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An Old Treatment for an Even Older Problem

Does Psychoanalysis Have a Role in the Treatment of Addictive Disorders? A Review of the Literature

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Abstract

The fact that addictive disorders have a significant negative impact on the health of the global population is well documented in contemporary health literature. What is less well documented is the uncomfortable realization that the tools in our armament to help individuals who struggle with addictive disorders are limited. Many individuals will spend their lives ''cycling'' through the addiction treatment continuum only to again be met with relapse. Third-party reimbursement for addiction treatment has focused on time-limited treatments and ''brief'' therapies with an additional emphasis on support group attendance (aka ''free'' services) with minimal focus on the fact that brief therapies have poor evidence for efficacy. In this article, we explore an alternative to brief therapies by reaching back to the earliest and most comprehensive treatment we have for behavioral change—psychoanalysis. This article engages in a literature review to determine whether sufficient evidence exists for the use of psychoanalysis as a treatment for addictive disorders. Implications for advanced practice psychiatric nurses are discussed.

Keywords: Addictions, Psychoanalysis, Psychotherapy, Treatment Failure

The history of addiction is extensive and has been chronicled in multiple countries across multiple cultures throughout recorded history (Maisto, Galizio, & Connors, 2015). Addictive disorders negatively impact not only the individuals' health and quality of life but also impacts their family, friends, and community. For as long as addictive disorders have been recognized, efforts to cure these disorders have been undertaken. Today, our approach to the treatment of addictive disorders includes a wide range of approaches, often with a focus on therapeutic settings (e.g., inpatient and outpatient treatment programs) as well as therapeutic approaches (e.g., individual, family, group therapy, manualized approaches). Self-help groups also came into being to combat addiction (e.g., Alcoholics Anonymous, Narcotics Anonymous, Overeaters Anonymous), and a wide range of professionals have devoted their careers to treating individuals with addictive disorders (e.g., clinical psychologists, licensed clinical social workers, nurse practitioners, physicians). Nonlicensed persons have also contributed to the treatment of individuals who experience addictive disorders (e.g., "spiritual counselors," "sobriety" or "recovery" coaches, and nonlicensed members of the clergy; Capuzzi & Stauffer, 2012; Douaihy, Daley, Marlatt, & Donovan, 2014; Maisto et al., 2015; National Institute on Drug Abuse, 2012).

RELAPSE AND RECOVERY

Despite exhaustive efforts, treatment of addictive disorders is not always successful, and efforts toward recovery frequently end in "relapse." Considerable controversy surrounds the definition of relapse and what it represents (Capuzzi & Stauffer, 2012; Douaihy et al., 2014; Maisto et al., 2015). Although many experts in the field of addiction studies believe that relapse is a "part" of recovery from addiction (Capuzzi & Stauffer, 2012; Douaihy et al., 2014; Frances, Miller, & Mack, 2005; Maisto et al., 2015), others argue that relapse is dangerous and should not be considered a part of recovery as it is believed that this mindset (a) blurs the distinction between pathology and health, (b) fails to acknowledge the potential for permanent recovery with no continued episodes of drug use, (c) minimizes the pain and potential loss of life involved in the resumption of alcohol and other drug use, (d) offers the person seeking recovery both an invitation and an excuse for continued use, (e) maintains the "once an addict, always an addict" mantra that further generates social stigma toward those who experience addictive disorders, and (f) provides addiction treatment programs an escape from accountability for posttreatment recovery outcomes (White, 2010).

Dovetailing from the challenges associated with defining relapse, statistics to describe relapse vary by source and methodology. These challenges are further complicated by the fact that measurement of relapse rates is highly contingent upon self-report. Gossop et al. (2003) conducted a 6-month follow-up study of individuals who had been discharged from an inpatient

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rehab facility for alcohol problems and attended Alcoholics Anonymous meetings. The authors concluded that "frequent AA attenders had superior drinking outcomes to non-AA attenders and infrequent attenders" and reported "greater reductions in alcohol consumption and more abstinent days" (p. 421). These results were obtained via self-report of Alcoholics Anonymous attenders, however. Hoch et al. (2014) concluded that, although participants in their study self-reported abstinence from marijuana, their urine screens were, in fact, positive, suggesting that the self-reports were deceitful. Efficacy studies should include objective measures to assess whether the person is currently using substances or if he or she is truly abstinent as social desirability bias on the part of the subject can have a significant impact on efficacy studies.

