The Mechanism of Codependence in the Prescription of Benzodiazepines to Patients With Addiction

by BRIAN JOHNSON, MD

Case 1: A forty-year-old father of two was admitted to a detoxification service for heroin dependence. He stated that he was boosting his heroin with alprazolam, 3 to 6 mg per day, which he obtained from a physician who was unaware of his heroin use. His course featured intense opiate and benzodiazepine withdrawal, complicated by depression. He deeply regretted many losses in terms of life goals and relationships with his wife and children. Following the opiate and benzodiazepine detoxification, depression and panic attacks gradually resolved over several weeks of treatment with desipramine. He was discharged to a halfway house.

Three months later he was readmitted because he had stopped his desipramine then relapsed to heroin use. His hospital stay was shorter, his depression resolved more quickly, and he was discharged to his apartment and day treatment. Over several weeks he complained of anxiety, was refused benzodiazepines by his psychiatrist, but received lorazepam from an unknown physician. Heroin use again supervened, and he stopped day treatment. He was last seen going to buy heroin with another former patient, both of whom were intoxicated on lorazepam. Both died that night from overdoses.

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The dynamics that follow are the result of seeing thousands of patients over a 16-year period as medical director or consultant to five academic inpatient detoxification services, as well as having a private practice over the same period in which I have treated many patients suffering from addictions of all kinds with psychoanalysis or with psychoanalytic psychotherapy.

DENIAL, SPLITTING, PROJECTIVE IDENTIFICATION, AND SELF MEDICATION IN ADDICTIONS

If one listens with interest, addicted individuals will constantly explain that they have had an experience with heroin that the physician will never be able to share, or that they can drink more alcohol than the physician will ever be able to tolerate, or in the case of bulimia or food addiction, that they can eat more than the physician will ever be able to enjoy, because of their unique ability to vomit.

Splitting, which involves a dissociation of the two kinds of experience affiliated with addictive behavior, is the primary internal defense that the addicted individual employs.[1] While intoxicated or actively using drugs, the addicted individual experiences a wonderful kind of internal intimacy, despite the real consequence that their addiction makes interpersonal relationships difficult or impossible. While intoxicated or active, the individual experiences a wonderful kind of pleasure, even though pain is guaranteed by their addictive

behavior and its consequences. While intoxicated or active, the addicted individual experiences a sense of omnipotence, even while growing increasingly impaired, isolated, and withdrawn. While intoxicated or active, the addicted individual experiences a kind of rebellious separateness and independence, even though they are making themselves more dependent on others and less able to fulfill tasks relevant to self-care. Idealization of the addictive behavior coexists with dissociated knowledge that it debases, degrades, and disables. Splitting allows the patient to know that using drugs is a bad choice and to feel at other times that it is the right choice, without any internal conflict.

Denial is a defense whereby the individual stubbornly refuses to consciously acknowledge an internal state or an external reality.[2] Projective identification is a defense whereby an individual cannot bear a feeling consciously, and so acts with another to provoke the unacceptable feeling in the other. Hostile control of the other is an aspect of this process.[3] Denial takes on an interpersonal aspect when splitting is combined with projective identification, the result being that the listener is expected to own the negative side of the addictive experience while the patient holds onto the idealized view of addiction. The patient tells a tragic story of distress caused by the addiction, then appears to "forget" what they said and defend the addictive behavior. The listener empathically identifies with the pain, suffering, anxiety, hopelessness, and low self esteem, and wants the addictive behavior to stop—while the patient embraces the idealized side of their illness. The listener now desperately wants something to be done, while the addicted individual is fantasizing about returning to active use. The defense of projective identification is usually employed so skillfully, unconsciously, and devastatingly that the listener shifts from feeling helpful and positive to anguished and eager to act somehow to end the now-shared dysphoria without stopping to see how interpersonal boundaries have been violated. This is a fertile interpersonal setting for the emergence of codependent behaviors in physicians interacting with addicted patients who are in denial.

