Strategic Family Therapy Concerning Drug Addicts Treated in Therapeutic Communities

Luigi CANCRINI

Introduction

The concept of double diagnosis within the theme of drug addiction is a concept which has not yet been specified. Prominent psychological difficulties constitute the necessary preamble of every substance addiction that is always the expression of problems linked directly to the organization of personality.

The fact that clear psychiatric disorders are present in a patient who assumes substances or is in the phase successive to withdrawal, however, often creates problems of noticeable complexity in structures that deal with drug addicts:

- from a containment point of view as the structure may not be and/or may not feel qualified to deal with behaviours linked to psychiatric symptoms.
- from a perspective of therapeutic intervention and articulation as psychiatric symptoms may urgently require the evaluation of a specialist and can only be relieved by the intervention of such specialist.

Temporarily and conventionally we shall herewith consider as drug addicts in a double diagnosis situation, patients which present:

(a) a history of addiction to heavy drugs

(b) an evidence of considerable psychiatric symptoms that are not directly linked to the use of drugs or craving.

Sample, methodology of the research and results

The sample used for the research contains 172 users with double diagnosis who entered, from 1998 to 2003, three of the Saman Communities which host this type of use: " Le Vergini Nuove" of Borgo Sabotino (LT), " Villa Cilla" of Ravenna and that of Apricena (FG). For all 172 selected cases the fundamental prerequisite was the psychiatric diagnosis (in axis I and axis II) based on the consultation of a specialist from the sending Services and subsequently reviewed in the course of the permanence in the Community.

Summarizing, it is possible to characterize in the following manner the survey proposed for the entrance in a Community presented as specialised to host drug addicts with double diagnosis:

- in the majority of cases, it concerns users with a long history (more than 10 years) of drug-addiction who have experimented many therapeutic interventions and failures; in some

cases, however, psychotic breakdown was evident after a shorter period (1 to 3 years) of addiction;

- in half the cases, it concerns users whose "double diagnosis" condition was already evident from the Sert or mental health services which had them in charge; the remaining half of cases concern users who had recently received a psychiatric diagnosis during the course of treatment that was directed specifically to their drug-addiction problem;
- it concerns, in a currently limited number of cases, however potentially more important, of cocaine addicts and alcoholics carrying chronic psychiatric problems;
- in all cases it concerns users sent to Communities from services which had them in care; the involvement of the families who had been therapeutically supported initially, was a determining fact in the majority of cases; considering that the admission is formally a voluntary admission, the families played a determining role in making it possible as it is very rare that the user will refer to the Community themselves;
- in the majority of cases, it concerns subjects who live in serious conditions of social alienation.

The majority of subjects which form the sample are males (72%), between the ages of 25 and 34 (57%), not married (79%), with an education level lower than average (58%) and unemployed in 76% of the cases. 96% of the users can be arranged in "transition" drug abuse (of type C) and 4% in the sociopathic one (of type D) based on the classification given by Cancrini (Cancrini L., 1982). The absence of type B drug abuses, the neurotic ones, should be noted; although present in Saman Comunities they do not present characteristic problems in users with double diagnosis.

Focusing on the substances of abuse, 40% of the consumers use heroine, followed by 26% who use various drugs, 16% are alcoholics, whilst 11% are primary cocaine users. Half the sample which enters Communities decide to do so after a long history of drug abuse (>10 years) and various therapeutic attempts.

Users enter structures for double diagnosis with a pharmacological therapy set by the Services which successively is taken charge of by the psychiatrist of the Community. The possibility of "parting" from critical life conditions allows users to reduce the pharmacological load with which they enter the Community. At their first entrance, 22% of the users manage to overcome the therapy and 42% manage to reduce the load of pharmaceutical dosages compared to those initially used. Only a limited 36%, do not succeed in getting rid of the pharmaceutical dosages, this amount refers approximately to the unsuccessful cases.

