

Individual Psychotherapy for Addicted Clients: An Application of Control Mastery Theory†

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Abstract — This article presents an overview of Control Mastery Theory, developed by Joseph Weiss, and applies this theory to the treatment of alcohol- and other drug-addicted clients. The article proposes that individual psychotherapy, in conjunction with self-help and other chemical dependency treatment programs, may be a significant component of the treatment of addicted clients. According to Weiss's theory, addicted clients are suffering not only from the direct effects of addictive disease but are also often suffering from unconscious pathogenic beliefs acquired from childhood experiences. Pathogenic beliefs result in shame, guilt, fear, and inhibitions that predate the development of addiction. Addicted clients are highly motivated unconsciously to recover from their addiction and to pursue normal goals. They are hindered by their pathogenic beliefs and by the effects of their addiction. They enter treatment with an unconscious plan to stop using drugs and to disprove their pathogenic beliefs. They test their pathogenic beliefs in relation to the therapist, with the hope of obtaining evidence against these beliefs. As the therapist passes the client's tests, these beliefs are modified and the client is helped to recover.

Keywords — addiction, Control Mastery Theory, drug abuse treatment, pathogenic beliefs, psychotherapy

Individual psychotherapy may be helpful in the treatment of alcohol- and/or other drug-addicted clients, if it is used in conjunction with chemical dependency treatment. Addicted clients need to stop using drugs, modify pathogenic beliefs, and develop strong connections to other people. They may accomplish these goals in a variety of treatment programs, such as self-help programs, therapeutic communities, drug abuse treatment programs, spiritual programs, and group and individual psychotherapy. In some cases, individual therapy may be a critical part of the addicted client's treatment plan.

There are differing opinions about the use of psychotherapy for drug-dependent clients. The value of individual therapy without concomitant drug abuse treatment for the client, prior to or early in recovery, has been questioned by many drug abuse treatment specialists, as well as by some psychotherapists. They have pointed out that clients from this population have often failed to respond well to this type of therapy (Miller 1992; Vaillant 1984, 1981; Zinberg 1981; Miller & Hester 1980). Currently, some mental health clinics as well as inpatient and outpatient chemical dependency treatment programs are providing only minimal individual psychotherapy for addicted clients. Also, as chemical dependency specialists and therapists experienced with the addicted population have come to emphasize the need to focus on addictive disease as a primary disorder, some have de-emphasized the use of individual psychotherapy. In the increased focus on the pathological behaviors caused by addiction itself and on the immediate goal of achieving abstinence from drugs (Babor et al. 1990;

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Miller & Gold 1991; Mirin et al. 1988; Bean 1981), there has been more interest in specific chemical dependency treatment programs with a group therapy format.

The long-standing struggle between chemical dependency treatment specialists and psychiatrists and psychologists over the etiology and meaning of addiction has contributed to this trend away from providing addicted clients with individual psychotherapy (Winick 1991; Zweben 1989, 1986; McLellan et al. 1988). Many psychiatrists and psychologists have regarded addiction as a symptom of underlying psychopathology (Treece & Khantzian 1986; Meyer & Hesselbrock 1984; Khantzian 1982, 1981; Wurmser 1978, 1977; Khantzian & Treece 1977) and some have suggested that treatment efforts must be directed to these underlying problems. This view of addiction has tended to minimize the direct physiological and neuropsychological effects of drugs and drug withdrawal and to attribute these effects to psychodynamic conflicts. Some therapists influenced by this view of addiction have inadvertently joined their clients in a denial of addiction, by the minimization or dismissal of these effects (Zweben 1989, 1986; Pattison 1985; Bean 1981; Vaillant 1981; Hall et al. 1977).

