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Treatment of drug addicts by a professional staff team using a therapeutic community and group psychotherapy

Gabriel Roldán Intxusta

ABSTRACT: The paper describes a treatment programme for drug addicts run by professionally trained staff using a psychodynamic model of understanding drug addiction, with a wide range of opportunities for work, training and for psychosocial interventions. Treatment takes place in three phases: admission/diagnosis and treatment planning, residential treatment, and follow up. Apart from a brief 'isolation' phase links are maintained with the patient's external environment. A central place is given to the use of group psychotherapy and the recognition of transference and countertransference in groups and in the TC as whole, and on therapeutic work with patients' families who often manifest addictive patterns of behaviour.

The author reflects on the nature and impact of the dynamics of working with drug addicts and the need to mobilise a change in the patient's perception of themselves from being passively brought to treatment to becoming aware of their underlying interpersonal needs.

Introduction

In Europe it has not been easy to incorporate the treatment of drug addicts into existing services. At first there was a rejection by many health professionals of people with drug addiction problems, either because they were difficult patients, challenging and unrewarding, who acted out their conflicts transgressing norms and making conventional treatment difficult, or because clinical knowledge was in dispute. This situation led to the creation of specific services. Some stressed limit-setting and norms, others the prescription of substitute drugs. It also led to the appearance of numerous non-professional groups which started caring for drug addicts within a framework of rigid and authoritarian therapeutic communities based on American models such as Daytop and Phoenix House,

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which used harsh group confrontation techniques. The teams consisted mostly of ex-drug addicts and/or religious organizations. This type of TC occupied an important social space, as a consequence of which many people came to believe that all TCs apply these kinds of techniques. Professionals in some countries rejected the TC for this reason.

In 1985 a movement developed in Spain among different professionals working with drug addicts in TCs aimed at a consensus in their practices and common norms to validate the existing professional TCs (about 40 TCs). This would provide a basis on which to debate working experiences and to research process and outcomes, thus creating the scientific knowledge which would allow this type of therapeutic intervention to evolve.

This work, which was started in the APCTT (Association of Professionals in Therapeutic Communities for Drug Addicts), has been continued within the framework of ERIT (European Federation of Drug Workers Associations), ITACA (European Association of Professionals Working with Drug Abuses) and FDHE-EUROTC (European Treatment Centres for Drug Addiction) among different therapeutic communities in various European countries. As a result different models for work with drug addicts in TCs are being defined, and this is essential in order to evaluate treatments in an objective way.

The examples I shall refer to derive from my own experiences in the Haize-Gain TC, San Sebastian, Spain, founded in 1982. It was the first centre of its kind in the Basque country and one of the very first in Spain. It was promoted by a benevolent private institution, A.G.I.P.A.D. (Guipuzcoan Association for the Research and Prevention of Drug Abuse), initially with financial support from public bodies such as the Regional Government of Guipuzcoa, and is presently funded by the Health Department of the Basque Government. The service is provided in cooperation with the network for primary health care, mental health care and social services. The TC programme has 3 phases: Admission-Diagnosis (outpatient phase), Residential Care, and Follow-up/Social Integration. This programme is complemented by a crisis service and a day-centre. In 1998 it cared for 115 people, 55 of whom took part in an intensive group experience.

Clinical aspects of drug addiction

The problems of drug addiction across a wide spectrum of young people in society are relatively recent, having emerged over the past 20-30 years. Drug addiction is a problem with different aspects - physical, psychological, social and/or family - which some authors define as a biopsychosocial disease. Each drug addict is unique with his/her own history and his/her own specificities, "a subject subjected to drugs" (Korman 1994) in need of a tailor made treatment.

When talking of drug addicts I shall refer to those people treated at the Haize-Gain Therapeutic Community, most of them males (80%) aged 20 to 45, who started using drugs in their pre-adolescent years and developed an addiction to an

illegal substance, heroin in 80% of cases. Their more recent years have been lived around this illegal substance allowing them to 'live as a drug addict' as if this were a profession, to the point where their closest social network, their attitudes and even language revolve around drugs. We cannot talk about a basic personality structure behind the drugs but we can talk of traits or character traits, and various severe pathologies including depressive disorders, psychotic disorders, narcissistic personality disorders, borderline personality disorders and antisocial personality disorders.

