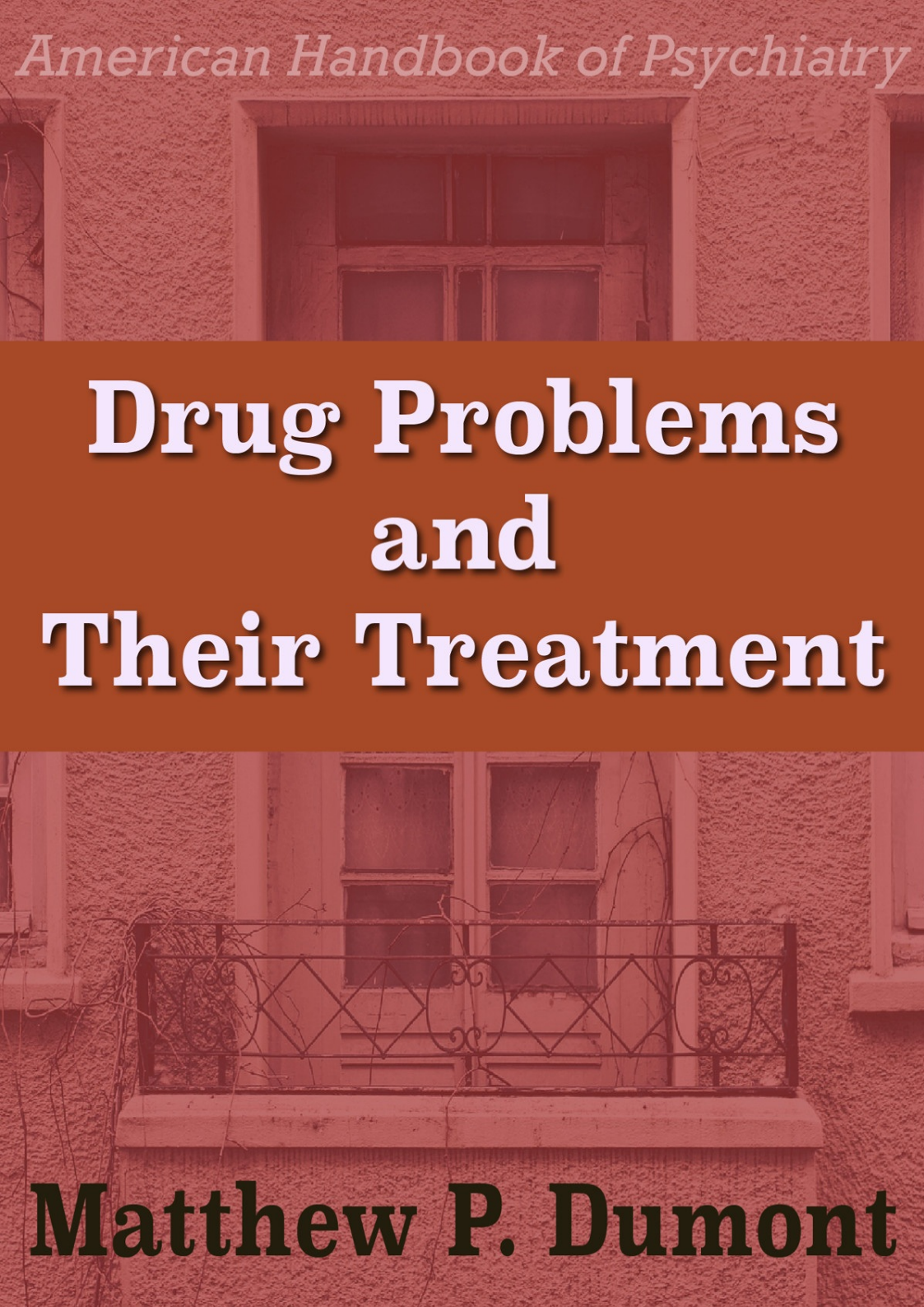
American Handbook of Psychiatry

Drug Problems and Their Treatment



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e-Book 2015 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 2* edited by Silvano Arieti, Gerald Caplan

DRUG PROBLEMS AND THEIR TREATMENT

Adolescent drug use will compel a moment of truth in American psychiatry. No issue is more deeply felt by the public. No issue more urgently demands a comprehensive approach encompassing preventative as well as therapeutic and rehabilitative interventions. And no issue more unequivocally challenges our traditional techniques.