Furthermore, some psychodynamically oriented therapists may have encountered additional difficulties with this population because of a theoretical framework that is not optimally useful. Influenced by the theory that individuals are unconsciously gratified by their symptoms, they may fail to recognize that addicted clients are highly motivated to overcome their addiction. In addition, they propose that addicted clients may take drugs to moderate disturbing affects and impulses, especially those connected to rage, aggression, and dependency (Khantzian 1982, 1981; Krystal 1982; Zimberg 1982; Mack 1981). In contrast, Control Mastery Theory suggests that addicted clients are always working to overcome their addiction, and that the affects most disturbing to addicted clients are those related to guilt and shame. It also suggests that this combination of factors — that is, the denial of the effects of drug use and drug withdrawal in conjunction with an inadequate theoretical framework — has limited the effectiveness of some psychotherapists in their efforts to help those with chemical dependency problems.

However, despite the many problems encountered using psychotherapy with addicted clients, a number of authorities suggest it may be an important component of the treatment plan of addicts. Some studies of drug abuse treatment with and without additional psychotherapy indicate that, at least in cases of clients with severe psychopathology, the inclusion of psychotherapy is a significant contributor to positive therapy outcome (Woody, McLellan & Luborsky 1984). Other studies of the usefulness of psychotherapy in conjunction with chemical dependency treatment are inconclusive and suggest that there are many significant variables, particularly with respect

to the fit between individual therapists and addicted clients (Crits-Christoph, Beebe & Connolly 1990; Woody et al. 1990, 1983). Despite the contradictory findings and opinions about the role and effectiveness of psychotherapy in the treatment of addicted clients, it remains an important component in many programs. In some cases, individual therapy may be the only treatment acceptable to the client in the initial stages of recovery (Smith, Milkman & Sunderwirth 1985). And in an introduction to a National Institute on Drug Abuse research monograph discussing psychotherapy with the addicted population, Onken and Blaine (1990:5) noted that individual therapy is available in almost all drug abuse treatment programs, and that psychotherapy and/or drug counseling is "the mainstay of drug abuse treatment."

CONTROL MASTERY THEORY

The theory of the mind and of psychopathology presented here, often referred to as Control Mastery Theory, offers another perspective on the addicted client's psychopathology. This theory was developed by one of the authors (Weiss) after years of informal study of process notes of analytic cases, and is based on those empirical observations and on concepts that Freud (1940) evolved piecemeal as part of his ego psychology. Over the past twenty years, this theory has been tested and supported by empirical research carried out by the San Francisco Psychotherapy Research Group (formerly known as the Mount Zion Psychotherapy Research Group). Control Mastery Theory suggests that addicted clients are not gratified by their symptoms. They suffer from their addiction and have an unconscious plan to recover from it. Recovery for addicted clients involves overcoming both the direct psychological and neurological effects of addictive disease itself, and mastering problems predating drug use. Therapists using this theory support an abstinence model of recovery and include in the addicted client's treatment plan involvement in appropriate medical detoxification programs (when needed) as well as an on-going active involvement in self-help, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and Cocaine Anonymous (CA), and/or other drug abuse treatment programs that contribute to maintenance of a drug-free lifestyle and the modification of pathogenic beliefs.

Unconscious Mental Functioning

In contrast to the early theories of Freud (1911-1915), Control Mastery Theory assumes unconscious cognition, unconscious control, and an unconscious wish for mastery. The theory's most general hypothesis assumes that a person unconsciously performs many of the same kinds of functions that are performed consciously: unconsciously thinking, assessing reality, making decisions, and carrying out plans. Moreover, a person exerts control over unconscious

mental life in accordance with these decisions and plans. A person unconsciously regulates repressions, which are maintained as long as the person unconsciously assumes that they would be endangered if they were to experience the mental contents that is being repressed. The person lifts these repressions and brings the mental contents forth when they unconsciously decide that they would not feel threatened by them; that is, when they believe that they may safely experience them. An example of this is the phenomenon of crying at a happy ending. A person who has repressed sadness may, after the sadness has been resolved, decide unconsciously that it is safe to experience it, and so decide to bring it forth (Weiss et al. 1986; Gassner 1982; Weiss 1971, 1952).

