Group Psychotherapy and Addiction

Edited by

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*Martin Weegmann*

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Preface

In a famous anecdote attributed to S.H. Foulkes, the founder of group analysis, he was once asked why he made the move from individual psychoanalysis to group analysis, to which his reply was that he wanted to see what his patients got up to the rest of the time. It was through the group, he thought, that a fuller picture of the life of patients became apparent.

When Bill W., co-founder of Alcoholics Anonymous, reflected on the origins of that movement, he said that all that he and the members had learned was 'hammered on the anvils of group experience'. Fellowship groups, like Alcoholics Anonymous, by definition, view progress as being possible only through human affiliation and in this way the group could be said to be prior to the individual, or at the very least helps the individual to recontextualise his/her problems. Foulkes, with his analytic groups, took a similar view. The rehabilitative and restoring effects of group membership are now widely acknowledged or assumed in a wider range of addiction settings – many rehabilitations units work largely if not exclusively in groups, day-centres offer structured group programmes, community treatment centres frequently provide out-patient groups, such as support groups or relapse prevention groups, and detoxification wards may offer educational groups. The importance of group values or 'community as method' is well summed up in de Leon's memorable phrase: 'you alone can do it, but you cannot do it alone'. In other words, both in the self-help and professional worlds, from residential to community treatment settings, strong traditions and rationales for group therapy exist.

With respect to our own professional formations, groups have played an important shaping and inspiring role. When one of us (Martin) first came into the substance misuse field in 1990, it was to work as a group therapist and later as group supervisor within a residential group therapy programme (the Regional group Therapy Programme based at St. Bernard's Hospital, originally set up by devised by Dr. Max Glatt in the 1960's); he
recalls witnessing dramatic changes in abstinent drinkers and drug-users during the course of five weeks of learning and living together in groups.

On commencing work in 1980 in a group therapy programme for problem drinkers delivered on an out-patient basis, one of us (Bill) was struck by the potential in groups for fostering a capacity for mutuality, self-disclosure and other forms of intimacy. Groups have this re-humanising effect.

Having both made contributions to developing and modernising the psychodynamic tradition in substance misuse, we stumbled upon the idea of editing a collection devoted to group psychotherapies and asking therapists with many years experience to reflect upon what they had seen. There were no apparent competitors in the UK for such a book, to be written by several authors from varied theoretical perspectives; books on groups available in the USA were usually written by a single author, developing a single viewpoint. Hence our collection is truly multi-professional.

Groups do not run themselves and group therapists are not born overnight. The chapters will indicate the carefulness and complexity involved in constructing and maintaining group work. We hope readers will derive practical as well as theoretical assistance from the book. More attention needs to be paid to the provision of training for group therapists and facilitators within this field. Group skills are complex and many-faceted, such as – managing assessment and referral to groups, creating the framework and boundaries around the group or group programme, looking after the group as a whole whilst retaining sight of the individual within, preparing people to change addictive patterns and so on. It is important for therapists to be able to facilitate good identification and feedback from fellows, thus helping sustain longer-term change or preparing patients to establish future and satisfactory, external group associations.

Our clinical experiences leave us in no doubt as to the power of the group in general and as a therapeutic agent in particular. Many of those who struggle with problems related to substance misuse will simply not recover without participation in groups in which they can both give to and receive from others in ways made possible only within this very special milieu. We have ample reason to know that, for many, the group not only makes recovery possible but also imparts a richness of experience that has a profound and lasting impact on the quality of recovery itself.

Of course, group therapy has other attractive potentials – economic and logistical to name but two. But, it is naive in the extreme to imagine that the simple gathering together of substance misusers will, in itself, produce desirable outcomes. Therapists flourish best when valued, supported and provided with an environment that enables them to express
their therapeutic commitment and achieve favourable outcomes. Similarly, groups have an equivalent set of needs, requiring a respect for the conditions which will enable them to best release their healing potential and that of their members. We hope that our book will succeed in assisting others to attend sensitively to the needs of groups and to the contexts which will most enable them to succeed in their purpose.