Gossop, Stewart, and Marsden (2008) conducted a 5-year follow-up study of attendance at Alcoholics Anonymous and Narcotics Anonymous. They concluded that "for alcohol, there was no overall change in rates of abstinence after treatments, but clients who attended NA/AA were more likely to be abstinent from alcohol at all follow-up points than were non-attenders" (p. 122). Their study did include urine screening to provide evidence of validity of self-reported drug use. Concordance rates of 93% were found among those who self-reported abstinence from heroin, cocaine, and amphetamines and urine drug screens.

The literature continues to be plagued with debate over both the meaning and validity of efficacy studies conducted on self-help groups such as Alcoholics Anonymous and Narcotics Anonymous. Dodes and Dodes (2014) summarize these issues by noting that "the AA question was considered settled almost before it was asked, and what studies exist that claim to substantiate AA have been riddled with problems in both methodology and analysis" (p. ix). Despite these limitations, the National Institute on Drug Abuse (2012) estimates annual relapse rates as ranging from 40% to 60%. These rates do not vary significantly from estimates of "cures," which were reported at the first meeting of the "American Association for the Cure of Inebriates," which took place in 1870. During that meeting, cure rates were reported as ranging between 33% and 63% (White, 1998), which challenges us to question how far we have really come in nearly 150 years of treating addictive disorders.

Individuals who struggle with addictive disorders have often undergone several treatment episodes encompassing several treatment modalities and venues. Depending on the substance involved, their treatment may have included "detox," followed by inpatient rehabilitation, or partial hospitalization programming, in some cases followed by a stay in a "halfway" house or outpatient counseling. Many individuals have also attempted lay treatment as well (e.g., Alcoholics Anonymous). Despite participation in these treatments, many patients will experience relapse. Unfortunately, once a person has gone through the cycle of treatment settings described above, he or she often has no other treatment options, save for repeating the same cycle of treatment (inpatient, partial hospitalization, outpatient treatment, etc.). Not only is this repetition frustrating for the individual, but there has also been increasing pushback from insurance companies loathe to pay for patients to be readmitted for treatment that was already rendered. According to the National Center on Addiction and Substance Abuse at Columbia University, "readmissions can be seen as evidence that treatment is not working and typically are not covered unless a physician can document a change in the patient's physical, emotional or social condition that makes it reasonable to expect that additional treatment would improve the patient's condition, or documents why the initial treatment was insufficient" (National Center on Addiction and Substance Abuse at Columbia University, 2012, p. 210).

However, what if nothing has changed? What if the treatment itself was simply not effective? This is clearly the case with many patients who struggle with addictive disorders. The tools available in our armament to treat addictive disorders are essentially limited to what insurance companies deem "medically necessary" and are ultimately willing to pay for. Although issues plague our ability to statistically describe rates of recovery and relapse, it is known that not everyone who seeks treatment for addictive disorders is able to achieve recovery. In consideration of the high rates of relapse (described above), other treatments that we can use in addition to existing therapies to help the client achieve recovery should be identified. One treatment modality that considers addictions not as a "behavior" that can be quickly extinguished but as resulting from a cascade of events that began early in life ultimately culminating in the addictive disorder is psychoanalysis. Psychoanalysis is perhaps the oldest of the recognized therapeutic techniques and may be an effective approach to the treatment of addictive disorders.

The proliferation of insurance companies followed by health maintenance organizations and managed care organizations shifted the emphasis of treatment to therapies that are limited in terms of time and cost (Cushman & Gilford, 2000; Hoyt, 2001; Panzarino, 2000). This has resulted in the placement of limits on the number of visits that insurance companies will pay for and has increased focus on the use of psychotropic drugs to treat mental health conditions (Capuzzi & Stauffer, 2012; Frances et al., 2005; Maisto et al., 2015; Panzarino, 2000; SAMHSA, 2013; Tavakoli, 2014). Hubbard, Craddock, and Anderson (2003) concluded that patients who had a longer treatment duration as defined by months or more in both long-term residential treatment and outpatient drug-free treatment had experienced overall reductions in prevalence of substance use in the year after treatment (in comparison with the preadmission year). These studies suggest that it may be prudent to ask whether treatments of a longer duration with a different focus than changing a single behavior (substance use) may be more appropriate for those who fail to respond to other forms of treatment. This question is of particular importance when considering the chronic nature of some addictive disorders, which have required multiple interventions throughout a person's lifetime. Some patients experience a life course punctuated by repeated cycles of periods of abstinence, relapse, abstinence, and so on, which

involves multiple treatment episodes (McKay & Hiller-Sturmhofel, 2011).