Psychopathology and Pathogenic Beliefs

The second general hypothesis of Control Mastery Theory is that people are always striving for health and normal development and are impeded in their pursuit of these goals by psychopathology. Psychopathology is derived from maladaptive beliefs about oneself and one's interpersonal world. These beliefs are often unconscious. They are usually acquired in early childhood from traumatic experiences with parents and siblings. They are concerned with both reality and morality. Since they give rise to psychopathology they may be called pathogenic. They are maladaptive in that they warn the persons guided by them that if they attempt to reach certain normal and desirable goals they will put themselves in danger. They may experience this danger as internal or external. They may inhibit their pursuit of normal developmental goals in order to avoid the guilt, shame, fear or self-torment predicted by their pathogenic beliefs. They may expect to hurt someone they love or to be hurt by them (Sampson 1992b; Weiss 1990a, 1990b, 1990c; Weiss et al. 1986). For example, people may develop the belief that if they are assertive they will be rejected or if they are sexual they will be shamed or if they are successful they will make siblings feel inferior.

Pathogenic beliefs often lead to maladaptive behaviors involving compliances and identifications with disturbed childhood caregivers and family systems. For example, a person may fight with their spouse irrationally, out of identification with a father who was assaultive to his spouse. Or a person may be unable to consider a sober lifestyle out of identification and compliance with a family in which alcohol was a part of the culture. Because pathogenic beliefs cause pain, people are motivated both consciously and unconsciously to change them and are always working to find ways to do this. They look for situations in which they may safely attempt to resolve their problems, by testing their pathogenic beliefs so as to modify them (Weiss In press, 1993, 1990a, 1990b, 1990c; Weiss et al. 1986).

The Therapeutic Process and Testing

A third hypothesis of Control Mastery Theory is that people may take initiative in the therapeutic process. In fact, people come into treatment with specific though often unconscious plans to work to disconfirm the pathogenic beliefs causing their symptoms and to master their problems (Curtis et al. 1988; Curtis & Silberschatz 1986). One of the ways clients work is by testing their pathogenic beliefs in relation to the therapist. They may pose "transference tests" in which they repeat behaviors, such as those that in childhood they believe caused their parents to traumatize them. They hope that the therapist will react differently than their parents, and so provide a corrective emotional experience. Or clients may pose "passive-into-active tests." In this kind of test, clients imitate the behaviors of their parents or siblings, such as those that traumatized them. In passive-into-active tests, people attempt to remember and to master through their behavior what happened to them as children. They hope that the therapist will react in a way that provides them with a model of how to deal with such behavior. In some instances clients test in a way that combines both passive-into-active and transference elements.

Clients who were rejected by their parents in childhood may have developed the belief that they deserve to be rejected, and will inevitably be rejected in significant relationships. In the course of therapy these clients may test this pathogenic belief by providing the therapist with the opportunity to reject them. Clients may say that they are going to quit therapy or they may behave in an offensive manner to find out whether they will evoke scorn or rejection from the therapist. When the therapist does not reject them, they may begin to change these beliefs. Other clients in the beginning of therapy may feel threatened by the belief that they must comply with others lest they hurt them. For these clients, the first phase of therapy may involve testing their therapists in order to disprove the belief that unless they comply with them, they will hurt them. They may do this by fighting with the therapist. When they disconfirm their belief in the need for compliance, they may be able to relax and permit themselves to more openly enjoy and feel affection for the therapist. Clients regulate their testing by their assessment of how safe they feel with the therapist. The task of the therapist is to provide the safety required for testing, and to pass the client's tests and so help them to modify their pathogenic beliefs.

APPLICATION OF CONTROL MASTERY THEORY TO THE ADDICTED CLIENT

This theory of psychopathology and of the psychotherapy process is particularly helpful in the treatment of addicted clients, who as a consequence of the effects of

addiction as well as of their testing of their pathogenic beliefs have often mistakenly been thought to be unconsciously resistant to treatment. Understanding the particular pathogenic beliefs of the addicted client enables the therapist and counselor to help the client to disprove them (O'Connor 1993).