In a study carried out between 1982 and 1992 with patients cared for in our centre, we found that the specific features of addicts in treatment seemed to be more in relationship to their exclusion from the education system (early abandonment of studies and school), their problems with the law (indicted for offences, 1/3 of them in prison) and their health status, rather than in their difficulties in social integration (García *et al*, 1995)

We are also continuously talking with the drug addict about addictive family patterns, which complement those factors that predispose an individual to develop a drug addiction. Addictive ways of doing things established within this primary relationship system are hardly recognised as such by the patient who is addicted to drugs. Thus there is a need to work with families which operate as if the possibility of thinking, waiting, or controlling impulses does not exist. In 42% of our cases there appeared to be drug addiction situations within the family unit, and in 32% of cases we detected psychopathological antecedents.

The people coming for treatment are, in many cases, brought by their families or referred by the judiciary system. They often arrive in a state of physical deterioration, 30% are HIV positive, and they also have serious problems with their social and relationship environment. There is little recognition of any problems or difficulties beyond drugs, no awareness of being ill, and the benefits they expect when demanding treatment are usually more to do with not going to prison, sick leave, unemployment benefits, keeping their jobs, etc.

The patient mistrusts and is suspicious of the therapist, whom he regards as foolish because he does not know what drugs are, or as hypocritical because he denies them. 'Drugs are the best, what can you know about them if you never were a drug addict?' There is no wish to explore the space occupied by drugs, nor is there any desire to give them up. This is something that the subject begins to discover in the course of treatment over a period of months. As the patient starts to acquire a knowledge of themselves within a process of differentiation, they undergo a transformation from a state of relative simplicity in their structure towards a more complex state. 'Drugs are not the only thing I lack, there are many other things lacking too.'

> "We all lack something: the difference is that some feel it, others do not or behave as if they did not and then they are hypocrites". (Miguel de Unamuno, (1993) *The tragic feeling of life*)

How does one work within a TC treatment with the characteristic demand from drug addicts: I came here to quit drugs

There is a wide and varied range of personal situations related to drugs which sometimes require care from professionals, which usually start with a request for help from the user. Working with this initial demand allows the establishment of a therapeutic relationship and an intervention strategy. 'The first demand is not the ultimate goal of the intervention but only a first fundamental element which points out upon what, and towards what, we have to act, a diagnosis of the situation' (Megías, 1987)

First phase: Admission-Diagnosis

The goal is to analyse the demand, to advise and to offer the type of treatment best fitted to the therapeutic and social-educational needs of each person. The time span goes from several days to months depending on the problems of each patient and the attainment of physical detoxification. The goals (individual, family and social) for different interventions in the various phases are established, and agreement for the goals among the different professionals involved (educators, psychologists, doctors, therapists, social workers). See Table 1.

Second phase: Residential

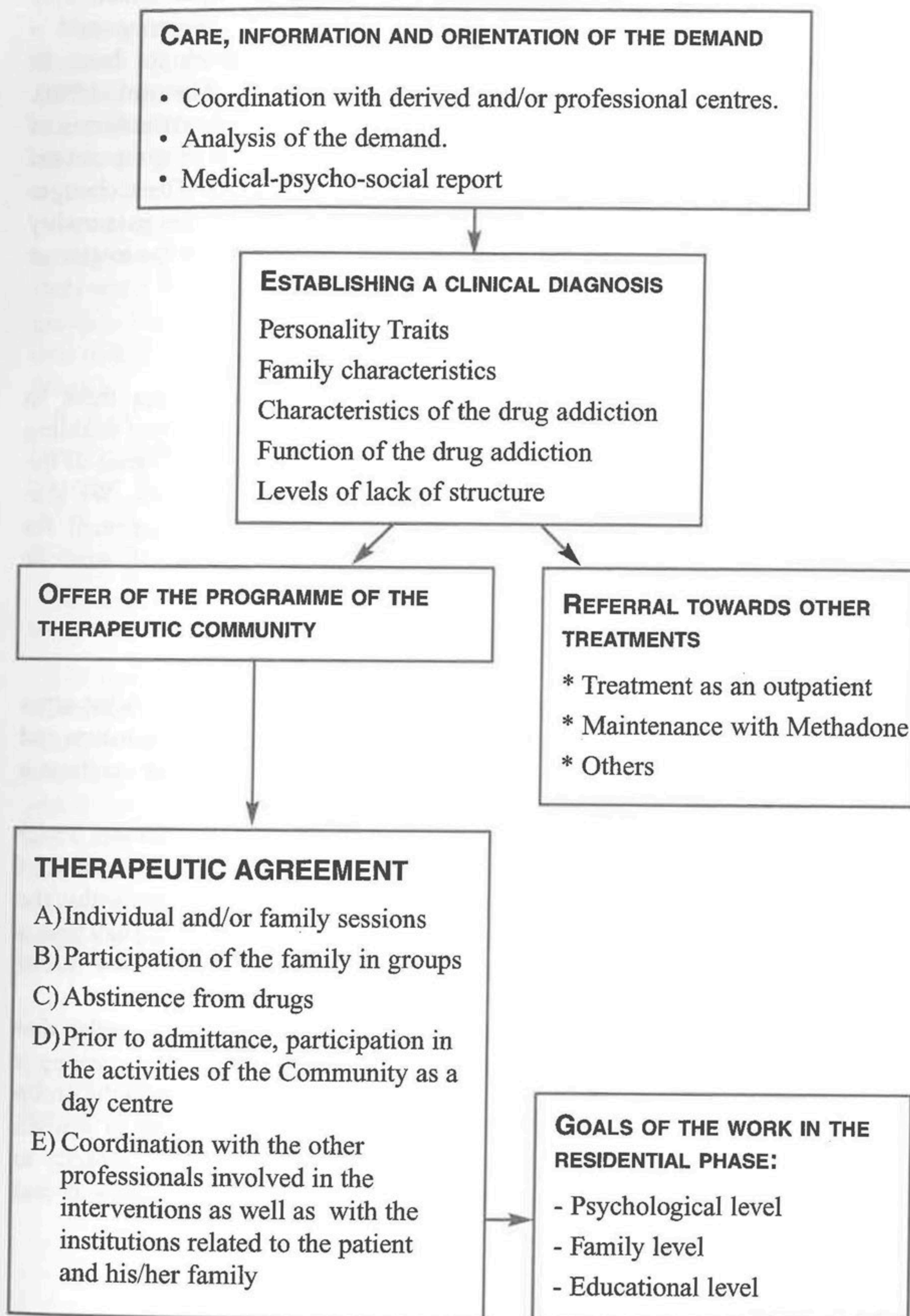
This phase, lasting from 6 to 12 months, is the only residential one. It is made up of two parts: isolation from the patient's usual environment for 1 to 4 months, then progressive contact with the usual environment.