Criticisms of brief therapies in the treatment of addictive disorders have asserted that approaches used may be "too brief" in consideration of the complex neurobiological and psychosocial issues that are inherent in addictive disorders (Hser, Anglin, Grella, Longshore, & Prendergast, 1997). Some studies have suggested that brief therapies may provide rapid benefits but, in the long run, are not as effective as long-term therapies (Knekt, Lindfors, Laaksonen, et al., 2008, p. 95) and, when applied to addictive disorders such as alcoholism, may be ineffective (Cutler & Fishbain, 2005). As Lazar (2014) aptly noted, "many patients are in need of more prolonged and intensive psychotherapy" (p. 423). Therapies of longer duration such as psychoanalysis have been abandoned in favor of brief therapies and interventions for a variety of reasons including duration and expense of treatment, which is not paid for by insurance companies, and lack of providers trained in the treatment modality (Brandell, 2013; Mintz, 2006; Plakun, 2006; Pyles, 2003; Tavakoli, 2014). Support for brief therapy as an approach to individual psychotherapy had its foundations in a study by Howard, Kopta, Krause, and Orlinsky (1986), who concluded that there was a dose/relationship effect in psychotherapy. The authors concluded that 26 sessions represented the "dose" at which 75% of clients undergoing individual psychotherapy showed benefit from therapy. Their findings were met with delight by insurers who sought a rationale to cap the number of visits that they were paying for psychotherapy. These earlier findings were supported by a later work by Stulz, Lutz, Kopta, Minami, and Saunders (2013), who concluded that treatments of longer duration were associated with less rapid rates of change (p. 593).

PSYCHOANALYSIS

Psychoanalysis has largely been linked to the work of Sigmund Freud who contended that "mental disorders arise mainly from processes in the unconscious mind, outside of our awareness" (Zimbardo, Johnson, & McCann, 2012, p. 17). Freud further asserted that his theory (which came to be known as "psychoanalytic theory") can explain the entire person—not simply components of experience such as behavior, attention, or memory. He endeavored to explain all aspects of the mind and behavior, and "psychodynamic theory" grew from his work. Freud and his students (referred to as *neo-Freudians*) developed the collective system of therapy, which has come to be known as "psychoanalysis."

Psychoanalysis was once synonymous with the field of psychiatry. However, as Plakun (2012) noted, the two disciplines moved away from one another in the last third of the 20th century as psychiatry sought to become more medically oriented and biologically based. As psychotropic medications were being introduced in greater numbers, the reliance on psychoanalytic approaches to treat psychiatric illness waned in favor of these new medications, which seemed to produce quicker results. During this time, there was also an increase in the number of other professions that offered psychotherapy services (e.g., psychology, social work, professional counselors) who were not trained in psychoanalysis but in newer, briefer methods of therapy. The proliferation of these professions and their approaches helped to further decrease the application of psychoanalysis in the treatment of mental health issues (Friedman & Downey, 2012).

General Principles of Psychoanalysis

Psychoanalysis is both a theory and a therapeutic approach. Since the time of Freud, psychoanalysis has grown and changed in many ways, but its core principles remain intact. Neo-Freudians have added to the field, as have their students and their students' students. Because of these additions, new schools of psychoanalysis have emerged, and the theoretical orientation of the analyst (e.g., Freudian, Adlerian, or Jungian) will influence the technique that the therapist will use (Thoma & Kachele, 2007).

At the foundation of psychoanalytic theory, Freud believed that the patients' symptoms were based on thoughts and feelings, which were outside their conscious awareness. The basic premise of psychoanalytic theory is that unconscious thoughts and feelings (beyond a person's awareness) both affect and motivate people in a variety of ways—many of which can lead to habitual, maladaptive ways of thinking and behaving (Cabaniss, Cherry, Douglas, & Schwartz, 2011). Becoming aware of these unconscious thoughts and feelings is one of the foundational goals of psychoanalysis. Therapeutic factors associated with this awareness include the releasing of sequestered feelings (which psychoanalysts refer to as an "abreaction") and the prevention of "proliferation in the dark"—a concept that refers to allowing unconscious elements to continue to grow to enormous and inappropriate dimensions in the person's subconscious. Finally, making the unconscious conscious helps the person to know himself or herself better and thus make better decisions (Cabaniss et al., 2011).

