Editorial

Clinical Implications of Countertransference in the Treatment of Addictions

César A. Alfonso, M.D.

Abstract

The author provides a historical overview of the psychodynamics of addiction with particular emphasis on countertransference awareness and its relationship with treatment outcomes and prognosis. Countertransferences that frequently occur in the treatment of substance use disorders include shared helplessness, hopelessness, sadness, anxiety, fear, anger, rage, shame, and guilt. These emotional states in clinicians may lead to fatigue, avoidance, and acting out unless therapists are able to ground themselves and disidentify with the projected affective states. Positive emotions may lead to excessive enthusiasm in clinicians and deflect from the therapeutic process, resulting in deviation from established practice guidelines. Coexisting negative and positive affective states may lead to rescue fantasies and transgressions of boundaries. Contemporary psychodynamic clinicians appreciate the quantitative aspect of emotional reactions, where countertransferences accumulate exponentially over time, causing allostatic overload and compassion fatigue. Unanalyzed negative countertransferences are linked to either clinical avoidance or aggression, resulting in withdrawing care, failure of empathy, and dissolution or fragmentation of the therapeutic alliance. The negativism associated with the treatment of addictions may be rooted in unanalyzed countertransferences and psychosocial factors such as internalized negative societal attitudes and stigma. Degrading and dehumanizing attitudes toward people with substance use disorders could stem from internalized negative societal constructs against disenfranchised, minoritized, and stigmatized persons. This editorial introduces the work of Bernardine Han, an addiction psychiatrist who utilizes psychodynamic concepts to guide interventions with people with substance use disorders.

Keywords: stigma, therapeutic nihilism, psychodynamics, aggression, avoidance, substance use disorders, harmful use of drugs

This issue of *Psychodynamic Psychiatry* features a key article that advances our understanding of the psychodynamics of addiction. Bernardine Han trained at Harvard University, UCSF, UC-Berkeley, NYU,

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NY Presbyterian-Cornell, and the Center for Psychoanalytic Training and Research at Columbia. She is an addiction psychiatrist who lucidly demonstrates how a psychoanalytically informed approach may improve treatment outcomes when caring for people who engage in the harmful use of drugs. Her article "Stigma and Countertransference in Resident Attitudes toward Patients with Substance Use Disorders" is a significant addition to the evolving literature on the psychodynamics of addiction. Han's clinical insights highlight the importance of untangling, decoding, and deconstructing complex countertransferences to facilitate the clinical care of people with addiction. She makes a convincing argument as to why discussions about countertransference should find their way into routine clinical supervision with trainees and students who may struggle with intense emotional reactions that could ultimately result in therapeutic nihilism.

In a recent editorial (Alfonso, 2021) I offered an overview of the psychodynamics of addiction and summarized the clinically validated psychodynamic treatments of substance use disorders, including the supportive-expressive psychodynamic treatment described by Gottdiener (2021), and Baurer's (2021) treatment approach that draws from Khantzian's ego-deficit model (1999), Winnicott's paradigm of the true versus false self (1960), and Krystal's trauma-based model (1995). Another psychodynamic treatment that deserves recognition is dynamic deconstructive therapy for comorbid borderline personality disorder and substance use disorder (Gregory, 2019), which focuses on expression of affect, understanding unconscious motivations, and making transference interpretations. Moreover, motivational interviewing, which has gained worldwide recognition, could be described as a series of psychotherapeutic interventions developed by Miller and Rollnick (2012) that build on Prochaska, DiClemente, and Norcross's (1992) transtheoretical-stages of change model. Motivational interviewing incorporates the psychoanalytic concept of empathic attunement into interventions that are supportive, neutral, and validating. Clinicians trained in motivational interviewing are respectful of the core concept of ambivalence, and promote willingness to change with interventions characterized by reflection, affirmations, and open-ended inquiry, with the aim of coupling insight with action as the patient navigates from precontemplation, contemplation, and preparation, to action and maintenance of treatment gains.

Although our psychodynamic understanding of addiction has become more sophisticated over the past century (Alfonso, 2021; Baurer, 2021; Gottdiener, 2021; Gottdiener & Suh, 2015; Gregory, 2019; Khantzian, 1999; Khantzian et al., 1990; Krystal, 1995; Rado, 1933),

minimal attention has been given to the role of countertransference and its relationship to treatment adherence, the therapeutic alliance, prognosis, and clinical outcomes. Han begins to fill this gap by addressing the clinical utility of countertransference in the care of persons with substance use disorders.

Countertransference Definitions

Countertransference in contemporary psychodynamic psychiatry is defined as the totality of emotions experienced by the therapist while caring for a patient (Auchincloss & Samberg, 2012; Cabaniss et al., 2011; Gabbard, 1994; Jiménez et al., 2012). Han elaborates on classical definitions of countertransference (Freud, 1910), recognizing the contributions of Winnicott (1994) and intersubjective theorists, and describes the challenge of "apprehending not one but two dynamic unconsciouses." Racker's (1957) subcategorization into concordant and complimentary countertransference subtypes introduced the notion of inherent or universal emotional responses that most clinicians would have when participating in certain clinical scenarios. A concordant countertransference, which could be of diagnostic utility, reflects a reciprocal and consonant emotional experience rooted in empathy.

Countertransferences are commonly classified as positive or negative, creating pleasurable or unpleasurable feelings in the therapist. Negative countertransferences that create tension include shared helplessness, hopelessness, sadness, anxiety, fear, anger, rage, shame, and guilt. Complex emotional states such as perceived burdensomeness and thwarted belongingness are of particular relevance when working with suicidal persons, and understanding these emotional states and the impact that they have on clinicians and caregivers may foster the treatment alliance. Negative emotions, in the context of empathic attunement, may lead to fatigue, avoidance, and acting out unless clinicians are able to ground themselves and disidentify with the projected emotional states. Positive emotions may lead to excessive enthusiasm in clinicians, deflecting from the therapeutic process and resulting in deviation from established practice guidelines. Coexisting negative and positive emotions may lead to rescue fantasies and transgressions of boundaries.

