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ABSTRACT

The authors discuss their first efforts at providing a contact point where young people could come for information crisis intervention and talk. Major mistakes, such as too exclusive reliance on ex-users, are elaborated. Clients' demographic and psychiatric data receive brief mention, as does the initial screening procedure. The bulk of the paper deals with the Day Treatment Center, open five days a week from 9:30 a.m. to 2:30 p.m. The weekly "program" is described, along with some of its underlying rationale. Among other results, it has been found that the use of professional, straight, middle-class personnel has been therapeutic for the client population. The paper concludes with a discussion about the use and outcomes of parent groups. (TL)

DEVELOPMENT OF A DRUG REHABILITATION CENTER OR MISTAKES WE HAVE MADE

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The Drug Rehabilitation Center, a branch of the Tulsa Psychiatric Foundation was established in November of 1969, following mass arrests for drug law violations on the city's well-to-do south side. Our first efforts were geared to simply providing a contact point where young people could come for information, crisis intervention, and to talk. The Center was manned by two ex-addicts who had had previous experience in such work. The response we had from the youth in and around the city was tremendous, confirming our beliefs in the need for such a Center. Services were available around the clock for emergency care. Rap sessions were held nightly, Monday through Friday for whomever wished to attend. Hospitalization and/or medication was provided as necessary.

In the beginning much reliance was placed upon the ex-users as no one at the Foundation had any significant previous experience with drug abuse per se. A staff psychiatrist was appointed Medical Director of the program and as knowledge was gained, much by trial and error, the project evolved into its present state. Our major mistakes in the beginning were perhaps over-reliance on ex-users to perform a service which we ultimately determined could best be done by those with professional training. It also became apparent that simply because one had previously been addicted to hard narcotics did not mean that person would be any better able to communicate with young users of LSD, Marijuana or Speed. In fact some clients openly voiced their feelings of being unlike the addicts.

Thus as we begin to shift the emphasis toward the more standard modes of treatment, we began to also obtain extensive psychological profiles of our

young clients and have found that they differ from those described in past studies. Before going on into the operations of the drug center, I would first like to describe our patients, psychologically.

They range in age from 14 to 49, with 71% being 16-20 years old. 70% are male. The following tests are given upon admission: MMPI, Zung Self-rating Scale, Rogers-Dymond Self Concept Inventory, Bender Visual-Motor Test, House-Tree-Person drawings, Powers Verbal-Education Inventory, Willoughby Personality Schedule, Clark and Sacks Sentence Completion Test. The majority (83%) of applicants display significant degrees of thought disturbance, anxiety, obsessive thinking, compulsive behavior, guilt feelings, extreme impulsiveness, social introversion, rebelliousness, alienation and poor family relationships. 62% show significant paranoid feelings. 48% show marked levels of depression and despair. The majority show very poor self-concept and very little ego strength, are passive and dependent.

Three basic personality types account for 94% of the young drug abusers who apply to the Tulsa Psychiatric Foundation for treatment. The first and largest category of personality, 51% of boys and 61% of girls are diagnosed as Personality Pattern Disturbance, Paranoid type. The second largest category, 18% of boys and 23% of girls is diagnosed as Personality Pattern Disturbance, Schizoid Type. The third category, 12% of boys and 14% of girls is diagnosed as Sociopathic Personality Disturbance, Anti-social Reaction. These patients are basically unsocialized and they appear to be incapable of significant loyalty in individuals, groups or social values. They are characterized by selfishness, egocentricity, and seem unable to learn from experience or punishment and as the adult sociopath, make poor candidates for psychotherapy. The remaining 6% of the young people who do not fall into one of the three

categories discussed were diagnosed as Depressive Reaction, Emotionally Unstable Personality, and Passive-Aggressive Personality.

In all categories, extensive drug abuse can result in psychotic episodes and many of the young people come to us while in a psychotic break, with the complaint that they are losing their mind. They are delusional and frequently hallucinating, and at that time appear to be acutely Schizophrenic. After they come into treatment and discontinue drug use, the psychotic episode clears up and they appear to be basically one of the three major types discussed above.