Addiction may in some cases occur entirely in the absence of preexisting psychological problems, as in the case of iatrogenic chemical dependency. And addiction itself is often if not always the direct cause of a myriad of psychological problems and symptoms. However, in many cases addiction occurs in people who have grown up in unhappy families, who experienced multiple traumas in childhood, and who, as a result, suffered from psychological difficulties prior to their drug use. People generally do not become addicted without taking drugs frequently, and individuals who are successfully pursuing normal goals are unlikely to take drugs frequently enough to become addicted. However, individuals who are inhibited by pathogenic beliefs may be vulnerable to frequent drug use. How quickly a person becomes addicted may be a matter of genetic predisposition. How often a person wants to use drugs may be linked to their pathogenic beliefs and resulting psychological problems and symptoms. The following pathogenic beliefs (many of which are overlapping) are common among addicted clients and warn them against recovery:

- the belief that one is omnipotently responsible for the happiness and welfare of others
- that to abstain from alcohol or other drugs is betraying a parent by breaking the family denial and thereby betraying a family secret
- that by *not* drinking or using other drugs one will risk a breach in attachment to parents, siblings or other loved ones
- that to be happy, comfortable, and successful will make another family member (or members) feel inadequate and inferior, and thus will cause others' unhappiness
- that recovery means outdoing or belittling a parent or sibling
- that to develop a successful life without drugs is to defy a parental dictate to be inadequate and out of control
- that one is bad, destructive or crazy (developed in compliance with parental opinions and judgments)
- that one's personality is too forceful and will overpower and hurt others
- that to be "good" — by enjoying a clean and sober lifestyle — one is defying parental dictates and deserting or sneering at a parent or sibling
- that one causes others to be depressed and/or violent
- that in childhood, one drove their parents to drink, to use other drugs, to depressions or to violent rages

- that the punishments and/or neglect one received as a child were appropriate and deserved
- that one does not deserve protection
- that the loneliness and feelings of being disconnected from family members experienced in childhood were because of some defect inherent to one's personality
- that one does not deserve to feel securely attached to others, and that one is a burden on others
- that one's need to feel intimately connected to others represents excessive neediness, and constitutes a danger to others.

THE CLIENT'S PLAN

Addicted clients come into treatment with a plan to stop using drugs, and to modify their pathogenic beliefs in order to pursue normal developmental goals. This basic plan applies to all addicted clients, whether entering treatment on their own initiative, as the result of an intervention, or even when treatment has been mandated by the court. In some cases this plan may be conscious; in many it is not. The fact that this plan is often unconscious has led to confusion for therapists who react to clients' surface behavior, which may for a while include continuing drug use.

Prior to treatment, clients who are in the grip of an escalating physiological need for drugs have increasingly organized their lives and thinking around getting and using drugs. Most have tried and failed to control their drug use and have come to feel hopeless and helpless (Brown 1985). This hopelessness is often unconscious and may lead to the defensive phenomenon known as alcoholic denial. And it may remain unconscious until clients come to believe that there is a solution to their problem. The therapist or counselor, understanding the client's plan, may be able to provide the hope that clients want and need. By providing education about addiction, and by referring to self-help and other chemical dependency treatment programs, the therapist may help to demystify the client's experience and provide a continuing hopefulness and support for the client's unconscious plan.

Most addicted clients enter treatment with deeply held beliefs (many of them unconscious) that warn them against recovery. The early phases of treatment consist of efforts to modify these pathogenic beliefs, such as the belief that to stop using drugs is to betray an alcoholic parent, or that to be happy, successful, clean and sober will make other family members feel inferior. Clients raised in alcoholic families often believe that if they admit the destructive influence of drugs in their own lives, they will be betraying the very culture of their families, and they will feel guilty and disloyal. For these clients, recovery may symbolize a violation of the entire family belief system, and in some cases may lead to a real break with the family (Brown 1988).