Although in classical psychoanalytic formulations little attention was given to concordant countertransferences, contemporary psychodynamic clinicians recognize affective resonance as valuable. Furthermore, we are beginning to appreciate a quantitative aspect of emotional

reactions, where countertransferences may accumulate exponentially over time when the clinician treats hundreds or thousands of patients with complex psychopathology over the course of a career. In the same way that traumatic life events are stored in our brain in the form of emotional and narrative memories and these memories may find their way into consciousness, negative therapeutic reactions can accumulate, and emotional memories triggered by clinical interactions may result in a surge of emotions that is destabilizing to the therapist. This phenomenon is analogous to what McCann and Pearlman (1992) described as vicarious traumatization. The allostatic overload and psychic erosion caused by unprocessed concordant countertransferences that accumulate over time may interfere with the therapist's stamina, neutrality, and attention, leading to failure of empathy.

Countertransferences in the Treatment of Addictions

Han describes common countertransference reactions that in her experience may obstruct therapeutic progress. These commonly include negative emotional states linked either to clinical avoidance or aggression, resulting in withdrawing care, failure of empathy, shared hopelessness, helplessness, overinvolvement, and compassion fatigue. She states that feelings of repulsion, fear, and aggression may have a psychosocial component reflecting internalized negative attitudes toward minoritized and disenfranchised individuals that are unconsciously perpetuated by unaware clinicians.

The first mention of countertransference in addiction psychiatry literature was by Ausubel (1948), who described countertransferential experiences of dread, disinterest, and despair among clinicians treating people with substance use disorders, associated with "cynical, unrealistic, and hostile attitudes towards the addict" (Ausubel, 1958). Imhoff and colleagues (1984) offered a comprehensive summary of the first 50 years of literature in addiction psychiatry, finding scant statements on countertransferences. However, an early monograph by Davidson (1977) identified problematic hostility, blamefulness, and tangible anger in patients with substance use disorders linked to defensive retaliation and dismissiveness from their anxious therapists.

From a clinical standpoint, it is important to observe, and teach, that countertransferences result in affective dysregulation in the therapist, with compensatory avoidance in the form of undertreatment or deviation from practice guidelines, or hostility leading to fragmentation or dissolution of the therapeutic alliance.

Therapeutic Nihilism

The negativism associated with the treatment of addictions may stem from unanalyzed countertransferences and psychosocial factors such as internalized negative societal attitudes and stigma. Han cites an important article that all clinicians should familiarize themselves with: Examining the relationship between substance use disorders and recovery status, Jones and colleagues (2020) studied data collected from more than 40,000 adults in the United States. While 11.1% of the U.S. population reported having had a substance use disorder, the vast majority (74.8%) reported being in recovery. In another study, Wu and colleagues (2003) found that only 9% of persons in the United States access evidence-based treatments for addiction, and among these, rates of access to care are three times greater in Whites than in Hispanics or Blacks. With recovery rates of 75%, even with compromised access to care and marginal insurance coverage, our perception of the prognosis of substance use disorders is greatly distorted.

Psychosocial Dimensions of Countertransference in Addiction Psychiatry

Internalized societal attitudes of xenophobia, racism, classism, sexism, homophobia, transphobia, misogyny, and addictophobia may adversely influence attitudes toward substance users (Cohen, 1989). Dehumanization in clinical care may have dyadic psychodynamic correlates reflecting the clinician's unconscious wish to separate from the other to avoid the experience of distress or terror caused by illness in the patient (Perry, 1984). However, degrading attitudes could also stem from internalized negative societal constructs against disenfranchised, minoritized, and stigmatized persons.

The relationship between stigma and negative countertransference is thoroughly explored by Han. She describes how bias trickles down from governments and institutions to interfere with our clinical need to maintain neutrality and a nonjudgmental therapeutic stance. Therapeutic nihilism is compounded by socially endorsed negative attitudes toward people with addiction; they are seen as being manipulative, terrorizing, dangerous, deceitful, intransigent, provocative, criminal, and unwilling to change, characteristics that could be misperceived as fixed and intractable, or adequately described as less than adaptive defensive maneuvers that are malleable and responsive to intensive and evidence-based psychotherapeutic interventions.

Pedagogical Implications

Caracci (1997) was among the first to formally propose integration of countertransference awareness into the didactic curriculum of psychiatric trainees. He recommended beginning countertransference awareness training in the first year of residency, and he favored group experiential learning over formal lectures (Caracci, 1997). All clinical supervisors should routinely discuss countertransference reactions with trainees and students to recognize misplaced emotions, help overcome treatment impasses, and alleviate distress. Discussions about countertransference awareness may also take place among trainees in peer supervision and in psychiatric resident wellness support groups/T-groups. Since most teaching programs in the United States are multicultural with a high proportion of international medical graduates, transcultural attitudes need to be carefully examined and deconstructed in supervision.

Future Directions

The editors of *Psychodynamic Psychiatry* welcome clinical and research articles that will advance our knowledge base of the psychodynamics of addiction, in addition to articles addressing the importance of countertransference awareness in clinical practice. Evidence-based treatments, including intensive psychotherapies, are effective to lower the burden of disease caused by substance use disorders. Most patients with problematic drug use recover, and the therapeutic nihilism that infiltrates the treatment of addictions may stem from unanalyzed countertransferences and internalized negative societal constructs.

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