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Feature Articles

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Uncovering the Elements of Success: Working with Co-occurring Disorders in Residential Support Programs.

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Today, nearly 10 million people in the United States suffer from at least one mental disorder and at least one substance-related disorder.1 According to national data from the Epidemiologic Catchment Area Survey (ECA), 47% of schizophrenic and 61% of bipolar (manic-depressive) patients have a substance-related disorder. 2 Historically, individuals with such severe mental health and complicating substance-abuse disorders were often entrusted to state mental hospitals. However, in today's era of managed care and deinstitutionalization, the old state mental hospitals are no longer a readily available option of care. In America during the past four decades, the number of state and county mental hospital beds has decreased dramatically, from 559,000 beds in 1955 to 92,000 beds in 1990.3 This 84% decrease has left families, outpatient substance abuse and mental health providers, families and communities at large bewildered, overtaxed and struggling to find solutions for the treatment of individuals with co-morbid substance abuse and mental health disorders. In fact, today the majority of persons with co-occurring disorders receive no treatment at all.4 And, for those who are treated for both disorders, most find it necessary to receive services from two providers in two separate offices, one attempting to treat their mental illness and one attempting to treat their addictions.

However, both providers, in struggling to comprehend the complex interactivity that exists between dual disorders, often misdiagnose clients or simply diagnose one problem while the other is unintentionally overlooked. Given these two silos of uncoordinated care, treatment failure has become commonplace. Moreover, clients that seek support for their sobriety from outside groups often face serious dilemmas, e.g., "old-timers" in AA or NA often advocate total abstinence from chemicals, including those medications prescribed for the treatment of psychiatric disorders. Additionally, clients often feel they are stigmatized by their psychiatric disorders by others in the group or simply become confused by the 12-step process because of their functional abilities.

All in all, client access to appropriate support and treatment is limited to the few programs and support groups that are staffed with trained professionals and designed to provide services to individuals with co-occurring disorders. Desperate, clients who have been deinstitutionalized and living in the community, where ready access to drugs and alcohol has become more and more prolific, often turn to those individuals with whom they have the most contact--their "residential support" counselors. These mental health residential practitioners, provide hands-on community care in a variety of settings, including transitional/nontransitional group homes, family-style community residences, supervised/supported apartment programs or within the clients' own residences in the community.

Although the services of these programs may vary in intensity depending on the individual's level of need, they often include supervision; counseling; life skills training; medication monitoring and education; transportation; housing assistance; health and safety education; prevocational, social and communications skills training; and coordination with all other necessary psychiatric and support services. Actively engaged in caring for these clients on a daily basis, these unique counselors are left with the overwhelming task of finding solutions to the complex needs of the clients they serve in an environment that often seems stacked against them. Despite the political and economic factors that preclude their ability to take action, they have nonetheless been compelled to find new and low-cost approaches that have proven successful for their clients struggling with co-occurring substance-related and mental disorders.

One such approach that has proven to be successful for residential providers has been weekly psychoeducational groups in which clients can learn about and discuss issues related to their co-existing disorders. At the St. Vincent DePaul Society of Waterbury, Inc. Mental Health Division, a community-based mental health residential support program, they have integrated these groups into their model of care and have found them particular effective in helping individuals with co-occurring disorders maintain their sobriety. After years of experience in facilitating such groups, they consider certain elements to be the key ingredients of their success. The following outlines their suggestions:

Active listening is essential
As clients share the routine activities of their week, the perceptive listener can utilize this information to help clients make insightful connections. Rather than just conveying discrete bits of unrelated information and apparently disconnected events, a so-called humdrum story may, in fact, be the substrate within which lie patterns of behavior or several thematic elements that are interrelated by common symbols and metaphors. Once clients become aware of these connections, they can better identify their patterns, triggers to relapse and the hidden resources they possess that can help them in the recovery process. By refocusing, paraphrasing, interpreting and truly attending to what is being said, the keen facilitator can gather valuable information from even the most benign stories that may enable clients to gain extraordinary insights from ordinary conversation. Consequently, active listening can enable a facilitator to become a potent agent for change.