During psychoanalytic treatment, the psychoanalyst helps the patient in a variety of ways such as supporting weakened ego functions and reactivating development—or returning to an earlier point in the person's development where developmental arrest or aberrancy occurred. Once development is reactivated, the person can develop along new lines that are occurring within the context of a healthy relationship with their psychoanalyst, the goal of which is to usurp previously unhealthy developmental lines in favor of healthier developmental tangents (Cabaniss et al., 2011, p. 11). This new line of development supports new ways of thinking about oneself, regulating one's self-esteem, developing new ways to relate to others, and developing more flexible and adaptive coping styles and mechanisms (Cabaniss et al., 2011).

Psychoanalytic Research

Psychoanalysis has been plagued by assertions that it lacks scientific grounding (Phillips & Phillips, 1997). As Plakun (2012) explains, "psychoanalysis…was and remains poor in its research methodology, with mistrust and skepticism

about empirical research until fairly recently" (p. 184). Plakun further noted that psychoanalysis's split from psychiatry seems to have been fueled by psychiatry's desire to be identified as an evidence-based field of medicine. This is not to say that psychoanalysis has not attempted to show efficacy or gain empiric support as a professional field; however, the issues inherent in studying the efficacy of psychoanalysis are many. First, the length and intensity of psychoanalysis make it difficult to conduct randomized clinical trials, which require the investigator to have a control group with whom comparisons with an active treatment group can be made. Finding believable placebos in therapy is more difficult than medication trials (Plakun, 2016, p. 2). One method that many psychotherapy research studies have used to create a placebo condition is known as the "wait list" condition. In this "condition," people who are currently waiting to receive an appointment are periodically assessed specific to their symptom severity to determine whether their symptoms have improved or worsened. The "wait list" control condition is not particularly effective for studies of psychoanalysis as people are usually taken into therapy long before the trial of psychoanalysis can be concluded, thus essentially removing the control condition from the efficacy study. Although psychoanalysis may never be able to be studied in the same way as phenomenon in other academic areas of inquiry such as biology or physics, it can still be studied. Several authors have studied the relationship between neurology and psychoanalysis (Beni & Raugei, 2014; Erickson, 2007; Gabbard, 2010; Johnson, 2008; Taubner, Buchheim, Rudyk, Kachele, & Bruns, 2012; Yovell, Solms, & Fotopoulou, 2015) and have concluded that psychoanalysis does result in lasting behavioral changes. Other authors have documented the expanding body of research that has considered the beneficial combination of psychoanalysis and psychopharmacology (Lebovitz, 2004).

Studies of the Efficacy of Psychoanalysis

Shedler (2010) undertook a meta-analysis that included 160 studies of psychodynamic therapy. He concluded that

> empirical evidence supports the efficacy of psychodynamic therapy. Effect sizes for psychodynamic therapy are as large as those reported for other therapies that have been actively promoted as "empirically supported" and "evidence based." In addition, patients who receive psychodynamic therapy maintain therapeutic gains and appear to continue to improve after treatment ends. Finally, non-psychodynamic therapies may be effective in part because the more skilled practitioners utilize techniques that have long been central to psychodynamic theory and practice. The perception that psychodynamic approaches lack empirical support does not accord with available scientific evidence and may reflect selective dissemination of research findings (p. 98).

Although Shedler provides us with a bird's-eye view of the literature, a more granular approach to the body of psychoanalytic research shows its efficacy in the treatment of many psychiatric conditions, including depression (Barber, Barrett, Gallop, Rynn, & Rickels, 2012; Barkham et al., 1996; Barkham, Shapiro, Hardy, & Rees, 1999; Churchill et al., 2001; Cooper, Murray, Wilson, & Romaniuk, 2003; Driessen et al., 2013; Gallagher-Thompson, Hanley-Peterson, & Thompson, 1990; Gallagher-Thompson & Steffen, 1994; Gloaguen, Cottraux, Cucherat, & Blackburn, 1998; Leichsenring, 2001; Levy, Ehrenthal, Yeomans, & Caligor, 2014; Maina, Forner, & Bogetto, 2005; Salminen et al., 2008; Shapiro et al., 1994; Shapiro, Rees, Barkham, & Hardy, 1995; Svartberg & Stiles, 1991; Thompson, Gallagher, & Breckenridge, 1987; Wampold, Minami, Baskin, & Callen Tierney, 2002), and a variety of anxiety disorders (Olatunji, Cisler, & Deacon, 2010; Crits-Christoph, Connolly Gibbons, Narducci, Schamberger, & Gallop, 2005; Keefe, McCarthy, Dinger, Zilcha-Mano, & Barber, 2014; Knijnik, Kapczinski, Chachamovich, Margis, & Eizirik, 2004), as well as schizophrenia (Arieti, 1974; Malmberg, Fenton, & Rathbone, 2001; Rosenbaum et al., 2012, 2006; Spotnitz, 2004). It also has shown efficacy in the treatment of personality disorders (Fournier et al., 2008; Grilo et al., 2010; Gunderson et al., 2004; Levy et al., 2014; Links, Heslegrave, Mitton, Van Reekum, & Patrick, 1995; Newton-Howes, Tyrer, & Johnson, 2006; Shea, Widiger, & Klein, 1992; Skodol et al., 2011; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2006). Psychoanalysis has also shown efficacy in treating other disorders such as "pathological grief" (McCallum & Piper, 1990), somatic conditions such as irritable bowel syndrome and other gastrointestinal disorders (Creed et al., 2003; Hamilton et al., 2000), chronic pain (Monsen & Monsen, 2000), multisomatoform disorder (Abbass, Kisely, & Kroenke, 2009), and eating disorders (Leichsenring, Klein, & Salzer, 2014; Levy et al., 2014).