Bill Reading and Martin Weegmann
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Addiction as an attachment disorder: implications for group psychotherapy*

PHILIP J. FLORES

Attachment and group therapy

Addiction treatment specialists familiar with attachment theory (Bowlby 1979) and self-psychology (Kohut 1978) recognize that there is an inverse relationship between addiction and healthy interpersonal attachment (Walant 1995, Flores 2001). Certain individuals, because of intrapsychic deficiencies related to genetic and biological substrates, are vulnerable to environmental influences (i.e. substance abuse) which further compromises an already fragile capacity for attachment. Because of the potent emotional rush that alcohol and drugs produce, they are powerfully reinforcing and inhibiting of the more subtle emotional persuasions in a person's life. Consequently, the vulnerable individual's attachment to chemicals serves both as an obstacle to and as a substitute for interpersonal relationships. It is rare, if not impossible, for a practising alcoholic or addict to successfully negotiate the demands of healthy interpersonal relationships. Members of Alcoholics Anonymous (AA) frequently remind each other, 'we don't have relationships, we take hostages.' Their relationships typically are exploitative, maladaptive, or sadomasochistic. The use of substances initially serves a compensatory function, providing temporary relief by helping to lubricate an otherwise cumbersome inadequacy and ineptness in their interpersonal attachment styles. Prolonged substance abuse, because of its toxicity, gradually compromises neurophysiological functioning and erodes existing structure (Parsons and Farr 1981). Consequently, any interpersonal skills they possessed early in their substance-abusing career deteriorate even further. Managing relationships becomes increasingly difficult, leading to a heightened reliance on substances, which accelerates deterioration and addictive response patterns.

Approaching addiction from a perspective informed by attachment theory has important implications for the stance that must be taken when offering addiction treatment. Most addiction treatment specialists intuitively understand that addiction and attachment difficulties are intricately intertwined. Whether relational problems are the cause or the consequence of addictive behaviours, addicts and alcoholics are best treated by helping them develop a capacity for healthy interpersonal relationships. The underlying theme that successful addiction treatments share is consistently simple. A fundamental but profound truth is that those substance abusers who stay in treatment demonstrate the most improvement (Leshner 1997). A sometimes overlooked, but crucial, fact about substance abuse treatment is that successful addiction treatment is dose related. The more treatment is provided, and the longer treatment continues, the better the outcome. Disruptions in attachment to either the therapist or the treatment programme leave many substance abusers vulnerable to dropout and relapse. Consequently, treatment providers must carefully manage treatment retention. All strategies need to be geared towards reducing dropouts.

Attachment theory applied to addiction and group therapy has important implications in this age and culture, where people strive for independence, autonomy, and self-sufficiency, but all too often at the cost of alienation from self and others. Nowhere is this played out with more consistency than with substance abusers. Addicts and alcoholics are notoriously counter-dependent individuals, living their lives at the extreme ends of the attachment-individuation continuum. Autonomy is purchased at the price of alienation and the absence of mutuality in their relationships. As Nicola Diamond (1996) points out, group therapy not only represents a movement away from one-person psychology, but also contains a fundamental interpersonal conception of human beings as always being situated in relation to others. Group therapy, like attachment theory, is based on the implied notion that the essence of being human is social, not individual.

**Group treatment of substance abuse**

**Alcoholics Anonymous and group therapy**

Addiction treatment has been intricately associated with group therapy for more than 60 years. Ever since alcoholism was first recognized as a diagnostic entity, its treatment has been provided in groups. Starting with the establishment of the 12-step group movement by AA in the 1930s, addiction treatment has shared a synchronicity and compatibility with
group therapy. Addiction treatment specialists have usually embraced group therapy with open arms and historically have welcomed it as an intricate and valuable part of their treatment regimen; it has never had to fight to prove its legitimacy as a viable treatment modality.

Group therapy and addiction treatment have been drawn to each other because of a very simple principle. Substance abusers usually respond favourably to group treatment and are more likely to stay sober and committed to abstinence when treatment is provided in groups. Any treatment modality that facilitates detachment from chemicals and attachment to abstinence will enhance treatment success. Remaining attached to therapy underlies a singularly influential principle of addiction treatment: as previously stated, successful addiction treatment is dose related – the longer the treatment, the better the prognosis. Group therapy, through the curative forces of affiliation, confrontation, support, gratification and identification, promotes attachment more favourably than do other forms of treatment.

Despite the wide popularity of group therapy in addiction treatment, the reasons for its preference have not always been clearly articulated or presented within a clear, comprehensive theoretical formula. A theoretical perspective is needed that explains why the inherent dynamics of the addiction process lends itself in a complementary fashion to the innate qualities of the therapeutic factors operating in a group. Such an explanation is important, because the same forces that contribute to the addictive process can be harnessed to provide its resolution if one is aware of the reasons why addiction manifests itself as it does. Attachment theory provides a theoretical foundation for such an understanding.