The importance of ceremony and ritual
Begin each group with a ritual and, when one maintains sobriety, celebrate his/her success enthusiastically. Not only can these small ceremonies be meaningful for the celebrant, but they can also be purposeful for the group as a whole, for it is through such celebrations that clients are given the opportunity to actively participate in the affirmation of their communal values, attitudes, beliefs and behaviors. These acts not only connect the individual to the ethos of the group, but also create a context in which

the clients can metaphorically mark the significant events in their growth. By emphasizing participation in these rituals, the facilitator incites an aura of importance that help clients recognize the significance of process and process thinking in the context of their recovery and in the development of fuller and more enriching lives. Through celebration, clients can highlight their rites of passage to those new and fundamentally changed patterns that allow them to experience themselves and others in a qualitatively different way.

Be flexible; throw dogma to the wind

Do whatever is necessary to promote therapeutic or growth experiences. One should not become inflexible or fixed on a single model of change. What works for one client may not work for another. In working with individuals with co-occurring disorders, one should not exclude any particular model. In fact clients may respond to several approaches including elements of the 12-step process. However, it is important to recognize the cognitive and functional abilities of the individual participants and to modify or simplify each approach accordingly.

Invariably, members of the group will be in various stages of recovery and this heterogeneity can be invaluable. Involving senior members in the process gives them the opportunity to share their experiences and successes with others. As role models, they feel genuinely appreciated by the newer members of the group in the earlier stages of recovery. These newer members may not only gain valuable recovery information from older members, but also often rely on their sponsorship, support and inspiration. However, older members who have been involved in outside 12-step support groups can become rigid and locked into a one-way process of recovery. It is crucial that the facilitator discourage such dogma since every person in recovery has his/her own path to sobriety and may not fit neatly into a prepackaged process. And, it is also important to note that length of recovery time, although recognized in the group as something to be "honored," should not be portrayed as critical by the facilitator since any sober time is indicative of a desire for a better life. Intuitively, clients know what they need to stay sober. Draw these strategies out and allow clients to use what works for them.

Uncover hidden resources and motivations

One should strongly focus on developing the client’s internal sense of value, with the assumption that clients need to feel they are worth sobriety and an improved quality of life before they will take any steps towards positive change. Ultimately, clients need validation and that validation is key to facilitating sobriety in a population that has been stereotyped, demeaned and dehumanized. Helping clients realize that they deserve improvement in the quality of their lives enables them to embrace sobriety as an essential component of that improvement. Once this has been established, one can begin with the simple process of substituting good ideas for bad ones by suggesting alternative solutions.

Although it is important to offer a host of skills and problem-solving strategies to clients, very often practitioners are simply amplifying and/or making conscious the skills that clients already possess. By supporting their endeavors and showing them how they have solved similar problems in the past, the facilitator, in many cases, is simply awakening the clients’ reservoirs of inner resources which enable them to solve problems using their own unique styles. Ultimately, the members know more about what they need and what will work for them than the facilitator. Often clients simply require an opportunity to consider a variety of new ways of thinking or acting in order to alleviate their problems. Once clients identify the source of their pain and have learned the skills they require, they have adequate resources--conscious and/or unconscious problem-solving and coping mechanisms--that they can call upon to automatically spur self-corrective actions. Essentially, the job of practitioners is to harness the clients' motivations and repository of resources of which they may or may not be aware.

Harness the power of the group

The facilitator should allow the group to shape their expressed desires. Through active listening and refocusing, the facilitator can often utilize the narratives of the group to reveal clients' underlying needs. For instance, if a client begins a "war story," the facilitator can interpolate inquiries about the resolution of the problems revealed to help the group focus on what has been learned or gained from the experience, rather than on the minutiae of the story itself. More importantly, the facilitator can use this information collaboratively to decide on future psychoeducational formats, which may not only empower the group, but also help others in the group prevent such a relapse from occurring in their livIn this way, the facilitator can often reframe war stories into constructive topics for future discussion. During this process, clients will share the coping techniques and alternatives ways of preventing relapse which have worked for them with the idea that they do not have a monopoly on the truth but are proud to share their successes. When clients share with empathy, acceptance and understanding, the group members bond to form an all-important support system and recovery network. When this is established, the power of the group is revealed.

