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PSYCHOTHERAPY OF THE INJECTABLE DRUG MISUSE

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ABSTRACT. The opiate dependency is a common phenomenon in the society of our days and in most countries the treatment consists of treatment with methadone. The scientific evidence suggests that the prescription of methadone varies considerably from one country to another and the admission criteria for treatment varies according to the eligibility criteria. The people who misuse drugs have various social backgrounds and some of the social categories appear to be predisposed to it. The most prone are users who present the following characteristics: males, single, live in large cities, young people, and those who are vulnerable: sex workers, children living in the street, and prison inmates. The most used illegal drugs used intravenously are the opioids (fortral, morphine, and heroin), ketamine, cocaine, and met-amphetamines. Recent researches hypothesise that subjects who misuse drugs presented a certain personality which may have placed them in a vulnerable position before they start misusing. They appear to lack the necessary resources to cope with the daily living challenges, do not have stable intimate relationships, have poor social insertion, and have poor academic results, poor school attendance and a history of offending behaviour. These subjects report being depressed and anxious; however, it is difficult to ascertain if this presentation is a risk factor or an effect of the drug misuse.

Keywords: drug dependency, psychotherapy, personality, complaints and dissatisfaction, clinical approach, heroin

INTRODUCTION

Approximately 16 million people in the world misuse illegal intra venous drugs. The average age of the start of the misuse of illegal drugs in Romania is 15-16 and the heroin is the most used drug in the class of the injectable drugs; 75% of the subjects of a study undertaken by the Bucharest Faculty of the Sociology reported that they were injecting heroin on a daily basis.

The experiments carried out revealed the fact that the effects of the drug misuse depends on the subjects' personality, especially the introvert/extrovert dimension and the type of anxiety (B. Ioan, D.Bulgaru-Iliescu- Romanian Magazine of Bioethics, Medical Professionals College, Iasi, 2007).

The injectable drug dependency can be defined as the loss of control over the use of opioids, more specifically the social, psychological and medical consequences. The substitution treatment represents the form of therapy that is organised and legal through the consumption of the psychoactive substances (methadone), which allows the termination of the addiction and prevents the occurence of the complications.

The speciality literature identifies certain types of compliance:

- Total- compliant or non-compliant
- Half- compliant
- Erratic
- Dop-out
- Unknown.

THE FACTORS THAT INFLUENCE THE THERAPEUTICAL COMPLIANCE

- The nature of the therapeutical prescriptions
- The relationships between the patient and the team
- The level of understanding of the patient (QI, level of awareness, the educational level and culture, etc.)
- The illness (severity, evolution, etc.)
- The experience and the attitude of the significant others.

The experiments on the subjects concluded that the reaction of a person to the effects of the drugs depends on their personality and more specifically on the introversion/ extroversion as well as their level of anxiety (B. Ioan, D.Bulgaru-Iliescu- Revista Română de Bioetică, editată de Colegiul Medicilor Iaşi, 2007).

The experience gathered at ARAS Bucharest and the methadone centres of the association have led to this personal interest in the topic of addiction and the pathology of the heroin use.

Now I am fully aware of the professional confusion I was confronted with; I was not able to clearly comprehend if I was observing clinical guidance or models that were underpinning a medical reality. All this has made me realise the enormous difficulty in practising the psychotherapy with the heroin users because I became aware of the gap that can exist sometimes between the theory and the real clinical practice.

Today, after years of further experience I can say that the professionals who work with this group are always prone to the risk of being frustrated by the failings of the therapy and the inherent difficulties of working with extreme cases.

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I can bring the example (perhaps the most common in working with this type of patients) - the URINE TEST- that is mandatory to prove the cessation of use. The question that arises automatically in my mind is related to the quality of relationship between the patient and the medical team (trust and positive functioning) if:

The patient is not honest;

The therapist does not trust the patient (the urine trust being used as the standard to prove the cessation of use).

The above theory has been challenged by my colleagues who have replied to me that the patients who are dependent on drugs are characterised by a reduced capacity of embracing the objective reality and by being prone to dissimulation and truth distortion. They invoked the argument that 99% of the practitioners had had at least one experience with a drug addict who started the detox program but later on would admit to having continued to misuse drugs, lied and deceived (including faking the laboratory tests).

Considering the above, it is hardly surprising that many authors tend to attribute a high severity to this pathology which involves personality and affectivity disorders i.e. the patient's inability to have an objective rapport with the external world and their tendency to act out and dissimulate (Paolo Migone, Quale psicoterapia per i tossicodipendenti-Psychomedia, page 4, 2003).

However, I am advancing another question- what if we could differentiate between the drug dependency as an effect of the factors mentioned above and as effect of some other pathological factors?

If only the first explanation were true (which supports the idea that the addiction is a singular diagnosis category), then we would be required to advance the idea that the behavioural and cognitive manifestations are caused exclusively by the drug use (that is, by the use's biological alterations cause by the used substance, which in turn reinforce the addiction). Following the same hypothesis, the rest of the manifestations are mere coping strategies and defensive mechanisms: denial of reality, projection, fabrication of the truth and dissimulation, etc. (Craig et al, Personality and addiction in Clinical and General population samples, 1979).

I suggest that we turn our attention to the second hypothesis (i.e. the addiction not as a diagnosis category but rather the consequence of a personality disorder/ affective disorder which given a negative set of circumstances, can turn the sub-clinical status into a full drug addict status). This hypothesis would then enable us to make much clearer distinctions between the independent variables and to establish more effective clinical interventions.