Different aspects are dealt with using the support of educational-therapeutic technicians in the areas of work, training, social and cultural interventions, etc, in order to acquire responsibilities in a progressive manner and to solve the interaction conflicts arising during the whole of the process.

It is the group itself, both its dynamics and structure, together with the team, that creates a sufficient environment to reach the goals set in the short, medium and long term. The TC structures itself in such a way as to respond to the family links, transference and countertransference situations, which appear in the relations with others and with the therapeutic team. The structure includes the following educational and therapeutic frames: family therapies, multifamily therapies, individual and group therapies, occupational ones, social/cultural and social/therapeutic ones. It is expected from the patients that they commit themselves not only to helping themselves but also to helping in the treatment given to others; each one of them progressively takes up responsibilities and actively participates in the activities of the TC.

The objective is to make it possible for the person to start questioning, and acquiring and developing capacities in their relationships with others so that these become less painful and conflictual. This process involves trying new responses in

Table 1. Phase one: Admission-diagnosis work with the demand of the drug addict



their interpersonal repertoire within the group, with the knowledge and support of their peers and the professional team.

This is a dynamic process which implies successive changes which may appear in different stages and which have an internal coherence and a progressive sense towards a human condition which we wish to deem as integration of the persons, maturing, emotional balance, etc (Mascaró, 1990). We ought to see these changes as moments of destructuring and restructuring of the personality. They appear in the behaviour of the patient, both in interpersonal relationships as well as in specific attainments and inner feelings. These changes are the statement of a deep transformation in the structure of his/her personality and may happen in a silent way or in an unexpected manner once the treatment is completed.

Third phase: Follow up-Social Integration

Each patient has an individualised follow up which accompanies them in adapting to their social environment, helping with the difficulties and enabling them to make use of their own personal resources as well as using those of the community to which they belong. It lasts approximately 12 months. We also respond to the requests of patients who have completed their treatment for support in moments of crisis or relapse, advice in relation to legal, work or illness situations.

The task of the psychotherapy group

In TCs which have as a goal the active participation of their members what often happens is that difficult situations and problems arise which make relationships and cohabitation difficult. There is a need for an open space for reflection, without a script, which allows examination of the group dynamics.

To this end we have built an institutional mixed group of between 15-25 members, with one weekly session, compulsory attendance, and for a duration of approximately 9 months. It is an open group made up of patients who are within the TC excluding those who have been there 2-3 months (isolation phase). They have a greater degree of autonomy and spend most of their time within their social environment.

The role of the therapist is to create the therapeutic space and the relationship that enables the patient to use their own resources for their own cure: by creating a matrix which gives cohesion to the group and becomes the depository of the group unconscious. It is a question of helping the group to elaborate and to contain anxiety within tolerable levels in order for the members to develop a capacity to understand and to help one another, enlarging the repertoire of their answers and making things happen differently.