Focus on the positive and reserve judgement

Recognize that even small steps towards recovery are signs of improvement. Clients need to move ahead at their own pace learning from their experiences. It is important for the facilitator and the clients to view relapse not as failure, but as an opportunity to gain new understandings. Encourage the group to share good events, not just war stories, and focus on the positive aspects of their lives and recovery. When the facilitator maintains an atmosphere of positive regard, members will make comments that are supportive and appropriate. Too often clients are seen as a set of problems, disorders or unrealized treatment plans, rather than as individuals with positive interests, pleasures and motivations. Draw them out. Find out what's beyond their problems, what motivates them, and what they do in their spare time. Clients are more than a set of disorders. A facilitator must be genuinely interested in the clients in order to build the relationships that are essential for success. If the facilitator is just performing a task and "talking the talk," the clients will "smell it out" and subsequently tend to withdraw. Intuitively, clients know that "what you are speaks louder than what you say."

Allow clients to share openly without fear of reprisal. The facilitator should encourage members to express the ongoing narratives of their lives freely so they are not restricted to addressing whether or not they used during the last week. Instead of asking each member, "Were you tempted this week?" try asking, "How have you improved this week?" If the facilitator has unconditional positive regard for the clients, they are more apt to view themselves as good individuals with bad problems to solve. If a client has been absent from a meeting, a simple "I really missed you!" will have a more desirable effect than questions that subtly imply that his or her absence was due to relapse. If the client feels accepted, he/she will most likely disclose that information without prompting. If a client admits to using, rather than dwelling on the relapse itself, the facilitator can ask, "What did you do to stop?" The facilitator must remain positive about relapse as part of the process of recovery, remembering that one can fall forward and still make progress, recognizing the validity of the adage, "If you fall and get up, you gain a step." And when clients are clean, reward them vigorously. The facilitator should never pass on an opportunity to praise or congratulate members on any achievement. In sum, treat every success as a major triumph and every relapse as a lesson learned.

Explore spirituality

"Spirituality" in recovery is best defined for clients as an awareness of and a connection to something or someone greater than themselves that can help them focus on their efforts to improve their lives. Once clients accept this concept and its importance in the recovery process, they are often faced with the question, "How can this greater consciousness live within me and outside of me at the same time? On its face this paradox may appear too difficult for often cognitively impaired clients to comprehend; however, teaching clients that this consciousness is within them and outside of them at the same time is not as difficult as it may appear. Familiar slogans like "I know I'm somebody, because God doesn't make any junk" reveal for clients their inherent value and capacity for improvement and their connection to a higher consciousness that is both internal and external.

For clients, an integral part of "knowing the will of (AA's) higher power" is to believe that such "will" includes the impetus to improve one’s life. Although this "will" is first understood as an external or abstract notion, once clients are able to internalize this "will," they begin to see it as a mirror from which they can view themselves and like what they see. Once they see their connection to spirituality from within and without, and strengthen their bond to it, their own concept of "self" becomes more positive and they are able to identify that ego strength on an emotional level, and become connected to that "good will" within themselves. With direction and frequent reinforcement from such professionals as group facilitators or residential counselors, clients develop a pattern of positive connections wherein exist the emotional and social (hence, spiritual) reserve to begin or to continue recovery.