Diagram n.1: Diagnosis of ct in axis 1

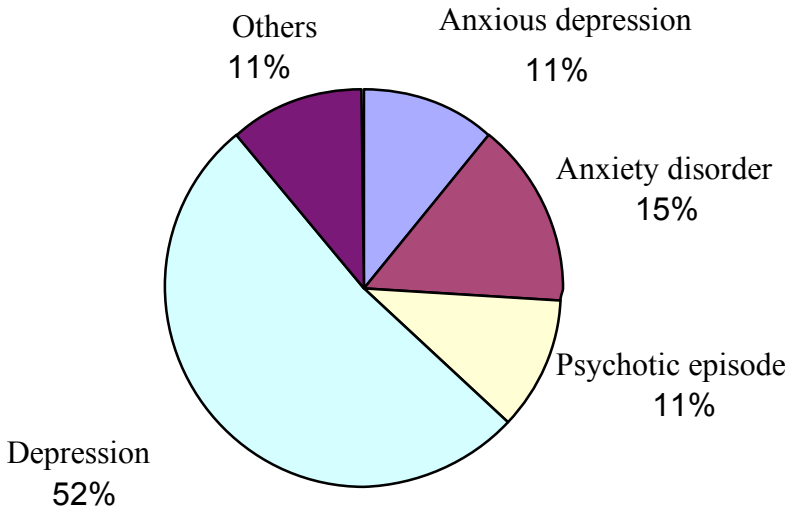
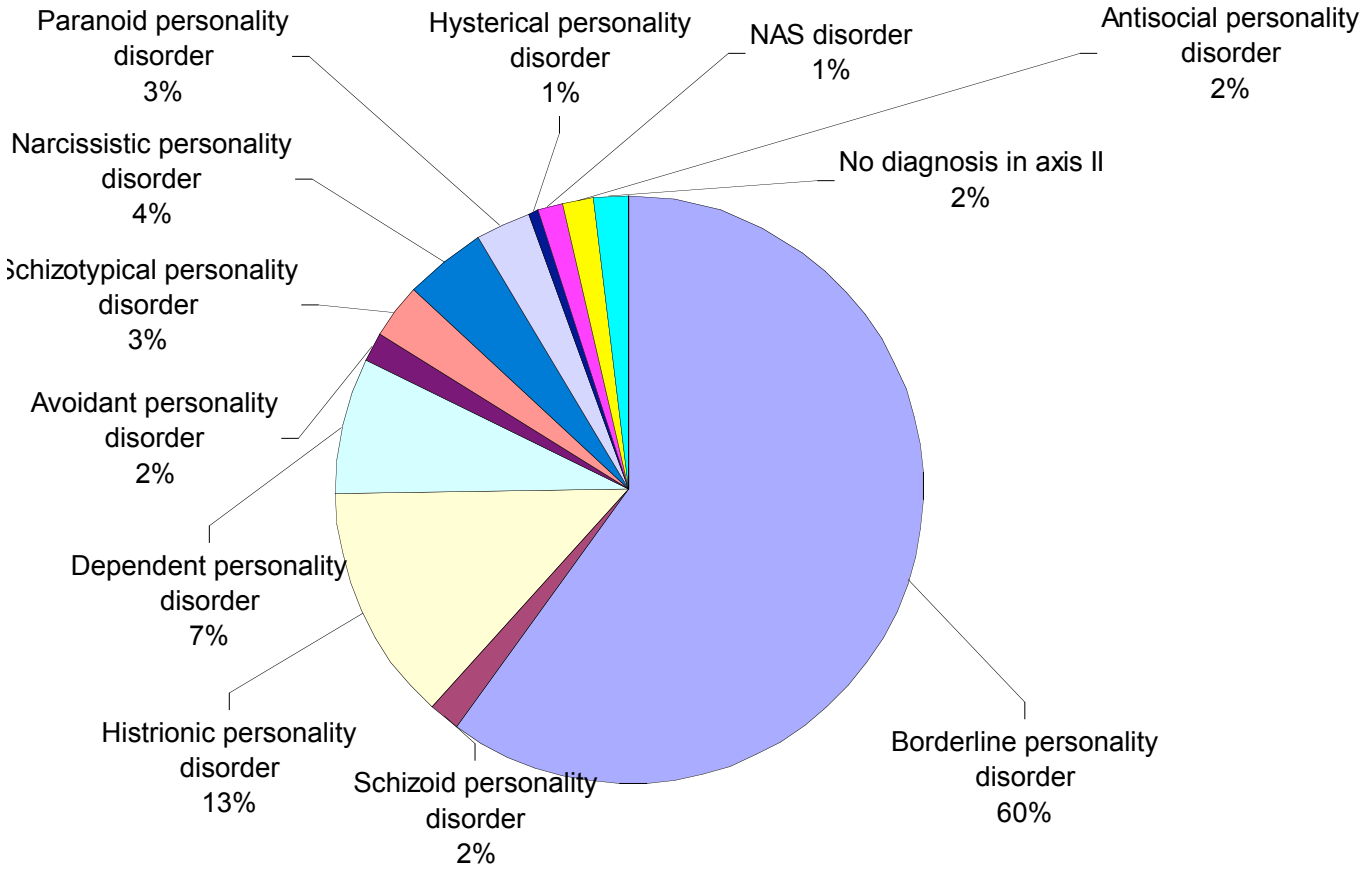