**Enhancing treatment retention**

This is where attachment theory has much to offer in understanding the strategies that must be adopted in treating this population. Foremost is the recognition that before substance abusers can become *attached to treatment* (establish a working therapeutic alliance), they must first become *detached from the addictive attachment* to the substances they abuse. Such a stance recognizes that it is extremely difficult, if not impossible, to establish or maintain a therapeutic alliance with a practising alcoholic or addict. There are other important implications for treatment if the relationship between substance abuse and attachment is closely examined. One will soon recognize that there is an inverse relationship between a person's capacity for attachment (intimacy) and substance abuse. It is rare, if not impossible, to find a substance abuser who can establish or maintain healthy interpersonal attachments. Attachment theory looks at addiction as both a consequence and a failed solution to an
impaired ability to form healthy, emotionally regulatory relationships. Consequently, treatment retention is not only crucial to substance abuse treatment; it implies also that the underlying driving force behind all compulsive/addictive behaviour is related to an inability to manage relationships.

The relational models

The recent works of attachment theory and self-psychology have taught addictions specialists that dysfunctional attachment styles interfere with the ability to derive satisfaction from interpersonal relationships, and contribute to internal working models that perpetuate this difficulty. Experiences related to early developmental failures leave certain individuals with vulnerabilities that enhance addictive-type behaviours, and these behaviours are misguided attempts at self-repair. Deprivation of age-appropriate developmental needs leaves the substance abuser constantly searching for something 'out there' that can be substituted for what is missing 'in here'.

Because addiction treatment in the USA has, for the most part, been historically dominated by the 12-step abstinence-based treatment approach, in-depth psychodynamic-oriented psychotherapy has often been dismissed as irrelevant to addiction treatment. Evidence gathered from the development of the newer relational models within psychodynamic theory reflects a conceptual revolution that not only synthesizes the best ideas of psychoanalysis, cognitive sciences, and neurobiology, but also provides a credible and practical way to understand and treat addiction. The contributions of attachment theory and self-psychology have helped shift psychoanalytic thinking from classical drive or instinct theory to a relational approach with its greater emphasis on adaptation, developmental arrestment and deficits in self-structure. The evolution of the relational models has shifted the focus away from intrapsychic struggles to an exploration of the interpersonal or relational difficulties that contribute to a person's present situation. Most importantly, the relational perspective has ushered in more innovative ways for treating addiction and the difficulties that the typical alcoholic or addict brings to treatment.

Attachment-oriented therapy

Treatment that follows the guidelines of attachment-oriented therapy does not adhere to the bias of the classic psychodynamic developmental model, where maturity or mental health is equated with independence.
As Kohut (1977) and Bowlby (1980) suggest, normal development is not a movement from dependence to independence, rather it is a movement from *immature dependence* to *mature interdependence* or mutuality. This shift in perspective is especially important in the treatment of substance abusers. Helping the alcoholic or addict obtain mature dependency on people has obvious implications for treatment. The regulatory power of mature dependency or a secure attachment relationship is absolutely necessary if substance abusers are going to be required to relinquish their reliance on substances—a destructive dependency that erodes whatever existing capacity for affect regulation they originally possessed. Independence, or more correctly, the alcoholic or addict’s counter-dependence, is a force that fuels the substance abuser’s narcissistic position and isolation, which form the cornerstones of every addictive process.

It is important to remember that attachment theory is not so much a psychological theory as a biological theory. Natural selection favours mechanisms that promote parent–offspring proximity in an environment of evolutionary adaptation. Attachment is not just psychologically driven, but is adaptive and propelled by powerful biological needs for interpersonal closeness. From this perspective, the need for attachment cannot be reduced to a secondary drive. A primary biological function is to secure assistance and survival in the case of adversity. This is true for all social mammals and applies to parent–offspring relationships in other species, not just human beings. Attachment theory also contends that infants and their parents are biologically hard-wired to forge close emotional bonds with each other. These attachments serve important emotional regulatory functions throughout life. All social mammals regulate each other’s physiology and modify the internal structure of each other’s nervous systems through the synchronous exchange of emotions. This interactive regulatory relationship is the basis for attachment.