THE CONCEPT OF CODEPENDENCE

Although many authors have written extensively on codependence,[4-7] the most exacting characterization has been Cermak's[8,9] *Diagnostic and Statistical Manual* (DSM IV)-style diagnostic framework. He states that the most essential feature of codependence is "continued investment of self-esteem in the ability to influence/control feelings and behavior, both in oneself and in others, in the face of serious adverse consequences." Based on my experience, both in general psychiatry of addiction and psychoanalytic therapy of addicted patients and patients bound closely to actively addicted individuals, I suggest the following amendment of his conceptual definition:

> Codependence is a behavior characteristic of individuals in an ostensibly helpful relationship with a severely ill person (for our purposes, ill with an addiction). The relationship inadvertently results in repeated harm to one or both individuals because the codependent has an inability to observe standard boundaries or limits in the relationship. A psychological system, referred to as "denial," is created around the relationship. Denial explains to the codependent individual why they must continue in the relationship no matter what harm ensues.

Self-esteem should be a constant feature of interpersonal experiences. However, when a severely ill person makes an unreasonable demand, healthy individuals will stay separate and explain that they cannot acceed to the addicted individual's wish. Codependent individuals fear anger and potential abandonment if they refuse to gratify an unreasonable demand. This is usually not thought consciously. As a result, the codependent person will not be able to maintain their personal integrity, but will enter the addicted individual's denial system. An example would be that a husband wakes up hung over from a bout of uncontrolled drinking and asks his wife to call work and explain that he is sick. The healthy wife will explain that he needs to bear responsibility for his actions. The codependent wife will compromise her personal integrity and perform the unreasonable and dishonest act of making the sick call.

Codependence can be a transient state (a set of traits that can be easily given up by an individual who feels helpless when confronted by the overwhelming experience of being embroiled with an actively addicted person) or can be a characteristic way of negotiating relationships.

THE MECHANISM OF CODEPENDENCE

Any physician contact with an addicted patient is likely to be a challenging encounter. The patient may present for care due to a complaint that is unrelated to their addiction, because of a symptom or sequelae of addiction, such as trauma or anxiety, or specifically to obtain either an opiate or a benzodiazepine prescription as part of their addictive behavior. In order to have the physician facilitate their continued addiction (ie, prescribe the desired mood-altering drug), the patient must include the physician as a partner in denial. The term *denial* does not simply refer to refusing to see that addiction exists. Denial may take many forms, including minimizing the importance of loss of control, rationalizing the use of dangerous drugs, or projecting responsibility for consequences of addiction onto others. Patients vary in defensive style and in degree of hostility.

The denial that we see operating involves a complex series of interactions that include

splitting and projective identification, and usually occur as the following steps:

1. The physician-patient interaction is initiated by an anxious patient who has an addiction. In many or most cases, the patient is not capable of seeing the physician as an expert partner in treating his or her distress. In many cases the patient comes to the physician accustomed to using chemicals to modulate distress, both to lessen it and, unconsciously, to increase it. The patient sees the physician as someone to help them deal with distress as they are accustomed: "you take something and you feel better."
2. The patient tells the physician about intolerable insomnia or overwhelming anxiety. The patient insinuates that if the physician cared to, she or he could control the patient's distress.
3. The concerned physician empathically identifies with the patient's distress. Through this identification, the physician experiences some of the patient's anxiety and suffering as his or her own, and wants the suffering to stop.
4. The physician fails to consciously identify with the patient's helplessness in the face of an addictive process. He or she fails to appreciate the cardinal importance of the unconscious aspects of the interaction, and instead defends against this painful sense of helplessness by assuming a mantle of power and authority that does not match the reality of the addictive process. In fact, the physician's use of the medication is quite similar to the patient's use of the addictive drug: deriving a sense of power from the ability to give the patient something that immediately reduces anxiety. This creates in the physician a sense of calm mastery. The physician is like the addicted patient in that they are used to using drugs to stop distress. (And rightly so. We do give drugs to stop distress. The difference between the addicted patient and the physician should be *No Nocere*—drugs we give should do no harm.)
5. The physician fails to consciously identify a threat of abandonment by the patient if their demands for a benzodiazepine are not requited and to address this dynamic directly with the patient. Over and over, when I ask physicians why they prescribe benzodiazepines for addicted patients, I receive the answer, "If I don't give it to them, they will stop coming to see me and go see someone else for benzodiazepines." Often the physician claims that they have a long history of treating this very difficult patient, know them and help them very well, and that they *must* give the benzodiazepine against better judgement, to protect their relationship with the patient.
6. Intensifying the distress that the patient induces in the physician is often a plaintive demand for attention. This is the hostile-dependent controlling aspect of projective identification and can also be an enactment of a childhood wish for love or memory of abuse by a parent. However, the physician is often not available, either in terms of being prepared for a long interview or for an intense involvement that requires sorting through and interpreting the patient's projective identification. The physician would like the patient to go away, and issuing a benzodiazepine prescription is an expedient method.