The true measure of the efficacy of any psychotherapy should be its ability not only to relieve acute distress but also to improve the client's function toward futurity. Gaskin (2014) undertook a review of meta-analytic studies that sought to determine the longitudinal efficacy of psychoanalysis. Patients represented in these studies included those with depressive disorders, anxiety disorders, and personality disorders. Patients included in these meta-analyses received between 234 and 921 psychoanalytic sessions lasting from 2.5 to 6.5 years. The studies showed that not only were distressing symptoms effectively treated, but also social functioning had improved, and studies that had tracked participants for as long as 3.5 years after termination of therapy showed that those improvements that were gained through therapy were maintained. Other studies have suggested that the reason psychoanalysis has lost traction to other brief therapies such as cognitive behavioral therapy (CBT) is because it takes a sufficient "dose" of the psychoanalytic treatment to achieve results. In their study, Knekt, Lindfors, Härkänen, et al. (2008) concluded that short-term therapies were capable of producing much more rapid results in the treatment of disorders such as anxiety and depression; however, in the long run (in the case of their study, 3 years), long-term psychoanalytic therapies were superior to short-term alternatives (p. 689).

As more research in the field of psychoanalysis emerges, evidence of superiority to shorter-term treatments continues to emerge. Reanalysis of previously conducted meta-analyses concluded that "data on dose-effect relations suggest that for many patients with complex mental disorders including chronic mental disorders and personality disorders, short-term psychotherapy is not sufficient" (Leichsenring, Abbass, Luyten, Hilsenroth, & Rabung, 2013, p. 361).

The scientific basis of psychoanalysis will most likely continue to expand in the future. A scientific foundation is important for the field not only to continue to refine technique and improve service delivery but also to continue building on the oldest and arguably most important psychotherapeutic technique we have—a technique that has lent so much to other psychotherapeutic treatment modalities. As Eric Kandel, the Nobel Prize-winning neurobiologist, stated at an American Psychoanalytic meeting: "Analysis is the most elaborate and nuanced view of the mind that we have" (Plakun, 2012, p. 184).

PSYCHOANALYSIS APPLIED TO ADDICTIONS

Substance use disorders have been treated by psychoanalysts since the field's inception. Sigmund Freud himself used cocaine and used it in the treatment of patients and colleagues alike (Maisto et al., 2015). He eventually came to notice that some people became addicted to cocaine, which led Freud to investigate the cause of addiction (Loose, 2011). Freud offered some insights into addictive disorders, noting that masturbation was the primary addiction that he believed to be the precursor of alcohol and drug dependency (Guigliano, 2003). Beyond Freud's observations, in the years that would follow the development of psychoanalysis, addictive disorders would become particularly problematic for practitioners in the field. Early analysts did not always meet with success in treating those with addictions, leading many of these early psychoanalysts to conclude that psychoanalysis was ineffective in the treatment of addictions. Sonnenberg (2010) pointed out that "historically analysts were taught that addicts were not treatable psychoanalytically so that even when an addiction came into clinical focus the analyst observer was motivated to ignore it" (p. 105). These beliefs may account for some of the delay in research associated with the efficacy of psychoanalysis in the treatment of addictive disorders. Literature in the field of psychoanalysis specific to addictive disorders has included theoretical discussions, case studies, and some research studies. Case studies seem to have permeated the analytic literature more so than research studies.