The manner in which the mental health professions respond to the widespread anxiety about youth and drugs will be a final common path to a host of other ambient problems. Questions about professionalism and non-professionalism, the sick versus the criminal role, our relationship to public policy and legislation, and mental health aspects of the generation gap and social revolution all become inescapable when one engages the issue of drug abuse. In short, it represents a crisis for us as well as society, and depending on whether we can develop new coping capacities, we may be overwhelmed and completely ineffectual or develop a reinvigorated professionalism.

It must be emphasized at the outset that traditional techniques are ineffective. Individual psychotherapy has shown itself to be incapable of interrupting a pattern of drug dependence in significant numbers of patients. The fact that as a treatment modality it is a precious and inequitably distributed commodity additionally militates against a heavy investment of public and professional resources in that direction. The traditional mental

hospital approach with whatever combinations of individual and group psychotherapies, occupational and recreational activities, and milieu approaches has demonstrated no greater effectiveness.

In some minds incarceration itself has been viewed as an appropriate response to drug use by a society whose capacity for terror and rage has never been sounded. There may be little to argue with against this position as long as it is unhesitantly justified as a measure to protect otherwise wholesome communities from the dangerous behavior of the addict. If, however, there is the slightest inclination to think in terms of modifying the behavior of the drug user himself, incarceration cannot be perceived as a rational measure. Not only does it not work, but it perpetuates an environmental press of criminality, alienation, and hopelessness that exacts an incalculable toll on individual welfare and ultimately on society itself. Even those institutions most preoccupied with security cannot maintain an environment free of illicit drugs.

The quarantine notion of community protection, which implies that innocent children will be saved from exposure to an infectious process of drug use by incarcerating a critical mass of users, ignores the pervasiveness of the problem. Even conservative estimates of illicit drug use among the young indicate a prevalence of 40.9 percent.

Finally, to consign to prison a number of individuals who are selected arbitrarily or, worse, through a process of social, racial, or political bias as the bearers of a social problem is to close our minds to the sources of that problem outside the individual.

In the final analysis, the hasty imposition of either patienthood or criminality on a large population of drug-dependent youth evades the reality of illicit drug use as a collection of behavior behind which is as broad a panoply of individual, familial, and sociocultural forces as any behavior in the human condition.

There is no single psychological profile to the drug user. And while there are rough constellations of social variables that distinguish modal users of different types of drugs, there is no sociogram of the drug user with any predictive value. It may have been true two decades ago that skin color, social class, and family disruption provided correlations with drug addiction, but it is not true today.

There has been a rapid growth of heroin use among white adolescents of all social classes and family backgrounds. The most salient influence on a young person's proclivity to drug use is a contingent one, peer-group pressure. Ball concluded:

> In the case of both marijuana smoking and heroin use, the adolescent peer

group exercised a dominant influence. The incipient drug user asked his older addict friends to be included in the group's primary activity.

There was no evidence that the onset of drug use was a consequence of proselyting, coercion or seduction.

Onset was, nonetheless, a group process.

The implication of these observations is profound. We are not dealing with a population that is uniquely pathological or criminal.

A societal response to drug use premised on psychopathology or criminality is, then, worse than worthless. Not merely will it be ineffectual in interrupting drug use but it may, by its expectations, actually generate secondary behavior patterns of an ego-alien or dyssocial type.

Two states in this nation, New York and California, in their anxiety about widespread drug use within their borders, have, at great expense, developed large, locked, centralized, medically dominated institutions to treat addicts with the help of an involuntary civil commitment code. Without even the adversarial protections afforded a criminal, an addict may, on the opinion of a physician, be involuntarily committed to such an institution. Not surprisingly the evaluations of these programs are attesting to their uselessness. But apart from their representing civil libertarian monstrosities, I would suggest that there is no more devastating thing that can be done to a human being who is not essentially pathological or antisocial than to be called

sick and treated like a criminal.