TESTS IN EARLY RECOVERY

Many clients in early recovery test the belief that to be clean and sober will harm others, either by surpassing them or by refusing to continue to comply with parental judgments of them as being out of control or bad. Clients test their therapists and counselors to see if they support their recovery, and may for a period continue to use drugs both as a consequence of physiological addiction and as part of a passive-into-active test in which they imitate an addicted parent. Or they may use drugs as part of a transference test in which they try to find out if the therapist believes they deserve and are capable of recovery. And often they may be trying to find out if the therapist will attempt to protect them in ways that their parents did not, in order to modify the belief that they do not deserve protection.

Early in recovery, clients often test the therapist's support of the recovery process by denying or minimizing the significance of drug use, and denouncing the recovery programs. They may test by complaining about program members and meetings or activities. They may report such things as "I can't stand the God stuff" or "It's a cult" or "They're much sicker than I am" or "There's too much smoke." While testing, the client monitors the therapist's response. The client is asking, "Do you really support my recovery? Are you in competition with AA or with my sponsor?" Clients offer these tests in the hope that the therapist will support their recovery and endorse their participation in recovery programs.

Other tests common in early recovery may involve behaviors that are difficult and offensive to the therapist in private practice as well as to the staff at treatment programs. These tests are almost always some form of passive-into-active behavior, in which clients are imitating maladaptive parental behavior that traumatized them in childhood. For example, clients in a treatment program may present themselves to the staff as entitled and belligerent. They may offend admission workers with demanding and hostile behavior; this type of testing may also occur in individual therapy. The therapist or counselor may be able to affect this behavior by reframing it through interpretation or historical explanation. For example, a client who has been belligerent, complaining angrily and irrationally to his therapist may be told, "I think you are trying to show me something about how it was for you growing up in your family. Wasn't your father always angry and complaining, telling you how you were causing him trouble? I think you might be letting me see how it felt to be you as a child. And by imitating your father, you're being loyal to him." Clients are often able to listen to this type of interpretation and then use it to reformulate their own view of themselves. They may adopt the therapist's interpretation because it provides a nonblaming explana-

tion for what is internally felt as inappropriate behavior, and they may also adopt the therapist's attitude, which is fundamentally friendly and optimistic, in that it views their most difficult behaviors as part of their efforts to get better. Also, they may derive relief from the therapist's reactions; rather than being hurt by their difficult behavior, the therapist has provided a new attitude and explanation. This type of intervention passes clients' tests by disconfirming the pathogenic belief that they are bad, destructive or harmful, and thus may provide a corrective experience.

Recovery programs — albeit self-help, outpatient clinics or therapeutic communities — may also work by modifying clients' pathogenic beliefs as well as by teaching practical cognitive and behavioral techniques, and by demonstrating a successful life without drugs. The self-help programs may be particularly useful. Some of the steps in 12-Step programs are specifically directed toward changing the pathogenic belief in an omnipotent sense of responsibility, which is common to those raised in unhappy families (Brown 1988, 1985). For example, Step One of these programs declares the addicted client's "powerlessness." This helps them to begin to change a long-standing pathogenic belief that in childhood they were responsible for their parents' or siblings' problems. The spiritual dimension to these programs may also help members overcome this exaggerated sense of responsibility. And addicted clients who come into treatment with profound feelings of inadequacy and shame may find relief in these steps. For example, Step Four gives recovering clients the opportunity to write their whole life story, including all the things they feel most ashamed and guilty about. In Step Five they are able to share this writing with a program sponsor, who in response may share with them some of their own story. In the steps that follow, recovering addicts ask their "higher power" for forgiveness, and also begin a process in which they apologize to anyone they feel they may have harmed in their years of addiction. In this process, clients are able to find relief from some of the shame and guilt that they have suffered.