(Thus, three qualities embody codependence: (1) a sense of power and mastery that hides helplessness and low self esteem in both patient and physician, (2) a fear of abandonment unless one abets active use of an addictive drug, and (3) a fear of being controlled in a hostile way accompanied by disengaging behaviors such as issuing a prescription. Codependence is a state to which the physician is predisposed by either his or her own issues or by ignorance of addiction. It is activated by projective identification by the patient. The patient says, "My problem is now your problem," and the physician submits.)

7. The physician gives the patient instructions regarding the proper use of the benzodiazepine. The patient's wish to control the use of an addicting chemical has now become the physician's wish for the benzodiazepine to be controllable.
8. Many patients are able to use benzodiazepines within standard medical guidelines, and they stay away from other drugs. Some are not, and use benzodiazepines in the same way that many opiate addicts use methadone, as a legal addition to the palette of mood-altering drugs. The physician undergoes a kind of intermittent reinforcement that intensifies the physician's conviction that benzodiazepines are indicated for perceived underlying psychiatric disorders in patients with comorbid addictions. Intermittent reinforcement is, of course, more reinforcing than steady success. In good outcome cases, the physician has the wonderful inner experience of triumphing where another (the patient or other treatment providers) failed. A sense of power and mastery is induced (similar to the patient's sense of power and mastery).
9. When the physician is confronted by a case in which benzodiazepine treatment of an addicted patient is complicated by other addictive drugs, and, for example, the patient requires detoxification, the physician tends to dismiss the evidence as irrelevant to their own behavior, and to redouble their efforts to have the patient use the medication in a responsible way. (The patient's efforts to control the addiction and to still be able to use chemicals has now become the physician's efforts to have the patient use the benzodiazepine in a con-

trolled fashion.) In other instances, where habituation and tolerance result in complaints by the patient that they still have anxiety or insomnia, usually accompanied by psychosocial dysfunction, the physician may attribute the cause to psychiatric illness rather than lack of recovery from psychosocial dimensions of addictive illness. The physician now needs to address their impulse to raise the amount of benzodiazepine prescribed. (The physician has now joined the patient in being tempted to enter a cycle of continuously escalating use, perhaps repressing what they know will eventually occur, that in a short time the benefits will wear off, leaving only a higher level of physical dependence.)

10. When outside observers (other caregivers, or physicians who receive admissions to inpatient detoxification facilities) object to the benzodiazepine use, the physician angrily dismisses the input as cruel, unempathic, dogmatic, or ill informed. (Example: "Like many other classes of drugs that are extensively prescribed, the benzodiazepines have also been the focus of intermittent criticism by the lay media, much of it sensationalistic and without adequate basis".[10]

The denial system of the patient has now fully infiltrated the physician. They now share a mutual system in which they seek together to protect the use of the benzodiazepine despite the lack of control and the recurrent consequences of out of control use, including the recurrence of the original addiction. Rage is a comcomitant of addictive behavior.[4] The rage that the patient felt about the abrogation of access to mood-altering drugs is now a part of the physician.

EXAMPLES

This fantasy of taking over control of drug use for the patient is nicely expressed in a few short sentences by a well known addictions expert writing without apparent conscious knowledge of the fantasy as an expression of codependence:

> One survey suggested that 20% of alcoholics used other addictive drugs conjointly while another estimated the prevalence as 60-80%. Our own experience suggests that even the higher estimate may be somewhat conservative. Because of this tendency of alcoholics to substitute sedative-hypnotic drugs, the usual clinical dictum has been to use such drugs very cautiously in the treatment of alcoholics, lest one foster dual abuse.
>
> (Right so far. Watch what happens next.)
>
> The judicious use of benzodiazepines in alcoholics, if carefully monitored, may be beneficial. Indeed, were it possible to substitute benzodiazepines entirely for alcohol, most authorities would consider the tradeoff to be advantageous."[12]

(We physicians could take this over and do it right!)