The prospective patient, after completing the standard application forms at the Foundation, is referred for a screening interview by the psychiatrist directing the drug program. One of our mistakes at the beginning was to accept all "comers" with the idea in mind that we must "do something" for everyone who applied. After much frustration and disappointment, we came to accept as fact that the patient had to have sufficient ego strength, motivation and good will in order for us to work effectively with him. In fact, to accept those who present without these qualities, is detrimental and destructive for those patients who are seriously trying to cooperate.

Occasionally young persons awaiting trial on narcotics charges decide to enter the drug rehabilitation program in order to impress the courts favorably and are naive enough to relate this to the director. Others have submitted to pressure from friends or relatives but have no desire themselves to change their behavior. For the most part patients who are referred by the courts fall into the sociopathic category; we inform them in the beginning that we are not anxious to take them and that we will tolerate no acting out. This approach has proved helpful in generating feelings of responsibility

on the part of some patients.

Those who are overtly psychotic are either hospitalized locally or sent to Eastern State Hospital, depending on finances and/or expected duration of hospital stay. When sufficiently recovered, these people may be admitted to our Day Treatment Center for further care. Approximately 5% of applicants are rejected. The reasons for rejection are given along with the suggestion that the person think it over and re-apply at a later date.

Once accepted the patient is assigned to either: individual therapy, group therapy, meeting 1-3 times weekly, or intensive therapy at the Day Treatment Center.

Day Treatment Center The Day Center has operated the past six and one-half months, and presents the most intensive therapeutic thrust of the program. It is open from 9:30 A.M. to 2:30 P.M., five days a week with two groups of 6 to 8 patients being treated concurrently. Each week they are presented with the following:

6 hours group therapy
6 hours Occupational Therapy
2 hours discussion on the stages of personality development and the tasks of each.
1 hour discussion of theological-philosophical questions with a minister who is trained in counseling.
1 hour sensitivity and body awareness techniques
2 hours dance therapy
1 hour musical instruments
1 field trip

Attempts to organize recreational activities have met with little or no cooperation from the patients.

The presentation of personality development has seemed to be useful in offering a theoretical framework in which to consider themselves. We have found them to be surprisingly unsophisticated about sexual development and what is considered normal sexual activity. This presentation has been fruitful in

providing material for group psychotherapy. Our patients are very interested in talking about philosophical matters and requested times with someone to whom religious "faith" is meaningful. The community meeting in which the program itself is discussed has yielded valuable feedback for the therapist, in addition to providing the participants a voice in program policy-making.

Recently, following an episode of two members "doing dope" the group took over the task of setting guidelines for acceptable behavior by its members; the group demands on each other are more severe than those originally set up by the therapists. Specifically each member is on probation if he misses an activity two times consecutively, or comes to the Center under the influence of drugs, or provides drugs for another member. The second offense results in termination from the program.

We have found these patients all seem to be living in their heads, quite alienated from their bodies, displaying the mind-body split of the Schizoid referred to by Alexander Lowen.[1] The sensitivity activities have made them more aware of this alienation as well as more comfortable with their feelings.

The dance therapy was another attempt to help them be capable of using their bodies to express their feelings, but we have just dropped this by a majority request. The patients consider it potentially useful but state the dance therapist has been too rigid and seems unable to react more flexibly even when confronted with her rigidity. The groups musical efforts evolved spontaneously. Field trips are planned to better acquaint them with the community. When the Day Center opened, about half the patients were court referrals who were required to come. They were the typical delinquents falling into the third category of personality types previously mentioned. Group therapy was especially threatening since any status they enjoyed with each other seemed to be based on the

[1]Betrayal of the Body, Alexander Lowen

concept of "toughness" i.e., not showing feelings. When a member of this all male group did become emotionally involved, the other members were not supportive but rather rejected him saying "I don't belong in a group with him, he must be crazy." After prolonged effort, the therapist became convinced that this type of client was not amenable to group therapy and suggested individual follow-up. None remained in the program although several have since requested re-admission to the day program. By and large these patients admitted using drugs at night and weekends, chiefly LSD and amphetamines.