Diagram n.2: Diagnosis of ct in axis II



The therapeutic program

The therapeutic program of Therapeutic Communities of SAMAN was organically restructured in 1996. In brief, it is a program based on a systemic-relational perspective which involves the user's family of reference therapeutically. It's the Community that, starting from a certain moment, takes care of the user. Particular attention is made during the initial phase, in the motivation of the users and their families; during the stay in the Community, on the consensuality of the transformations that may occur at two levels; in the final phase, regarding problems which arise in the family after discharge.

Bearing this in mind, the possibility to open a Community to patients having double diagnosis has been seen, since the beginning, as something to be verified. There is in fact an important connection between the seriousness of the psychopathology and depth of the bonds which connect the user to the family. The problems which had to be overcome to make the experiment realistic, on the other hand, were essentially two: the lack in their community of competent psychiatric and psychotherapeutic specialists and the rules on which the life of a Therapeutic Community for drug addicts are based upon which have to be adapted to the particular needs of this kind of patients.

The applied modifications to the basic program of the Community to admit users in double diagnosis were in this direction. An expert psychiatrist has scheduled a weekly presence in the Community and is in charge of following the pharmacological therapy of users with double diagnosis: updating it and supplying adequate information and consultation, to the operators of the Community. The number and presence of psychotherapist and psychologists has increased considering such problems. As far as the flexibility of rules is concerned, the following has been agreed:

- to maintain the percentage of users with double diagnosis below 30% and to ensure the presence, in Community, of a high number of users close to the final phase of treatment and who are therefore able to collaborate with operators to maintain an organised community life as close as possible to that foreseen by other Communities of the group;
- to discuss from time to time with the psychiatrist the possibility of identifying a timetable and list of activities that the user must respect, considering their actual resources, the pharmacological load and level of their symptoms;
- to personalize duration of residential program: making clear contract with the user before the admission;

- to socialize in the group, the reasons for which flexibility was adopted and the predictable time of its duration.

One last decision was taken regarding supervision. Entrusted to a "systemic" psychiatrist with long experience with this group of operators, this takes place, preliminarily, on a weekly basis; it is open to all operators, professionals and non professionals to guarantee a homogeneous and coherent behaviour of the staff; it takes place in locations external to the community.

Results

The literature on this argument shows a significant correlation between the duration of stay in CT and the success of treatment. This circumstance allows us to retain that the duration of stay in CT is a useful indicator of efficacy.

Particularly interesting, from this point of view, are the results shown in diagram n.4, which indicate that 57% of the subjects remain in the Community for a time longer than that initially agreed.