In an article on anxiety and addiction, the author[13] demonstrates this alliance between an addicted patient and a codependent physician as his recommended method of treatment:

> Because addicted patients in recovery are likely to encounter negative reactions to their use of benzodiazepines in their AA or NA meetings, I suggest that they not mention their use of these medications in such meetings. . . . I have seldom seen a problem when these guidelines are followed, although on several occasions clinically anxious patients whom I considered to be using their benzodiazepines responsibly later defined their benzodiazepine use as problematic for their sobriety and took a dim view of my approach.

This passage shows steps 7 through 9 above. The physician is instructing the addicted patient to keep their use away from a public forum of knowledgeable experts on addiction, and restricts communications to situations where the physician and addicted patient can take on third parties who may not be in a position to oppose the physician's power and authority. The objections of patients who tried this physician's recommendations and had a bad experience are given no credence.

The non-prescribing caregivers involved in the treatment of these patients are weakened by the denial system of the benzodiazepine-prescribing physician involved. This physician is convinced beyond any reason that his or her treatment is of value to the patient. She or he luxuriates in being identified on the positive side of splitting, as the one who understands that the patient really "needs" this drug or the "good" doctor, while the other caregivers are hammered by patient and physician alike as ignorant, uncaring, doctrinaire; exactly the behaviors of the physician-patient pair that need to be projected out in the service of maintaining drug use.

The physicians who are particularly caught in this conundrum are those who assume the care of these patients in detoxification and are instantaneously identified as the "bad cop" (the benzo police) who is ignorant regarding a "biochemical imbalance" that requires benzodiazepine "regulation."

> Case 2: I admitted a 35-year-old patient for heroin detoxification. His psychiatrist was prescribing clonazepam, 2 mg twice a day. During the first admission this psychiatrist was contacted. He insisted that clonazepam was indicated for overwhelming anxiety of post-traumatic stress disorder (PTSD). The PTSD was the result of an incident that took place several years earlier when the patient was sitting in a movie theater while intoxicated on diazepam. The person next to him was shot to death, and the patient was accused of his murder. Both psychiatrist and patient insisted that the PTSD resulted from witnessing this overwhelming trauma. The psychiatrist insisted that the clonazepam was indicated, and that I was cruel to suggest that the patient should be detoxified from clonazepam, despite repeated abuse of this and other substances. The patient signed out

against medical advice, stating that he was going to get clonazepam from the doctor who "understood him." When the patient was admitted a second time for detoxification, the psychiatrist called, furious that I had told the patient that prescribing clonazepam was not good psychiatric practice. He listed his credentials (which, I inferred, were to show his superior knowledge). The patient had three more admissions for heroin detoxification within the next 6 months, all while maintained by his psychiatrist on clonazepam.

This was a case in which two physicians disagreed on how to treat a patient who was suffering and on the edge of death. Each was earnestly applying his model of illness to the patient's well-being. In the first model, anxiety was taken as an overwhelming state that had to be controlled for the patient to improve. In the second, anxiety was noted but relegated to a secondary status. The patient was encouraged to endure his anxiety in a supportive inpatient detoxification setting, to become free of addicting drugs, and to have a reassessment of his anxiety state after abstinence had been achieved. Importantly, the insistence of the first physician that anxiety must be controlled with clonazopam made treatment of the patient by an abstinence-based program impossible.

Codependence, like addiction, is a phenomenon that can only be established by two cooperating parties. In this particular case, there is not enough information given to settle the disagreement over how to approach this patient. The main value of this discussion is that having it equips each individual physician to examine his or her own inner feelings, and that it empowers non-physician caregivers or patients to consider the possibility that their colleague or physician has fallen into a codependent pattern. In the above case, a suggestion that the prescribing physician receive a second consultation from a psychiatrist specializing in addiction might have been in order. Within an institution such as an addiction treatment center or a methadone program, there can be a group "norm" that benzodiazepines are prescribed only after a discussion among multiple caregivers as to advisability.

COUNTERTRANSFERENCE IS INEVITABLE

Countertransference, the emotional response of a caregiver to a patient, is always only partially conscious. The following clarifications are intended to mitigate what might appear to be a critical tone.