Since the drug abusing population is characteristically transient, it should not be surprising to learn that word of Tulsa's drug rehabilitation effort got to California and Colorado, at least, and three of our patients came to Tulsa from these states for help. About two and one-half months ago, we became aware that we were beginning to see hard drug users, whereas previously, most of our population had used speed, acid, and pot. We now have four heroin addicts, three of them ex-servicemen who were clean when they came but were fearful of getting back on drugs. Another reason for coming to Tulsa was the fact there was virtually no heroin in Tulsa after the mass arrests by the Federal Government in February. These patients now realize drug use was just a symptom of long standing problems and seem highly motivated and committed to the program.

It is interesting to note that the group leader, the chief occupational therapist and the volunteer workers who are in the program all day, preparing lunch, etc., are all early middle aged, "straight looking" establishment type people. After initial reserve and verbalized hostility, the patients now express their appreciation of the opportunity to discover that all such people are not rejecting, unwilling to listen and primarily "thing" oriented. The Day Center director feels the interaction with these people has been a therapeutic experience for the patients.

In regard to length of treatment, we have not determined as yet an optimum period. Where older people with more ego strength are concerned, it is felt that they work more purposefully if they are aware of time limitations. On the other hand our people begin, usually just barely off drugs, and generally present a kind of physiological hangover with symptoms of fatigue, mental confusion and apathy. It seems to take at least two or three weeks for them to become alert and able to use their faculties. In relation to this, one patient said "I've been shooting dope for 11 years; I haven't had any structure, discipline or difference between night and day during that time and one of the things about this program that keeps me is its dependable structure for several hours each day, but I can't assimilate this change in a matter of weeks after years of doing otherwise." Thus, how to avoid as much as possible, fostering dependency by extending the treatment period, yet not to cut it too short, is one of our many remaining problems.

Parents Group Unwillingness to become involved seems to be characteristic of the parents of drug users. And when they do involve themselves, they quickly terminate when their child drops out or completes treatment. This seems to be an indication of their inability to focus on themselves as part of a troubled family and marital interaction which has chosen their drug-using child as its expressor. Parents are seen in a group and the majority have fairly severe pathology in the individual personalities, plus a pathological communication system which requires more intensive treatment than most families are willing to undergo. With this in mind, we see the drug abuser as having a better opportunity for change if he can extricate himself from the family situation.

Most of these families have strong mothers who are either overtly domineering or covertly possessive so that the child is caught in a "for-or-against"

situation. In fact one of the common messages the child gets is "mother will be around to get you out." The child is not really expected to be responsible, yet he is told that he should be. Many of these families have an alcoholic member thus, tuning-out is a pattern easily picked up by the potential drug user. Their families use "con" games on the child and want to use therapy to learn how to be more effective at it. And, when it doesn't work they discontinue therapy and feel, "it did no good to come because Johnny didn't change."

We have found techniques which emphasize communication and messages in the family, like transactional analysis, have had greater effectiveness than techniques which focus on the child and usually exacerbate the feelings of guilt and frustration parents feel. If the patient is too young to go his own way and leave the family, then our experience points in the direction of family therapy as the more effective tool since it focuses on the interactional and communication systems and helps lift the burden of responsibility from the drug user as symptom bearer. Unfortunately, many families are not amenable to such treatment particularly because the father is unwilling to be involved. In this case we work with those family members who will come. As the need arises we have made available such housing as has been necessary for our patients either in a half-way house, or rooming house, or private quarters with persons friendly to the program.

In closing, we have not yet arrived at a solid state in our program and continue to try new ideas, thus, I am sure it will undergo more changes, hopefully each will bring some improvement. We welcome those interested in visiting, or those with new ideas or suggestions.