THE NEED FOR CONNECTION

Many addicted clients from troubled families were neglected and/or abused as children, and were not provided with opportunities to fulfill their normal needs for attachment and dependence. Their parents may have been depressed or addicted and therefore not available either literally or emotionally. Clients from such families may have been able to maintain a sense of connection with abusive and neglectful parents by complying with the abuse and neglect, by blaming themselves for their parents' behavior, and by imitating their parents' maladaptive behaviors out of loyalty. They may have inferred from their

experiences that they do not deserve to enjoy connections to others and they may believe that the deprivation they experienced was justified by their defectiveness. They may believe that if they express their needs they will harm or burden others, or that they will be burdened by others. They come into recovery with a fear of and also a need for healthy attachments. In some cases, permitting and encouraging an attachment to the therapist as well as to people in recovery programs — friends, sponsors, and mentors — may be crucial to the recovery process. All of these relationships may help clients to modify the pathogenic belief that they do not deserve connections and thus may provide curative experiences.

In some cases, a close relationship to a therapist permits a client to begin developing attachments in the programs. In other cases, a client's attachment to program members precedes his or her being able to feel safe enough to enter psychotherapy. The pathogenic beliefs warning clients against secure relationships and successful lives without drugs may be modified by a therapy conducted with an understanding of these beliefs. And these beliefs may be most effectively modified when therapy is offered concurrently with recovery programs.

IMPLICATIONS FOR TECHNIQUE

Control Mastery Theory leads to greater variations in technique than are commonly used in individual psychotherapy (Weiss 1993), since anything that the therapist does to help clients carry out their plans and disconfirm their pathogenic beliefs is good technique. Because every client is different, with a particular history and pathogenic beliefs, the techniques used in therapy are case specific; that is, the techniques used in any specific psychotherapy depend on the specific pathogenic beliefs of the client and the tests that he or she gives the therapist in efforts to disprove these beliefs. The therapist may infer from understanding the client's particular history and pathogenic beliefs, how best to help the client.

Some psychotherapists and drug counselors have suggested that it is unwise to encourage the addicted client in early recovery to develop an intense relationship with a therapist. They question intensive psychotherapy for these clients (Kanas 1982; Mack 1981; Vaillant 1981) and suggest that such relationships may encourage too much dependence. Currently, some chemical dependency treatment programs offer minimal or no individual counseling, and instead emphasize the group setting, in part due to economic constraints and in part because of the perception that intense one-on-one relationships should be discouraged (Galanter 1984; Kanas 1982; Vaillant 1981). Vaillant (1981:51-52) argued that the development of the transference in early recovery may be a problem because relapses

are common and "disruptive to any ongoing relationship." He discussed the frequency of relapse and its effects on the therapist-client relationship, and suggested that an intimate therapist-client relationship early in recovery leads to excessive demands from the client, and withdrawal by the therapist. Vaillant proposed that considering dynamic as opposed to chemical aspects of drugs will cause clients who relapse to suffer from excessive guilt toward the therapist.

In contrast to Vaillant's concerns about relapse, the theory presented here assumes that the disruption caused by a relapse, so much a part of recovery from addictive disease, may be moderated by the therapist formulating the relapse in terms of the client's current objective conditions, pathogenic beliefs and tests of the therapist, as well as in terms of a manifestation of drug addiction. The hopelessness resulting from a relapse may be strongly countered by a therapist's continuing interpretation of the client's wish for recovery and of the pathogenic beliefs warning them against recovery. In some cases, individual psychotherapy may be essential to interrupt a pattern of relapse behavior.

The problem of dependency noted by Vaillant and others relates to the condition of growing up in problem-filled families in which addicted clients were not able to fulfill normal needs for care and dependence (Fisher et al. 1992; Brown 1988). Some addicted clients come into treatment expressing denial of and/or contempt for their needs for relationships. If they were burdened as children by disturbed and needy parents, they may initially appear to require a great deal of autonomy and freedom. If they were abused, neglected and rejected, they may test their right to a dependent relationship. Sometimes they may exaggerate these needs in the process of testing, and this may be seen as excessive dependency, and lead to the rejection that they fear.