One additional caveat must be alluded to before we discuss feasible alternatives. The practices of mental health have never existed in a political vacuum. The societal response to drug use in particular has throughout history been colored by an establishmentarian hostility to forces perceived as politically threatening. Blum et al. noted that seventeenth-century Moslem rules provided for the death penalty for coffee drinking as "the coffee house had become a meeting place for leisured political malcontents who were thought to be secretly hatching plots against established political and religious authority." The pharaohs suppressed drinking in houses of beer and wine for the same reason. Blum et al. concluded that "the holders of power responded violently to new drug use, which was symbolic ... of rebellion, separatism, or other dissatisfaction with the status quo."

We may not indulge the fantasy that contemporary America is immune from such irrationality. We seem to be entering a time in history when the young are looked on with fear. The polarization of generations, along with the growing fury of the color line, has created a political ambience in this country that many have likened to the onset of German fascism. It is the young and the black who are perceived as the users of illicit drugs. It should not be difficult for us to understand how such issues as preventive detention, "no knock" entry, and involuntary civil commitment as applied to drug abuse may be

perceived as having political significance.

These, then, are the issues against which a plan of public policy concerning the treatment of drug problems must be laid out: the ineffectiveness of traditional professional approaches, the inappropriateness of incarceration, the salience of peer-group pressure, and a sensitive political context.

With this background, a renewed and focused interest has been expressed toward the phenomenon of the ex-addict-run self-help program. A psychiatrist's initial exposure to such a program is likely to be intensely negative. One may observe that a man is wearing a dunce cap on which is written the words: "Ask me why I'm wearing this," as if his humiliation is to be compounded by having to be reiterated at every encounter. Another man is made to submit to his hair being shaved off. A woman is wearing a stocking on her head. A couple is told that they may not have a relationship. An adolescent girl is ordered to scrub a dozen toilet bowls. If there should be any complaints, even greater indignities may be imposed as well as a verbal whiplash, furious and obscene. These are frequent occurrences in ex-addict, self-help residential treatment centers such as Synanon, Daytop Lodge, and Marathon House. On a more constant basis, there is a distinct hierarchy of privileges and authority, with those at higher levels able to command obedience from those at lower levels. Such a system makes no pretentions to

be democratic and egalitarian. Its constituents are junkies who are not, so the argument goes, responsible enough to make decisions about themselves, let alone other people. Until they "mature," they must be treated as though they were babies or crazy.

There are some interesting similarities and some even more interesting differences between such a setting and the more traditional psychiatric inpatient facility. Psychiatrists, as a group, tend toward liberal and egalitarian sentiments. They are, as a result, revolted by the paramilitary specter of controls and sanctions in the ex-addict centers. Controls and sanctions are, nonetheless, a conspicuous component of life on a psychiatric ward. They may be stated in terms of therapeutic decisions in case conferences, but patients tend to see punishments and rewards for what they are.

While psychiatrists like to think of the patient as the raison d'être of mental hospitals, studies by sociologists have demonstrated that the patient holds distinctly lower status as an actor in the social system. Even when this is recognized, it is not articulated by the hospital staff as it offends the official ideology of medical personnel who are supposed to minister to a patient's needs, to serve him and treat him without violating his dignity. In some progressive psychiatric wards, attempts are made to minimize the low-caste status of patienthood by a variety of patient-government techniques. Rarely is significant decision-making authority vested in the patient, however, and

when it is, there are intermittent assumptions of control by the physicians.

Psychiatrists tend to be revolted by the denigration of new patients in the self-help centers, and adhere to a formal rhetoric of dignity and respect for patienthood. The informal, unstated, and perhaps unconscious role sets in psychiatric units may still relegate the patient to an undignified position however. It is also possible that the conflicted messages that the psychiatric environment communicates to the patient are perceived as an indication of deceitfulness and hypocrisy on the part of the staff or are not consciously perceived at all, in which case such messages may be pathogenic.

In the self-help center there is little or no difference between the formal and the informal hierarchy. In a sense, there is only a formalized, informal hierarchy with decision-making openly and unashamedly a peer-group phenomenon. Attitudes about each member are expressed freely so that everyone knows who is loved, who is hated, who is feared, and who is respected. One achieves both status and authority as a result of peer-group allocations of love and respect. For this reason there tends to be charismatic leadership at the top of a self-help program. It is a system that is predicated on personal skills being recognized and rewarded.