What Research Tells Us

The literature supports the premise that psychoanalysis is superior to no treatment (Brandsma, Maultsby, & Welsh, 1980; Crumbaugh & Carr, 1979). Early studies also suggested that psychoanalysis was comparable with other treatments for addictive disorders (Zimberg, 1974). Several researchers have considered the efficacy of psychoanalytic psychotherapy in comparison with other therapies such as drug/alcohol counseling, behavior, and CBT and concluded that psychoanalysis is at least as effective as these other methods (Ends & Page, 1957; Pomerleau, Pertshuk, Adkins, & D'Aquili, 1978). In their study, Woody et al. (1983) examined individuals in a methadone maintenance program who were randomly assigned to drug counseling alone or to drug counseling plus 6 months of psychodynamic therapy or CBT. All three groups showed improvement, but patients who received both the psychodynamic therapy and the CBT showed more improvement and used less medication. Limitations to this study included location where the study was performed (hospital based, university-affiliated/research-based methadone program, and using an all-male veteran population). To correct for these limitations, Woody, McLellan, Luborsky, and O'Brien repeated the study in 1995, but this time, they used a community-based program that included both men and women in their sample. In the revised study, psychodynamic psychotherapy gains persisted and, in some cases, appeared to strengthen for 6 months after therapy when compared with individuals who received only drug counseling.

In a 1999 study, Crits-Christoph et al. considered the efficacy of four different psychosocial treatments for individuals experiencing cocaine dependence. These included (a) individual drug counseling (IDC) plus group drug counseling (GDC), (b) cognitive therapy plus GDC, (c) supportive–expressive (SE) therapy plus GDC, and (d) GDC alone. The intervention lasted over 6 months, and follow-up assessments were continued for 12 months after baseline assessment. CBT and psychodynamic psychotherapy plus the addition of GDC were no more effective than GDC alone when it came to treatment of drug abuse. IDC and GDC were superior to both forms of therapy, and in terms of psychosocial and social outcome variables considered in the study, all treatments were equal in efficacy. When Crits-Christoph et al. reexamined these data in 2001, they concluded that "the superiority of individual drug counseling in modifying cocaine use does not extend broadly to other addiction-associated problems" (Crits-Christoph et al., 2001, p. 825).

In a 2008 study by Crits-Christoph et al., data from the National Institute on Drug Abuse Collaborative Cocaine Treatment Study were used to examine the differences in treatment outcomes (specifically days of cocaine use) among individuals who received SE psychodynamically oriented psychotherapy plus GDC versus IDC; the authors concluded that SE was superior to IDC in terms of changes in family and social problems at the 12-month follow-up period. This was especially true for those individuals who had more severe problems in the family/social domain at baseline. Furthermore, the authors concluded that "SE patients who achieved initial abstinence decreased cocaine use from a mean 10.1 day per month at baseline to a mean of 1.3 days at 12 months" (p. 483). Their findings supported an earlier work by Woody, McLellan, Luborsky, and O'Brien (1986) who examined the use of drug

counseling alone versus drug counseling combined with SE or CBT. The authors concluded that greater improvements were noted among those who received psychodynamically oriented therapy as opposed to those who received only drug counseling alone.

Is Length of Psychoanalytic Treatment the Key to Efficacy?: Mixed Results

The literature supports the contention that therapies of longer duration may be the most effective in helping individuals with addictive disorders. If these contentions are accurate, then psychoanalytic therapy should show enhanced efficacy because of the longer duration of treatment associated with this modality. Some authors have contended that the main problem associated with discussions of the efficacy of psychoanalysis stems from its failure to yield "immediate" changes in behavior that are often achieved with briefer therapies. Researchers assert that efficacy and superiority of psychoanalytic approaches over other brief forms of therapy can only be realized via longitudinal treatment. These authors also point to the ability of psychoanalysis to impact more areas of the person's life than just the addictive disorder. This is important as addictive disorders are often conceptualized a "symptom" of other psychosocial issues.

In a randomized trial of 49 male and female patients assigned to psychodynamically oriented time-limited group psychotherapy versus CBT for alcohol dependence, Sandahl, Herlitz, Ahlin, and Ronnberg (1998) noted that individuals who participated in the psychodynamic group maintained more positive drinking patterns during the follow-up period in comparison with those who received CBT, who actually deteriorated in the follow-up period, suggesting that, although both approaches were effective in the short term, psychodynamic therapy maintained its gains at 15-month follow-up in terms of days abstinent and improvement in overall psychiatric symptoms. This study also suggests that psychodynamic psychotherapy may be effective for those who seek a harm reduction approach to their addictive disorder. Although different researchers operationalize the term differently, harm reduction can be considered an approach to addictive disorders that focuses on reducing negative consequences but continues to allow the person to use the substance (or engage in the behavior) in a "moderate and safer use, thereby, reducing the harmful effects of the disorder" (Bayles, 2014, p. 22).