Recent research advances the idea that the people who misuse drugs have a certain degree of personality vulnerability prior to the start of misuse pattern. These people very often appear to lack the resources to manage the daily life, have difficulties with their intimate relationships, are socially unable to adapt and conform (with manifestations as school truancy, involvement in criminal activity). In the drug users who report experiencing anxiety states it is difficult to ascertain if the anxiety is a cause of effect of the misuse.

I am of the view that a clinical approach should take into account the fact that the patient is unable to alter their circumstances; rather they should be encouraged to alter their way of perceiving the reality. The relief of the suffering could be achieved through communication including the specialised form of communication in psychoanalytical therapy. A perceived objective reality which proves to be difficult to contain and manage usually generates inadequate feelings of fear, hatred or love.

The patient who seeks relief from the tension caused by this situation tends to develop a strong love-hate relationship with the substance they use. It is not uncommon, therefore, for a patient (in the hate phase) to dispose of the drug by throwing it in the toilet bowl, only for minutes later to despair due to the loss (and the consequent behaviour of approaching a drug deals in search for another "fix") (C.Gugu, Consideraţii psihanalitice aspura consumului de droguri,Revista psihanalitică CafeGradiva, 2012).

It is therefore, important to stress the importance of the patient's assuming responsibility for themselves in the psychotherapeutic process, and the importance of the patient's cognitive and affective reframing of the events that led him to start misusing; this has been confirmed by the studies undertaken by Cordier on 20 users and 20 non-users, with the use of the "Tennessee Self Concept Scale".

The researchers have concluded that the drug user had a poor self- image and self-esteem (inconsistent self-image, negative physical and family self-perception) in relation to the external reference system i.e. society. The same author, using IPAT-Cattell, says that the stronger the drugs used, the higher is the level of their anxiety which is compounded by other factors such as: lack of self acceptance, difficulties in adapting to the environment due to a certain level of emotional immaturity (B. Ioan , D.Bulgaru-Iliescu- Revista Romana de Bioetica, editata de Colegiul Medicilor Iasi, 2007).

Reflecting on my experience in working at the methadone centres and psychiatric hospitals that help such clinical cases, I hold the strong view that the therapies employed are more often than not harsh, with rules seemingly absurd and the rigid therapeutical contracts that appear to disadvantage the patient. After what is usually a long period on the waiting list (due to the lack of capacity of the centres), the patient is visited by a multi-disciplinary team that establishes the methadone dosage (which would be continuously decreased by 5mg per day, according to the individual circumstances).

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The initial dosage would be established after the medical and psychological interview and assessment based solely on the patient's account (dosage, costs, etc.), and less on other more objective information (such as the venous sclerosis).

In general the complaints and dissatisfaction of the patient were disregarded as they were deemed to be manifestations of the patient's tendency to dissimulate (they were believed to be prone to "invent" and say anything in order to avoid respecting the rules of the therapeutic process). Another factor which contributed negatively to not listening to the patient was the limited available time the medical staff had at their disposal and the rigidity of the interaction between the patient and the professionals.

The patient who was caught misusing drugs whilst enrolled in the detox program was excluded without the possibility of appeal, rule that seems similar to the theraputical contract with the bi-polar patient (Kernberg).

Perhaps due to the fact I was new to psychiatry I was unable to understand the rationale behind those rules which seemed so severely divorced from what I had learnt as a student- that the relationship between the patient and the medical professional is based on a dialogue which enabled the patient to disclose and share, and enabled the psychotherapist to develop a good understanding of the patient as a human being with their past and present life experiences, strengths and difficulties.

As time went by and I accumulated more experience I have started to understand why only a theraputical environment with very clearly set rules can form the best framework for intervention with people who misuse drugs. Two years ago, whilst in a secondment to a clinic in Venice, Italy, I had the chance to seek the opinion of other specialists in the field. One of my former colleagues shared with me his previous experience when he had tried to revolutionise the rules system of such a detox centre.

He was the acting manager of the centre as the manager was long term off sick. One of the first measures that he took was to change the initial methadone dosage and the level of interaction between the patients and the medical staff. This has led to major discontent, even in the patients who has been spent some time there in the detox program. This colleague's shared experience made me understand that psychotherapy is not always "an unconditionally positive approach".

CONCLUSIONS

The patient needs to trust the therapist but they do not need necessarily to be/ to feel comfortable. In fact, I may even advance the idea that if the questions and issues raised by the psychotherapist do not create a certain discomfort, the intervention may not be as effective. Psychotherapy does not mean giving advice. The patient may anyhow feel lost in a world that is full of advice, sometimes contradictory advice.

The purpose of the psychotherapy is to discover oneself and one's priorities, and to build up the courage to act. A psychotherapist would never tell the patient what to do about their careers, marriage, anxiety, etc. If the psychotherapist helps the patient to raise the level of consciousness and self-awareness, the patient is enabled to make decisions in their best interest.

In psychotherapy one could very appropriately follow the proverb "Give one man a fish and you will feed him for a day; teach him how to fish and you will feed him for the rest of his days".

The difference between psychotherapy and giving advice, providing support and teaching about feelings and behaviour is that the latter do not provide an intellectual teaching.

We talk about a very personal, intense and stimulating experience which should form the core of any psychotherapy (Dr.C.Muşat, Ce este psihoterapia, www.thera-psy.com, 2012).

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