By contrast, there is a marked distinction between formal and informal hierarchies on a psychiatric ward. The special case syndrome has only lately

been recognized, but it has always been part of the drama on inpatient units. While physicians are nominally in control of the ward, the informal authority structure frequently finds the nurses having most to say about day-to-day issues. There is, as a result, a certain amount of confusion about who is in charge, a confusion that is difficult to articulate and define and to which new patients are particularly vulnerable. Added to this confusion among the professional groups impacting on the patient is an ambiguity about authority structure within the professions. There may be therapist-administrator splits among the psychiatrists, specialist-generalist splits among the nurses, and group-work-casework splits among the social workers. Each distinction is another arena of subtle, unstated jockeying for position carrying an antitherapeutic potential. What seems to characterize the psychiatric ward is a kaleidoscopic array of diffuse authority structures, an inarticulate ecology of control mechanisms into which is thrust the patient, already burdened with the ambivalence about authority that characterizes drug dependence.

The ultimate sanctions imposed by self-help programs are distinctly different from those of psychiatric units. Recidivism or hustling in the self-help program, if perceived to be intractable, may result in exclusion. Participation in the program is deemed to be a privilege and an opportunity, perhaps the last one for attaining true independence and freedom. Being put out on the street is being condemned to the inherent slavery of continued addiction. There is no need for locked doors or restraints in such an

environment; the peer-group ideology perceives escape and acting out as comprising inherent bondage.

In the psychiatric ward, peer-group pressures may be opposed to the institutional press. While the hospital expects obedience and conformity ("primary adjustment" in Goff man's terms), the peer group, particularly when adolescent, frequently demands rebellion, elopement, and illicit drug activity as a condition for acceptance and respect. The hospital responds to such behavior with more restraints, constantly reinforcing the challenge to rebel. Adolescent treatment units in psychiatric settings are, therefore, marked by a preoccupation with locked doors, chemical restraints, and all the other paraphernalia of external controls. The ultimate sanction in such an environment is further restriction and isolation, progressing to chronic hospitalization in a maximum security situation. It is difficult for controls to be internalized when they are so readily forthcoming from the institution.

The most important distinction between the authority structure of the self-help program and that of the psychiatric ward is that the former is open and the latter closed. No matter how oppressive or humiliating one feels at the bottom of the ladder in the self-help program, the possibility of reaching the top is always present. In fact, achieving the top is the purpose of the program. The only obstacles to achieving that purpose are self-imposed. The demonstration of self-control, honesty, and respect is the means to attain

freedom from addiction as well as enhanced prestige and authority. Graduation from the program may mean a life of involvement and autonomy outside or the assumption of managerial responsibility within the program or a related one.

On a psychiatric ward, regardless of how well one behaves, how much "health" one manifests, or how successfully one juggles the conflicting expectations and fealties, one can never attain the position of a nurse or a doctor. Authority, diffuse as it is, remains forever unattainable, and regardless of one's inherent or emergent capacities, the low status of patienthood remains an onus until the moment of discharge, when the stigma of ex-patienthood may continue to exact its toll.

If we look at the two environments as laboratories for experimenting with life styles, or as educational institutions rather than treatment facilities, their differences are brought into sharp relief. In the self-help program, the individual is trained to perceive himself as an agent who has a broad array of options, each of which will stimulate a different response. In the psychiatric environment, the patient must be trained to manipulate the conflict forces from the environment as well as his own behavior in order to achieve some autonomy and gratification. Freedom, there, is perceived as an accidental phenomenon or one that involves a capacity to play roles well, if inauthentically.

The psychiatric ward trains the patient to act more competently in the kind of world he is accustomed to, where the individual must carve out a life space within ambiguously but rigidly defined environmental constraints. It is a world where mastery is an arbitrary and capricious business, frequently lacking in equity and justice. The self-help program trains people for success in a different kind of world, one in which a man may order his affairs in concert with others and where mastery is a function of one's own competence as a human being. Such a program has implications far beyond a group of drug-free individuals. It seems to be directed toward a restructuring of society itself, utilizing its graduates as the agents of change.

The "concept" program of the ex-addict-run therapeutic community is one manifestation of a spectrum of drug programs oriented around the self-help principle. Some of these programs are beginning to depart from the exclusive reliance on ex-addict staffs. Professionals with a variety of credentials and non-addict (straight) nonprofessionals are increasingly being found in positions of responsibility. The implication is that having broken through the artificiality and arbitrariness of the old professional hegemony over human services, it would be foolish to be locked into an equally artificial but newer credentialism. Being an ex-addict is not a standard of competence. New standards are being forged in these programs and will, when they emerge, deal with such issues as communication skills, sensitivity, empathy, and self-mastery, regardless of the formal education or lack of it commanded

by the trainee.