There are two rules for the members of a group of drug addicts.

(1) Not being intoxicated when attending the group meetings.

Stating as a pre-condition the disappearance of the symptom which creates the demand sounds paradoxical. However, dealing with acting-out is one of the repeated moments of crisis in the life of the group which is going to challenge the tolerance of frustration and the acceptance of difference, and as a consequence of which, the growth and the life of the group. Working with different groups of drug addicts in an outpatient mode and in residential mode, I have found that it is an essential pre-condition to recognise and to exclude those members who are unable to stop using drugs, and this during the very first months of the life of the group. Only when the group has already been working for a long time is it possible for the group to handle episodes of drug use, and this once it is pertinent, when it owns its own matrix and when the members can establish links from experiences other than drugs.

It then becomes necessary to control abstinence and to do this from a complementary individual space, for example, urine tests performed by an educator or assistant. If such a task is performed by one of the members of the group (therapist included) the work becomes more rigid and the tension and anxiety of the group makes its development much more difficult.

(2) Confidentiality (the information from a therapy group cannot be taken out of the group)

The transgression of confidentiality appears frequently in groups developed in institutions (i.e. therapeutic communities) and in programmes where there is a combination of families on the one hand and drug addicts on the other. In small communities such as ours, where rural and/or marginal ties are closer, there appear added difficulties in therapeutic work because the members of the group can share new social spaces, and it is difficult to preserve group intimacy. This is the reason why I try to restrain the exploration of traumatic situations which may have consequences for those outside the group and try to steer towards helping the subject to approach them within a space offering greater safety.

Different processes within a group of patients addicted to illegal drugs.

At first there is no other personal history than the history of drugs. The subject appears without memory, he/she does not remember anything outside drugs.

- New member: "I've come here just to see what it's all about".
- Another member comments on some aspects of how it works.
- Another member: "Introduce yourself, tell us about your life".

- New member: "Well, like everybody else I started smoking joints (hashish) with my mates at 12, then at 13 speed at the week-ends, and at 16 I sniffed coke and horse (heroin) and then, at 18, I started shooting up every day ..."

There is a probing amongst peers of the elements which shape the identity of the drug-addicted person. The story is repetitive and monotonous, there is an unfolding of well-known episodes, an exploration of common codes and places (prison, dealings, substances, rituals, drug networks). He is going to relate what the others expect him to. "I say something in order to speak" is replaced by "I say something in order to define myself as a drug addict speaking".

At the beginning group therapy is badly accepted by the patient, it is threatening. In some instances the subject falls asleep as a sort of defence mechanism against the foreseen unbearable anxiety (Foulkes, 1969). To rethink and to question oneself in a group means to become aware of the deprivation, a painful questioning for a subject who affirms that the only thing they are is deprived of is drugs; it is only after a few months that they can start identifying other interpersonal needs.

A process is put in motion in the matrix of the group where the first changes can take place, the first insights so that, and only in time, the patient may tolerate things which he rejected before. There appears a recognition of authority either through an attitude of submission or of rebelliousness: "Can you repeat what you've just said?" "I don't understand a thing". The work of the therapist as enabler of communication and of the growth of the group process is arduous and wearying. The mechanisms of defence (flight, silence, theorising, displacement, attack) multiply; there is advancement and regression.

I believe it is appropriate to cooperate with a co-therapist of a different gender, which allows working with the intense transferences of parental figures. We often find that many of these subjects have endured traumatic episodes of continued violence and/or abuse from the father or the mother. In critical or unsettling situations, I observe that members benefit more from active interventions than from attitudes of observation or of listening. It is necessary to be directive and to interpret the acting-out.

From the beginning of work with persons with a dependent structure it becomes clear how important separation is: the breaking-off and the haunting of death are elements which are going to accompany the encounter from the very beginning. Fatalism is the end of the encounter: "to perceive that which I lack when it is not there anymore".

Healing factors intervening in the experience of the group

The relationship among equals encourages the learning of negotiation, cooperation and competition, areas that are basic for interpersonal development. Introjective identification helps the patients to better understand each other's problems and

through this better emotional links are established. Through the experience of universality the patient perceives that others also share guilt feelings and affective problems (Mansilla, 1996).

> "In the group I can see people inside out; I can connect with the feelings and emotions of some, I feel them, I am not the only one who is afraid, anxious or wants to cry and cannot. I can share my fears of failure because I realise I am not the only failure in the world". (Javier)

Psychodynamic exploration allows the re-experiencing of conflict within the family relationships in the here and now, and also the possibility to get to know oneself better by rewriting one's personal history.

