enables a client to experience strong emotions and learn how to engage with them.

During the counselling/ therapeutic process it is expected that the client will experience many emotions that are similar to the intense and confusing emotions felt outside the therapeutic space. Most often we can look back to an earlier stage in life for the embryonic beginnings of these feelings, such as childhood. Some of the emotions that can arise include: disappointment, anger, confusion, feeling misunderstood, feeling devalued, feeling abandoned.

Therapeutically it is necessary for the counsellor to be aware of the counter-transference issues. Counter-transference can be considered the reverse of transference; that is, the term describes the psychotherapist's unconsciously activated reactions to the client. If these feelings are taken personally, the psychotherapist could become angry, abusive, spiteful or indifferent.

Counter-transference, however, should be distinguished from the psychotherapist's in-the-moment feelings about the psychotherapeutic situation, because these feelings can and should be used clinically. For example, if the therapist begins to feel bored, it could be an indication that the client is unconsciously avoiding an important issue. Therefore, the psychotherapist's emotional reactions to the treatment are neither "right" nor

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“wrong.” The real issue is whether these feelings are used clinically, for therapeutic benefit.

Generally a client will not be able, nor afford, to deal with all the issues of life at one time. It is possible that client will present with a multiple of issues. Therefore it is imperative for the therapist and client to agree on what it is that the client is wishing to achieve during the counselling sessions. To that end a focused line of enquiry is needed. For a client attending for drug and alcohol counselling, the Social Learning models of Motivational Interviewing and an awareness of the Stages of Change cycle help to maintain the focus. The identification of the how and why of the use of the substance and the place of the substance in the life of the client are explored.

The counsellor’s role is to look for the patterns that are impinging upon the life of the client. Once client and therapist have an agreed goal as the main pattern that is causing distress they together during sessions maintain this focus. If working in a strict short term therapy model, the therapist ignores all other matters not pertaining to the treatment. We all operate out of a number of patterns. Due to the time factor available for treatment we need to help the client to alleviate/change the one pattern at a time. Other patterns that may be causing distress can be left for another time, or for follow up treatment.

The therapist attends to the words as used by the client and as necessary inquires into the personal or unique meaning of the clients words. This also includes paying attention to the seemingly unimportant statements. In these cases the therapist responds to client’s descriptions by seeking concrete details. A psychodynamic therapist is looking for the predominant affect as expressed in each session. The motive is to enable the client to become more attuned to their inner feelings and expectations of self and then to be in a position to make a connection to their instinctual way of feeling, thinking and behaving.

The therapist maintains an optimal participant-observer stance. An attitude of curiosity is maintained and thus the client brings to the session their inner selves and this plays itself out within the session. This allows the client to have an experience that may be a different way of acting and re-acting to both internal and external stimulus.

In summary the treatment can be seen as:

- Explore the pattern that might be called maladaptive
- How does the client ‘feel’ about self?
- Link the interpersonal to the pattern
- Address the ‘defences’ e.g. denial, avoidance, intellectualisation, sublimation
- Provide new experiences to view the client’s particular maladaptive pattern

Conclusion

The relationship between therapist and client is central to working in a psychodynamic manner. A psychodynamic therapist seeks to understand what the client is experiencing and what they are feeling in the given moment.

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In working with drug and alcohol using clients it is imperative to work with the goals as agreed upon with the client. The therapist in using a Social Learning Theory approach based with the fundamentals of Psychodynamic Therapy is in a position to allow the client to understand their past and how it is impacting upon the present.

Most psychodynamic approaches are centred around the idea that some maladaptive functioning is in play, and that this maladaptation is, at least in part, unconscious. The abuse of drugs and alcohol can be seen as one such maladaptive form of behaviour. The presumed maladaptation develops early in life, and it is posited that in later years the client will begin to feel some dissonance in their day to day lives as a function of this paradigm. The psychodynamic therapist first intervenes to treat the discomfort associated with the poorly formed function then helps the client acknowledge the existence of the maladaptation, while working with the client to develop strategies for change.

Whatever the length of the therapy, it is important that the therapist: be genuine, respectful and affirming of the client's reality; attempts to help the client bring to the surface the buried principles that govern his or her life; communicate, above all, empathy to the client.

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