Leichsenring and Rabung (2008) conducted a meta-analysis of studies of long-term psychoanalytic psychotherapy (LTPP) conducted between 1960 and 2008. Their study, which consisted of 23 studies (11 randomized control trials and 12 observational studies) and included 1,053 patients, concluded that the use of long-term psychodynamic psychotherapy is effective in the treatment of complex mental disorders. This meta-analysis did not specifically focus on addictive disorders, although some individuals in the studies did experience addictive disorders. Later work by Bhar et al. (2010), which reexamined Leichsenring and Rabung's study, concluded that the evidence outlined in the authors' 2008 meta-analysis failed to show the superiority of LTPP over brief therapy approaches.

An even later meta-analysis by Smit et al. (2012) concluded that the "recovery rate of various mental disorders was equal" after LTPP "or various control treatments, including treatment as usual" (p. 81). The authors of this study further concluded: "In contrast to previous reviews, we found the evidence for the effectiveness of LTPP to be limited and at best conflicting" (p. 81).

There is some evidence to support the assertion that, although psychoanalysis is not superior to brief therapies initially (within the first 6 months), it may show its superiority in the long term and may have a positive influence on both familial and social problems. It is also noted that some studies reported that the efficacy of brief therapy was short-lived and that its effectiveness deteriorated over time in comparison with psychoanalytically informed treatment, suggesting that psychoanalysis may be superior in a longitudinal manner. There was also limited evidence to support that that psychoanalysis provided added benefit to those who had serious baseline psychosocial and mental health issues.

LIMITATIONS OF THIS LITERATURE REVIEW

Many limitations were inherent in this literature review. The first being the wide variety of techniques/approaches subsumed under the psychoanalytic umbrella and thus made it difficult to compare studies head-to-head. The short duration and lack of longitudinal studies provided additional limitations. Still, another limitation was the issue of extrapolation—studies were often conducted with one type of substance/addictive disorder (for instance, opiates or alcohol). This resulted in the efficacy of psychoanalysis in the treatment of other addictive disorders being "inferred," which was problematic as the results of the studies with one population may not be readily transmitted to individuals with different types of addictive disorders.

Another limitation is related to the fact that many psychoanalysts were traditionally taught that addictive disorders were beyond treatment. Because of this teaching, few analysts undertook the care of individuals with addictive disorders. It is proposed that this idea—which permeated psychoanalytic thought for many decades—is one of the reasons that there was such a paucity of literature specific to the treatment of addictive disorders through psychoanalytic approaches (in comparison with psychoanalysis in the treatment of other disorders such as depression). Because the field clung to these beliefs, a significant delay can be observed in the literature addressing the use of psychoanalysis in the treatment of addictive disorders. Once psychoanalysts began to challenge these earlier assertions and began to apply psychoanalysis to the treatment of addictive disorders, we see an appreciable swelling in the research literature specific to this topic, reaching its zenith during the period of the 1950s through 1970 followed by a decline of these studies during the 1980s when Howard et al. (1986) first described the "dose/relationship

effect in psychotherapy" (as described above), which resulted in psychoanalysis being abandoned in favor of briefer treatments.

Another limitation is related to the use of case studies in the psychoanalytic field. When case studies were published, they were of treatment success. However, what of treatment failures? Because of what has come to be known in the field of research as the "file drawer problem" or "publication bias," there has been a tendency to not publish studies that failed to yield significant results or positive findings (Rosenthal, 1979). Therefore, the true extent of successes among all types of psychotherapies may never be known.

Still, another limitation was pointed out by Lohr (2011), who observed that studies in the literature addressing questions of therapy efficacy only stated that they had used "psychotherapy" without specifically naming or describing the actual type of therapy used. This remains one of the most significant limitations in making direct comparison of studies and limits our ability to pool research data for meta-analytic purposes. Consider also the fact that few therapists are "purists" when it comes to the techniques that they use. Most competent therapists will use a version of one treatment or another or may even combine techniques from several treatment approaches based on the results of the assessment of the client and their own experiences with treating individuals. When research studies are read, we have no way of knowing whether the purported therapeutic approach (e.g., CBT, acceptance and commitment therapy, or even psychoanalysis) were the therapeutic approaches used. This has the potential to be a major limitation in any study of psychotherapeutic approaches. Finally, many of the studies that did report positive findings relied on patient self-reports, which (as already discussed) is less than optimal when attempting to determine rates of abstinence.