Diagram n. 3: duration of stay in CT

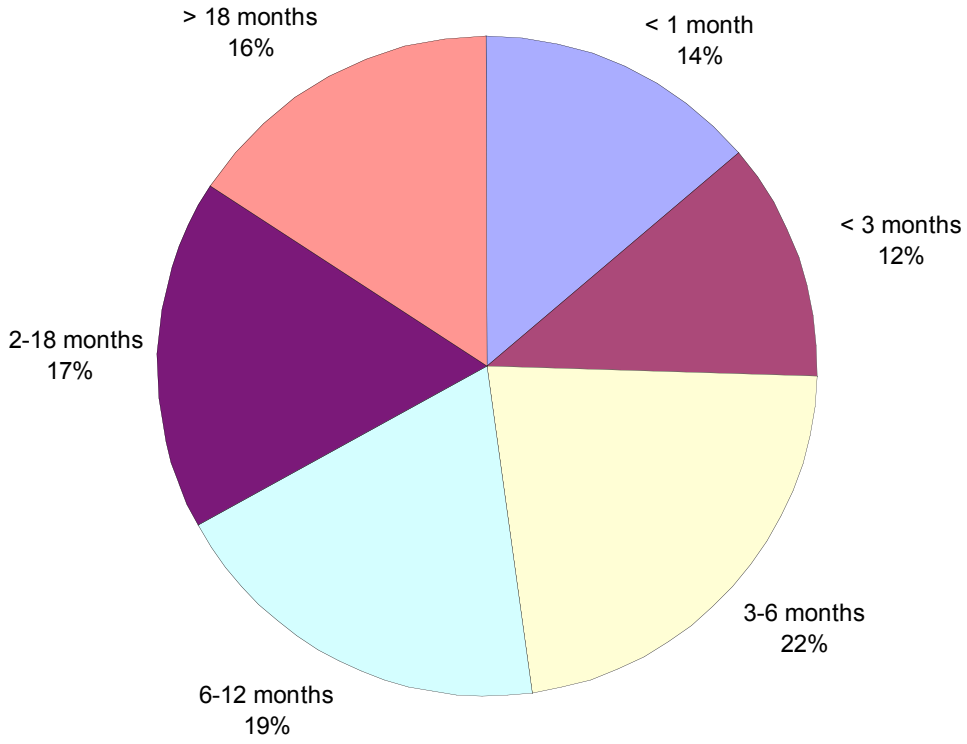
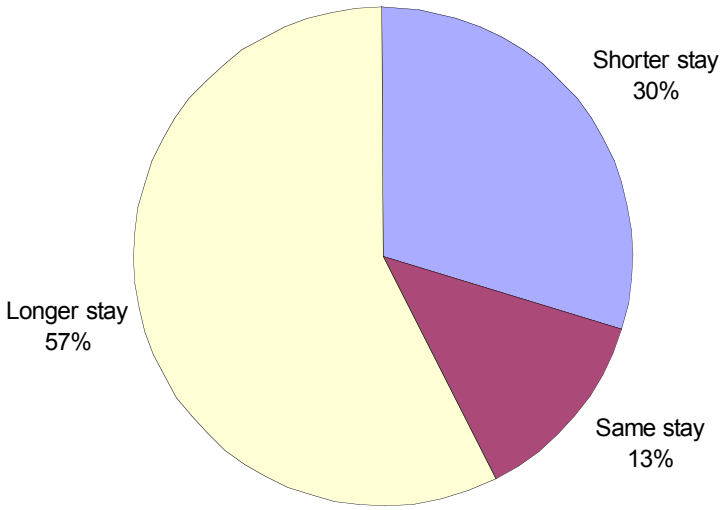


Diagram n. 4: duration of the program with respect to the program initially agreed



As far as the number of entrances is concerned, the majority of the subjects (70%) only enter the Community once, 28% enter two or three times, and only 2 % enter more than thrice.

The evolution of the program followed by the users of the Community has been elaborated, by the operators, considering three aspects of the community course of the subjects in double diagnosis: the ability to adapt to community life accepting its rules and activities; the chance of reducing or eliminating the pharmacological therapy maintaining drug abstinence; reaching final objectives in the therapeutic contract such as relationships with family members (in the family of origin, the couple and the family of procreation) and economical and residential autonomy. Based on these criteria the efficacy of the community was evaluated: a noticeable improvement in line with the three points examined was determined in 57% of the cases and a significant, but modest, improvement clashing with some of the criteria examined, in 25% of cases.

Conclusive observations

The obtained results clearly show the reliability of the hypothesis which we formulated regarding the possibility of adapting our standards program to the particular needs of these users. More specifically the reception of the users took place with certain ease. The non professional operators reacted developing affectionately protective reactions. The conflict between specialists and educators was contained within governable limits and however without much difference from those recorded in other Communities of the group.

A rapid improvement of acute psychiatric disorders evident at the entrance was evident in almost all the cases. This allowed a high percentage, to reduce or eliminate the pharmacological treatment.

Psycho pathologically, such improvement was connected mainly to the parting from situations of violent tension lived within the family environment or other structures of origin. The adaptation to a new interpersonal situation, structured but substantially welcoming and willing, on the other hand corresponded to the mitigation of behaviours characteristics of the personality disorders. At this point, in most cases, a more realistic evaluation of one's conditions, a structured request for help, a more aware acceptance of one's need of therapy is possible.