A broad array of nonresidential, community-based, self-help activities are developing throughout the nation: hot lines, drop-in centers, runaway houses, free clinics, and a host of other acute social and health service facilities, all relying on youthful, indigenous, and nonprofessional staffs with the backup, training and support of occasional professionals. Young people in trouble with drugs have been turning to facilities with such names as "The Open Door," "The Kool 'Aid," "Bridge," "Help," "Concern," "Sanctuary," "Place," to be talked down from a bad trip, for a meal, for a place to sleep, or because of a feared overdose, as a way of getting back home or just for someone to talk to. These services are conspicuous for their informality, accessibility, and lack of concern for protocol, records, appointments, and other amenities of more established service systems. They generally convey an atmosphere of openness, dedication, and youth. These programs frequently survive on a week-to-week basis, with inordinate energies being expended to raise funds for rent, food, or an occasional salary. They are frequently harassed by local authorities, who provoke police surveillance or unduly rigorous enforcement of zoning, public health, or safety ordinances. Despite this, the morale is usually quite high in these centers, where a sense of common destiny, the accoutrements of a counterculture, and interminable encounter sessions sustain the cohesion and commitment of the staff.

The therapy that such programs provide differs from the traditional group psychotherapy administered by mental health professionals in two major ways. (1) It focuses more on the health and competence of the client than on his pathology. (2) The orientation is almost exclusively on the here and now. While the programs vary widely in the intensity, frequency, or formality of group experiences, there is rarely any preoccupation with the nomenclature of pathology or with the origins of current behavior in the distant past. An uncovering technique is premised not on exploring a repressed oedipal conflict but on identifying as vividly and urgently as possible the immediate behavior of an individual in a social system.

The emergence of such self-help programs has an importance greater than the provision of an array of services for young drug users. These programs represent models for other human-service systems, which will have to meet their manpower needs by developing pragmatically trained nonprofessionals rather than relying on a system of elitist guilds. They are models for helping relationships where the gap between the person giving the help and the person receiving the help is not so vast, so imperialistic, nor so exploitative as it has been in the past.

Perhaps even more importantly, the self-help program has an implication for the rest of society as a model for institutions for the young. The school has rarely shown itself to be a societal arrangement for meeting

the current needs and recognizing the current capacities of youth. It not only has done a rather poor job of meeting society's own needs but it has emerged as a joyless, alien, stultifying environment imposed on that part of the population usually referred to as society's hope but treated as its refuse. These programs provide models for new ways to deal with the young, where they may learn important skills, such as how to communicate, how to get along with peers and authorities, how to organize, and, perhaps the most important skill of all, how to help a fellow human being. In many communities they are the only places where adolescents may congregate without being told to move on or buy something.

As examples of institutions for the young, self-help programs have implications for the primary prevention of drug abuse that may be more profound than any other effort, including the expenditure of millions of dollars on drug-education curricula in school systems which in other ways do violence to young minds.

I have not discussed the role of methadone maintenance as a treatment technique. It has shown promise as a method controlling illicit drug use and the associated criminal behavior in adult populations of hard-core, long-standing recidivist opiate addicts. It has not been demonstrated to be an appropriate treatment for youthful drug users. Federal guidelines, as well as clinical and ethical constraints, would indicate some caution in the

widespread experimentation with a technique that consigns people to an indefinite opiate addiction.

A final word about the role of government vis-a-vis drug programs: It is clear that municipal and county agencies should facilitate rather than interfere with the development of community-based programs of the self-help variety. Given the political environment and the relative incompetence of civil-service dominated bureaucracies, state government should not itself be the provider of service to drug users. As an administrative unit, state government is appropriate for the establishment of standards, the evaluation of performance, and the allocation of resources. Local communities are too impoverished to support drug programs and federal and private sources are too capricious.

Finally, as the first rule of medicine, *primum non nocere* might serve as a first principle of public policy. It would appear that the imposition of criminal sanctions on the use of drugs has resulted in harm. A rational and compassionate society should not feel the need to further punish the victims of its own negligence.

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