IMPLICATIONS FOR PSYCHIATRIC NURSES

The implications for professional practice of this literature review are both blatant and nuanced. The study supports the contention that there is sufficient evidence to support the use of psychoanalysis as an approach to the treatment of addictive disorders. Although conflict exists over its superiority to other approaches to addictive treatment, the literature does support the assertion that psychoanalysis in and of itself is an effective treatment, independent of superiority to other approaches, and as such, should be considered for use in those individuals for whom other "briefer" forms of treatment have failed to show efficacy.

The implications for professional practice of this finding are also limited in terms of our capacity to implement psychoanalysis on a wide scale because of the small numbers of practitioners who are licensed/certified as psychoanalysts. The American Psychoanalytic Association, the oldest national psychoanalytic association in the nation (American Psychoanalytic Association, 2016), reports a membership of 3,109 members with an average age of 66 years (Leonard, 2015). These figures call into question the ability to implement psychoanalytic therapy on a large scale because of a lack of available psychoanalysts to provide this treatment modality to individuals in need. Although advanced practice nursing programs discuss psychoanalysis and provide a foundation for the learner in psychodynamic techniques, psychoanalysis itself is not taught in the training/entry-into-practice program of advanced practice nurses (APNs). Psychoanalysis is a course of study that is learned at an institute of psychoanalysis and can take several years to learn. For those APNs who would attempt to use psychoanalysis in the treatment of addictive disorders, additional study will be required. It is also conceivable that not many APNs would pursue psychoanalytic training as training centers are found mostly in major metropolitan areas, with limited options for online study. In addition, training as a psychoanalyst requires the learner to undergo his or her own analysis, which is not paid for by insurance companies. Therefore, individuals would have to pay privately for analytic sessions, which can last up to 5 days per week for several years while they undergo their own analysis.

Even if APNs are not interested in pursuing psychoanalytic studies themselves, they should attempt to identify and forge relationships with psychoanalysts in their geographic areas for the purpose of making referrals. Co-treatment is also an option if combinations of brief and long-term psychoanalytic therapy are being considered as this combination may provide some benefit. The advent of telemental health may also afford patients access to psychoanalysts in other cities or states. Issues of legal liability and licensure law challenges exist in the treatment of patients across state boundaries, but telemental health is an unfolding area that the APN should keep abreast of.

Another implication for practice has to do with limitations imposed on the use of psychoanalysis by insurance companies. As Thomas (2010) eloquently summarized, psychotherapy is undervalued if not devalued by insurance companies. She points to examples of her colleagues who practice psychoanalysis who have been plagued with challenges from

> insurance company demands to produce "treatment plans" for sessions of eight or ten weeks, complete with behavioral objectives. Complex human problems, with tangled roots in childhood trauma and pain, cannot be resolved in a few sessions. Nor can medication alone achieve resolution of such complex deep-seated problems (p. 305).

The literature has shown that psychoanalytic approaches appear to yield similar benefits to CBT and other brief approaches to the treatment of a variety of mental health issues. APNs must be willing to take up this cause with insurance companies and advocate for their clients who have experienced multiple relapses and whose addictive disorders appear resistant to standard treatments.

The findings in this study further suggest that those APNs who treat patients using a psychoanalytic approach need to consider efficacy research as a priority in their own practices. Even if the APN does not provide psychoanalysis, when possible, interdisciplinary collaboration with psychoanalysts and

cognitive neuroscientists should be undertaken to measure efficacy of the approach.

CONCLUSIONS

Although this literature review attempted to determine the efficacy of psychoanalysis as an effective treatment for addictive disorders, the available body of literature was unable to provide a definitive answer. The findings do show the need for high-quality studies in the use of psychoanalysis in the treatment of addictive disorders.

Although clarion evidence for the superiority of psychoanalysis over other forms of treatment is lacking in the literature, evidence does exist for the modality's effectiveness as a treatment. Psychoanalysis should be considered for those individuals who failed to respond to current approaches to the treatment of addictive disorders. Instead of continuing to subject the client to a never-ending cycle of treatments, which have already shown themselves to be ineffectual for that individual (or, as one of my former patients eloquently put it, "a cycle of wash, rinse, and repeat"), why not consider psychoanalysis?

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