These considerations allow us to propose a simple hypothesis on genesis of situations in which services provide a "double diagnosis". We will articulate it in five steps here below.

A. Childhood and adolescence of people who develop drug addiction are marked, usually, from a series of difficulties which may determine the development of personality disorders.

B. The crystallization of personality disorders is determined, usually, at the beginning of the adult age in the phase which systemic therapists define as phase of release from the family; the regular use of drugs and the environment in which it is used play an important role in determining this crystallisation.

C. The successive phase is, usually, a phase of "apparent equilibrium" in which the regular use of drugs is accompanied by typical behaviours of disturbed personality but hides the presence of psychiatric symptoms in Axis I

D. The moment of double diagnosis occurs when the equilibrium linked to the regular use of drugs breaks. The depressive reactions, problems of anxiety, psychotic breakdown are determined when the drugs are no longer enough. The requests of the person change, the point where the drug addict "reaches the bottom line" is nearer. This last consideration should be underlined. Symptomatically, the moment of double diagnosis presents itself as a particularly serious moment. However, from the point of view of developments, from this phase a true therapeutic job can begin. The patient no longer believes in drugs, they can become an efficient partner in a therapeutic alliance with whom risks being close to them during this phase.

E. Observed from the perspective of the cycle of life (Haley, Erickson) the passage which the user had not undergone is that of release from its family of origin. The years lived in phase C have been years in which their projects of autonomy have been stopped and their illness maintained them in a condition of emotional, and often economical,

dependence. Psychiatric crisis and work developed in care with family members push them to make a change utilising their dependence, paradoxically, to search for autonomy but interrupting, with the therapist's help, all the complicity with the symptomatic behaviour and with the condition of "child who can't make it". The Community, then, provides psychotherapeutic work targeted in recognizing the depressive limit and difficulty of the moment in which a person can no longer use mechanisms of denial connected with the use of drugs. It is the care unit again or other therapists, at the end, who have to support the user to achieve the designated release from the family.

You can surely declare, summarizing, that the work done by the care unit and community is, in time, A JOB OF SYSTEMIC FAMILY PSYCHOTHERAPY. The premises are not only the therapist's studio and it is not just one therapist. The organization and supervision of the therapists in the different phases is systemic.

A typical case

Simona, 26 years old, lives by herself from a few years; she studied but is not in a position to support herself alone. Two years before the admission she began misuse of different drugs, particularly cocaine. The addiction was immediately heavy, Simona interrupted her studies and relations with the family. Psychotic breakdown intervenes after the breaking off of a love story. Alarmed by neighbours, the parents find Simona locked in the house. She has terrifying "visions" screams and threatens to commit suicide. Admitted to the psychiatric department of a hospital she stares into space, cries, talks in a senseless manner but follows the nurse and accepts the proposed treatment without particular difficulties.

Simona's recent story is proposed by family member as a story of increasingly sharp conflicts which have been going on for the past two years. Simona does not accept any type of rule, takes drugs, sees "dangerous" people, refuses to justify her behaviour. There have been at least two or three episodes similar to that which forced Simona to be admitted, they say, connected to mass assumption of drugs, maybe, cocaine. The attempt to try and compromise and let her live alone, they insist, failed miserably as Simona, with this crisis, proved that she cannot take care of herself.

In hospital, Simona improves rapidly. She speaks of "voices" and "visions" but she gets rid of them. The passage to a Therapeutic Community helps her further and allows her to "rewrite" her story. Speaking initially, of her adolescent anxiety and "rebellions"("as many other do at this age") and after, of a complex relationship as a couple. It was in this relationship, unhappy from the start, that Simona feels like she has changed blocking her studies and beginning her addiction to drugs.

The progressive increase in tensions with the family brought about complete interruption of relations and parents and sisters never knew anything about the importance of her love story. Breakdown came few months later in a situation characterised by loneliness and addiction. The family perceived an increasingly strong challenge with them, she lived the situation as a total failure.

Simona's story clearly shows the fundamental passages of the therapeutic course summarized in this paper. The release from Simona's family is the fundamental objective of intervention. The involvement and collaboration of the families allow development in a project which is then targeted on the person. The coordinated work of more therapists is developed in a systemically-relational perspective. The resulting experience opens interesting prospects, in my opinion, for the organization of efficient protocols of systemic intervention at an educational level which takes care of drug addiction and double diagnosis.