Since it is biologically impossible, even as adults, to regulate our own affect for any extended length of time, individuals who have greater difficulty establishing emotionally regulating attachments will be more inclined to substitute drugs and alcohol for their deficiency in intimacy. Attachment theory from this perspective complements Khantzian’s affect regulation theory (2001). Because of their difficulty in maintaining emotional closeness with others, certain vulnerable individuals are more likely to substitute a vast array of obsessive–compulsive behaviours (e.g. sex, food, drugs, alcohol, work, gambling, computer games) that serve as a distraction from the gnawing emptiness and internal discomfort that threatens to overtake them. Consequently, when one obsessive–compulsive behaviour is given up, another is likely to be substituted unless the deficiency in self-structure is corrected.
Principles of attachment-oriented therapy

There are few things in the field of psychology and psychotherapy for which the evidence is so strong as the importance of the therapeutic alliance (Strupp 1998, Beutler 2000, Horvath 2001, Norcross 2001). There is an abundance of research evidence demonstrating that the therapist’s ability to establish a therapeutic alliance is the single most important contributing factor to successful treatment outcome. Thousands of studies and the historical accumulation of expert clinical opinion dating as far back as Freud’s early papers (1912–1913) acknowledge the importance of the many ways in which the working alliance determines treatment outcome. More recent empirical investigations into the ways that different attachment styles – of both therapist and patient – shed new light on the ways that alliances either fail or succeed in therapy.

These findings have important implications because they dictate to a large degree how therapy needs to be delivered when working with the addicted patient. Attachment-oriented therapy (AOT) focuses on the relationship, its implicit rules, and the transformational power inherent in any authentic intimate relationship (Flores 2003). Because substance abuse, and all addictive-driven behaviour, is to some degree a compensatory determined substitute for a person’s inability to derive satisfaction from relationships and close personal contact, the therapeutic challenge of engaging the alcoholic or addict in a therapeutic alliance is both enormously difficult and enormously important.

Because the therapeutic alliance has emerged as a consistent predictor of positive treatment outcome across an entire range of different psychotherapy approaches, it has sparked an interest in the generic elements common to all forms of therapy. AOT can therefore be viewed as a ‘pan-theoretical’ approach that transfers across all models of psychotherapy and ideological perspectives. From this perspective, AOT is not so much an approach to therapy as it is an attitude about therapy. It is less concerned with the techniques or the theoretical model that guides the therapist’s interventions than with who is applying the treatment and in what way the therapist is managing the therapeutic relationship. Any approach to therapy, no matter how sophisticated or substantially grounded in solid scientific theory, will be only as effective as the person delivering the treatment. It is not so much what the therapist does, as how the therapist creates the proper emotional climate of the relationship, because it is this environment that promotes the patient’s engagement in the therapy venture. Kohut (1977) suggested that the origins of the specific pathogenesis in an individual’s early development is related not so much to the particular rearing practices of the parents as to the emotional climate of the home. In a similar fashion, it is not so much
the specific practices of the therapist applying treatment that influence successful treatment outcome, as the creation of the proper therapeutic climate.

Attachment theory holds the view that mental health or maturity is defined by a person's capacity to move towards interdependence rather than independence from relationships. Staying connected is the primary aim of this model. Remaining in relation, even when the patient is detached, angry, or avoidant, is accomplished not by clinging to the patient, but rather by remaining empathically understanding of the patient's attachment fears and difficulties with relationships. Negotiating the vicissitudes typically involved in the give and take of any relationship eventually helps the alcoholic or addict move towards experiencing even more subtle satisfying ways of being in relation. Eventually, the substance abuser will learn how to transfer these subtleties outside the therapeutic milieu in the form of mutuality with others.

Mutuality can be defined as any growth-enhancing relationship that benefits both parties in the relationship. It is not about being enmeshed or co-dependent; it is more about the efforts to know and understand another's experience. This is true for both the addicted and non-addicted, but it is an especially important capacity for the alcoholic or addict because, as Jeffery Roth (personal communication, 2002) says, 'addiction is a disease of isolation'. Being joined by another empathically in an atmosphere of mutual respect and trust helps reduce the addicted individual's sense of alienation and aloneness. Mutuality from this perspective provides each person in the relationship with the simultaneous affect regulation that is the hallmark of emotional stability and mental health. Lewis, Amini and Landon (2000, p. 86) agreed when they wrote, 'Total self-sufficiency turns out to be a daydream . . . . Stability means finding people who regulate you well and staying near them.'

All interventions need to occur in the service of moving the relationship along. As will be discussed later in the section on negative process and repairs in ruptures of the therapeutic alliance, a key to successful treatment is the therapist's capacity and skill at working through the inevitable conflicts that arise in any relationship. This model looks at the relationship of the therapist with the simultaneous affect regulation that is the hallmark of emotional stability and mental health. Lewis, Amini and Landon (2000, p. 86) agreed when they wrote, 'Total self-sufficiency turns out to be a daydream . . . . Stability means finding people who regulate you well and staying near them.'