1. It is the patient's responsibility to make the treatment work. In some cases, the physician will never be able to help because the patient will only accept help to stay addicted. In these situations, the physician can only choose between helpless anger about being approached for this purpose, or abetting the addiction. The patient will oppose attempts to facilitate recovery.
2. Not all patients manifest the degree of manipulation alluded to in this article. These patients are looking for help and are ready to receive it from an empathic physician.
3. Manipulation is the product of unconscious hostility that is an aspect of addictive illness. The physician's stance of uncorruptable boundaries is in itself a healing stance inasmuch as the physician maintains availability as an advocate for recovery when the patient attempts to pull the physician into a denial system.
4. Self-efficacy by the physician requires motivational enhancement of the patient's desire to engage in treatment. "Cure" is not the goal.
5. Physicians who treat other chronic illnesses such as HIV or diabetes may encounter similar feelings of helplessness regarding the use of opiates for pain. The urge to assume too much responsibility for the patient's outcome is an occupational countertransference hazard.
6. There is a fine line between empathy and codependence that involves overstepping one's boundaries and limits. Exactly where the boundaries lie in terms of prescribing benzodiazepines to patients with addiction is controversial, as can be seen in the accompanying papers. The goal of elaborating a potential countertransference error is not to condemn any specific psychopharmacologic decision.

CONCLUSION

Treatment of these patients is as complex as any problem encountered in psychiatry. From the physician's point of view, key questions to ask when considering benzodiazepine treatment for a patient with an addiction would be (1) should I prescribe a benzodiazepine when other drugs, which have a latency of onset but more or less equivalent long-term effect, exist, and (2) do I notice a countertransference warning that the patient is using projective identification, and feel an inner urge to assume a codependent role? In selected cases in which patients demonstrate convincing refractoriness to adequate trials of other efficatious non-addictive medications (such as antidepressants in the classes of SSRIs, tricyclics, trazodone and nefazadone, or buspirone or valproate), very careful trials of benzodiazepine medication might be undertaken. However, this should occur only with agreement as to which target symptoms are to be followed, and that bad outcomes, including renewal of active addiction, will be regarded as evidence that the benzodiazepine is contraindicated. Treatment of these patients is as complex as any problem encountered in psychiatry.

The use of psychopharmacologic interventions is sometimes a relatively simple and straightforward part of practice. At other times

physicians must be acutely aware of the dynamics of the patients they are treating, as well as their own. Nowhere is this collaborative approach of theoretical models more relevant than in the clinical treatment of the anxious patient with an addiction.

REFERENCES

1. Johnson B. A developmental model of addictions, and its relationship to the twelve step program of alcoholics anonymous. *J Subst Abuse Treat.* 1993;10:23-34.
2. Laplanche J, Pontalis, J-B. *The language of psychoanalysis.* Tr. Donald Nicholson-Smith. New York: Norton; 1973:18-20.
3. Sandler J: The concept of projective identification. In: *Projection, identification. projective identification.* J. Sandier (ed) Connecticut: International University Press; 1989:20.
4. Johnson VE. *I'll Quit Tomorrow.* San Francisco: Harper and Row; 1980.
5. Black C. *It Will Never Happen To Me.* Denver: MAC; 1981.
6. Brown S. *Treating Adult Children of Alcoholics, A Developmental Perspective.* New York: John Wiley and Sons; 1988.
7. Wegscheider-Cruse S, Cruse J. *Understanding Co-Dependency.* Deerfield Beach, Florida: Health Communications; 1990.
8. Cermak TL. Al-Anon and recovery. In: *Recent Developments in Alcoholism.* Ed. Marc Galanter. New York: Plenum Press; 1989;7:91-104.
9. Cermak TL. Co-Addiction as a disease. *Psychiatric Annals.* 1991;21:266-272.
10. Shader RI, Greenblatt DJ. Use of benzodiazepines in anxiety disorders. *NEJM.* 1993;328:1398-1405.
11. Dodes LM. Addiction, helplessness, and narcissistic rage. *Psychoanal Q.* 1990;59:398-419.
12. Hollister LE. Interactions between alcohol and benzodiazepines. In: *Recent developments in alcoholism.* Ed. Galanter M. New York: Plenum Press; 1990;8:233-239.
13. DuPont RL. Anxiety and addiction: a clinical perspective on comorbidity. *Bull Menninger Clin.* 1995;59:AS3-A72.