Many psychotherapists have assumed that dependence is maladaptive, and should be frustrated. They have also assumed that independence is a primary goal of therapy. As a consequence some therapists have responded to clients' rejection or dependency tests with neutrality. This has hindered some therapists in their work with clients who experience this neutrality as rejection. Some clients may respond by more extreme testing, which the therapist takes as proof that the client's needs are excessive. However, the clinician utilizing the theory proposed here may formulate this behavior as a useful form of testing, conducted by clients in order to disconfirm pathogenic beliefs that warn them against attachments to others, and thus as both purposeful and therapeutic. This in essence reframes the behavior, and allows both the therapist and client to view it in a positive light. The client's tests may be passed by interpretations of their pathogenic beliefs, as well as by the therapist presenting himself as a person with whom it is acceptable to be connected.

This perspective on the dependency needs and difficulties in relationships common to addicted clients in early recovery has implications for technique: in some cases, the therapist working with a recovering client may find it helpful to maintain a relatively flexible frame, and to be willing to be available for more frequent appointments or telephone contact in between appointments. And in some cases it is most useful for the therapist to permit the client to come and go in treatment, accepting the client's need for both distance and closeness (Smith, Milkman & Sunderwirth 1985).

The self-help programs may also function to counter the pathogenic belief that it is harmful to seek connections with others, or that others will be inevitably burdening (Brown 1988, 1985). These programs maintain an open-meeting structure, where clients are able to come and go as they feel comfortable. Recovering clients often describe feeling as if they never belonged anywhere until they entered their 12-Step group. There they find that it is acceptable to want to belong, and to feel dependent, and it is also acceptable to maintain distance. From the first encounter with these programs, clients are told to get many phone numbers of members, and to use them. It is common for an "old-timer" to tell a newcomer, "call me any time, morning, noon or night." Clients are able to call people as suggested, and yet they are also able to easily back off from these acquaintances should they feel they want distance. Many recovering clients are able to develop significant attachments to sponsors, and later to sponsees whom they help with similar problems. However, in some cases in which clients are severely inhibited in the development of attachments to others, they may first have to establish a significant relationship with a professional helper, drug abuse treatment counselor, therapist or mentor before attempting a close relationship with a nonprofessional peer, such as a self-help group member.

Some therapists have objected to the relationships between program members recommended by the 12-Step programs. Believing that a client is able to form only one significant relationship at a time, they have suggested that relationships with other self-help group members "splits the transference" and acts as a type of resistance to treat-

ment. This attitude may lead to therapists appearing to be in direct competition with the program, friends, and sponsors. For the recovering client from a problematic family system, this may recreate the kinds of loyalty conflicts so common in such families. Chemical dependency and other problems cause a history of conflicts and fights within families, and often the children find themselves forced to choose between parents, and to be loyal to one means being disloyal to the other. This is replicated when a client feels that his or her attachment to a program sponsor or to program friends is hurting their therapist. This confirms a client's pathogenic belief that to move toward normal healthy goals — a clean and sober life in a clean and sober social group — hurts those he or she loves.

However, when clients in therapy are supported in their efforts to establish and enjoy other relationships, they may feel safer in developing attachments to their therapist. A significant therapeutic experience for the addicted client is the experience of relating to others, thus breaking their often lifelong feelings of isolation. This process may be facilitated when clients are able to use a combination of psychosocial treatment models, including self-help and other chemical dependency therapies, as well as, when needed or possible, individual psychotherapy.

Individual psychotherapy may be a significant and sometimes essential contribution to the recovery process. Therapists who assume that clients are strongly motivated to recover may be particularly helpful. Furthermore, therapy that is conducted with an understanding of a particular client's social and psychological history and pathogenic beliefs, as well as knowledge of the effects of addictive disease, may provide the ongoing support and encouragement needed by many addicts in the most difficult phases of early recovery. And a therapy informed by this theoretical understanding of a person's problems and wish for recovery may be useful at varying stages in recovery. According to Control Mastery Theory, the process of providing addicted and recovering clients with a therapeutic relationship in which they may work to disconfirm their pathogenic beliefs may be a valuable treatment method with which to help clients enter and remain in a successful and abstinent life in recovery.

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