This approach, while concerned with the dangers of enmeshment and infantile gratification, also differs from the more classic psychodynamic model with its counter-transference concerns about the therapist getting too involved. AOT is more concerned with the therapist not being
involved enough, or being too distant. Consequently, AOT is not so much a change in technique, or even a change in theory, as a change in principle. More emphasis is placed on the importance of the relationship and the development of mutual respect, trust, and responsibility. When one can bring oneself more fully and authentically into a relationship, one not only embraces and gets to know the other, but also gets to embrace and know oneself. Knowing oneself can never be accomplished in isolation, only in relation.

Talking intimately with another about oneself is a developmental function that not all adults achieve. Communication about one’s feelings in relation to another person is also a skill that many alcoholics or addicts do not possess. Knowing oneself and sharing that knowledge with another requires the capacity to put one’s feelings into words, a developmental task that requires the acquisition of inner speech, or what Meares (1993) refers to as self-narrative. Attachment theory, especially informed by the work of Margaret Main (1995) and her development of the adult attachment interview (AAI), has shown a connection between attachment status in childhood and narrative styles in adulthood. Fonagy et al. (1994) write about the reflexive self function (RSF), which is the ability to think about oneself in relation to another – a necessity for intimacy. Using narratives to accurately recount one’s past (insight) is a key determinant in knowing oneself and knowing others. As Holmes (1996, p. 14) says, ‘Acquiring inner speech means becoming intimate with oneself; knowledge of oneself goes hand in hand with knowledge of others.’ A clinical example will help to illustrate this principle.

Andrew was more than five years sober and very actively involved in AA when he sought out a psychotherapy group. A number of weeks into the group, Andrew’s style of relating became painfully obvious to the group leader and the other group members. He had great difficulty relating to others interpersonally about the emotional material stirred up in the here and now of the present relationships in the group. Andrew could be supportive and compassionate of other’s painful experiences or stories, but he could not stay engaged with others once the interpersonal exchange required that people relate beyond the historic content of their experience. Some of Andrew’s narrative style may have been shaped in part by his repeated exposure to AA meetings, where the telling of one’s stories is often stereotypically scripted, and ‘cross-talk’ is strongly discouraged. When Andrew spoke of himself, he could not keep others engaged. Group members would become distracted or drift off because his exchanges became bogged down in the minute details of his painful past history. People in group could feel sorry for Andrew, but they could not feel drawn in by him. It wasn’t that it was unusual for new group members to feel compelled to tell their story when they first joined the group; that wasn’t the problem. Everyone usually enters a group having to spend some time letting other
group members know their history. Andrew's problem was that he remained stuck in his narratives. His stories became rote and stereotyped. It took a concerted effort by the group leader to steer the group away from their eventual indifference or boredom and their stereotyped responses to Andrew ('Oh, that's horrible, you had a terrible childhood, I can't believe they did that to you', etc.), and guide them to deal directly with the feelings that Andrew evoked in them. Using his knowledge of Margaret Main's work on narrative styles and attachment, the therapist was able to cut across the dichotomy between historical truth and narrative truth. By focusing on the form of Andrew's narratives, rather than their content, the group leader was able to help the group and Andrew see that Andrew's preoccupation with his history was a way for him to stay attached to his past pain and hurt in the hope of evoking protective attachment behaviour in potential caregivers. The group leader's actions in this example serve as an important reminder that therapists are more helpful when they attend as much to the way their patients talk as to what they talk about.

Addiction and the working alliance

Attachment theory applied to psychotherapy in general, and addiction treatment in particular, has important far-reaching implications for how the patient needs to be approached in therapy. It is important to remember that attachment theory is not so much a new theory as a new way of thinking about relationships, and about the crucial developmental functions attachment provides for developing children, and the important regulatory functions it provides for mature adults.

However, important as the ability to establish a working alliance is, this alone will not solve most of the dilemmas that patients, especially those suffering from addictive disorders, bring to the therapeutic encounter. A good theory and solid training in the proper application of the techniques that are guided by that theory are also essential. But as Lambert and Barley (2001) suggest, it is the therapist's ability to relate that creates the capacity for attachment and leads to the establishment of a working alliance, without which little influence can be exerted on the patient's behalf. If an attachment is not created, the therapist will be provided with insufficient opportunity to apply the technical skills that his or her theory dictates. Strupp explains why the integration of theory, technical skills, and the ability to establish a therapeutic alliance are so important:

Technical skills, I believe more strongly than ever, are the hallmark of the competent psychotherapist. They are encompassed by what I have termed the skillful management of a human relationship toward therapeutic ends. To my way of thinking, these skills are undergirded by a theory of therapy (in keeping with Kurt Lewin's dictum that nothing is as practical as a good