> "They thought I had nothing to tell, they said: 'go into therapy!' What for? ... what am I going to talk about? As I listened to you I realised the burden I carry, of how my brother is in prison dying of AIDS; I always imitated him, I wanted to be like him in order to get my parents to love me because they worried so much about him when he used drugs! But today, they say: it is better after all that he is in prison! Less problems. (Crying) It's gut wrenching". (Sebas)

Another essential healing factor for dependent people is to know how to express feelings and to understand that the advice and support we may get from others have limits, and that the ultimate responsibility for our behaviour is ours. Even though we can relate to others there is a point beyond which nobody can accompany us any more, an essential solitude to life which should be confronted and is unavoidable.

> "My parents never loved me; we got by among siblings. My father maltreated my mother and she left on four occasions, one of them with another man. My father is like a big beast which terrified me and which I wished to kill. I've always been wretched, I need your affection, don't reject me!" (Aitor)

Quite a large proportion of heroin addicts attending the groups are HIV positive or are developing AIDS. This is a harsh reality which has been appearing in Spain in the last 10 years, adding a further blow to the psychopathology of some drug addicts (Roldán, Berasategui, 1987). The foreground of the picture is taken up by the fear of death and by interpersonal relationships, it depresses him to feel abandoned, rejected by the world of the living, what to do against the unavoidable? I consider it adequate for HIV positive patients to combine their stay in the Community with attendance at specific groups for those who are HIV positive formed within associations for them, where they can find continued support and advice for as long as they need it.

Non-verbal techniques, and especially psychodrama, have been very much

developed in working with drug addicted patients, given the difficulty of working with only verbal groups and the fact that much of their psychopathology is characterised by going into action. For Fernández March (1986) the group is the transitional space between the family and the outside. In psychodrama the resolution of the fusion with the mother is achieved and the deprivation of affection can be acted out.

As to the duration of group psychotherapy, Yalom (1975) comments that between the third and sixth month patients in group therapy often change their therapeutic goals. Their initial goal, to relieve suffering, is later replaced by other goals, generally of an interpersonal character. Thus the goal of expecting relief from anxiety or depression changes to a wish to communicate with others, to trust more and to be more sincere with others, to learn to love. One of the first aims of the therapist is to propitiate this change of symptoms into interpersonal projects.

The experiences I know of group psychotherapy with drug addicts are limited in time (1 year). However, these people have needs that are much more long term, and we encounter patients who endlessly go from group to group, from institution to institution, who we call "chronic consumers of treatments". Groups appear to be their lifestyle or their life project. The observations of the Haize-Gain team agrees with previous work (Kosten *et al*, 1986) in suggesting that these "chronics" include patients who adapted themselves very well to our programme, and were discharged when it was completed. Not all the drug addicted patients benefit equally from the group experience. In general, depression and social adjustment improves but anxiety is not modified and extraversion increases in almost all of the cases (Espina, 1989). The end of therapy ought to be characterised by the realisation of a personal life project and by the elaboration of grief, because all personal evolution entails grief. Even the loss of marginalization is accompanied by grief because, although it is painful to be marginalized, it provides the subject with an identity.

Conclusions

The response given to drug addiction as a multi-causal problem entailing physical, psychological and social factors, should be given by a multidisciplinary team with well defined roles, with enough technical training and with a wide administrative autonomy which allows the team to carry out adaptations and changes deemed appropriate. Supervision of the members of the team is also necessary to help them by retrieving them from a form of human suffering which, insofar as it does not find relief, impregnates the institutions with disappointment and pessimism. This gives way to intense defence mechanisms in the patients, families and team contributing to add to the illness.

Treatment in TCs has as a basis for its effectiveness the attainment of goals related to the psychopathological and family problems implicated in the process. To

this end it is necessary to have an adequate system of family therapy, with a good group framework, which adapts to the needs of different people, plus individual attention for each specific problem.

Increasingly I see the TC programme as a resource with which to work with the initial demand of the patient: 'I wish to be without drugs for a time', enabling the person to connect with his/her own wishes, needs and limitations within a group context, but also giving attention to his/her own individuality. This base allows the work with the therapeutic team and steers the treatment and the future follow-up, complementing this with other care services. The person, in general terms, is more aware of what he/she wants and of how he/she wants it, making this an important step ahead in looking after oneself and in choosing what one wants to do with his/her own life.

Group therapy has limitations, but it appears as an adequate means of detoxification, and the group of peers seems valid too insofar as it acts as a place of transition for the making of a personal project, whereby the growth of a drug-free identity can be started.

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