Emphasize psychoeducation

It is essential that clients understand the link between their psychiatric treatment and their sobriety as well as their mental illness and their substance abuse. Education and support can help clients understand these fundamental concepts which are so important in preventing relapse. Fortunately, residential counselors are often in the unique position to reinforce these connections on an almost daily basis. Clients with co-occurring disorders must recognize that their substance abuse may be an attempt to cope with their psychiatric symptoms and that if they continue to drink or use drug, they will have even less control over their psychiatric problems, e.g., alcohol can worsen depression, and opiates or stimulants can increase auditory hallucinations, paranoia and delusional thinking.

Additionally, clients must understand that continued alcohol or drug abuse often results in medication non-compliance which only exacerbates their psychiatric symptoms and that without medication they are more likely to spiral out of control. Part of educating the clients about both problems must include the message that they deserve a better life and that sobriety is the foundation or the best path they can take towards the improvement they deserve. After all, clients have been attempting to feel good without first being able to feel good about themselves. The "double-whammy" of substance abuse and psychosis has greatly diminished their sense of control and ability to make sound decisions. Ultimately, the harmful choices they have made have introduced even more chaos into their lives and alienated them from many of the resources they could use to restore their independence and control. Through ongoing support and psychoeducation, clients are more likely to make the connections they require in order to improve their decision-making abilities, remain abstinent and maintain their medication regimen and psychiatric treatment compliance.

Incorporate relapse prevention in everyday activities

Professionals, such as residential counselors who work with clients with co-occurring disorders on a day-to-day basis, can often help them identify potential triggers or develop the coping mechanisms they require to avoid relapse. By identifying potentially stressful situations before they become critical, counselors can help clients either avoid stressors or cope with them on a daily basis. These relapse prevention plans should include not only the development of individualized strategies, but also hobbies, games, meditation and relaxation techniques, social events, the development of support networks, as well as diet and exercise routines which often have an immediate affect on the clients' clarity of thought and decision-making abilities. Such self-directed activities help clients resist temptation, boost self-esteem, and develop the kind of associations that decrease the opportunities and the desire to drink or use drugs.

Closing Notes

Overall, the techniques suggested throughout this article may not be appropriate for all providers or client populations. Ultimately, it is important design a program that works, one that not only meets the needs of the clients, but also the structure of the organization. It is equally important to recognize that clients may feel more relaxed and receptive to services when they are in familiar territory or on their own home turf. And, this is often the case for clients in mental health community-based residential programs where services are available to them within the same apartment complex or group home in which they reside. As a result, clients do not feel obliged to "fit in" to an artificial programmatic role and providers find it easier to develop rapport and work with those clients that are more prone to bouts of paranoia. Perhaps this home court advantage should be considered when allocating funds to providers who serve this ever taxing and growing population.

Conclusion

According to data from the National Co-morbidity Survey, between 41% and 65.5 % of those with an addictive disorder also have at least one mental disorder, and 51% of those with a mental disorder have at least one addictive disorder.5 Clearly, addiction and mental health providers can no longer avoid working with individuals with co-occurring disorders. They have become more of the norm than the minority. And, given their rates of chronic relapse and rehospitalization, it is obvious that the status quo is no longer adequate to meet the needs at hand. With this in mind, local, state and federal funding organizations need to renew their focus on the identification, treatment, and rehabilitation of individuals with co-morbid disorders and recognize that mental health residential providers are frequently left with the overwhelming task of serving these individuals on a day-to-day basis with often limited funding and training. Despite these barriers, community-based residential programs have done much to develop resources and services in their attempts to improve the lives of those in need. Nevertheless, more funding and a coordinated systemic effort are necessary in order for positive change to be realized—efforts that involve residential providers who can serve clients where they live, who can influence lives on a daily basis, and who can support these challenging clients in their rehabilitation and recovery.

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Halfway House: An Alternative to Rescue the Rights and Citizenship of the Mentally Ill Person.

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Abstract: This work analyzes the halfway house as an alternative psychiatric assistance and important means for practice of rights and citizenship of the mentally disabled. Based on the experience of interns at a halfway house belonging to the psychiatric hospital of Ribeirão Preto, state of São Paulo-Brazil. It rescues part of the evolution of the psychiatric assistance from the Mental Health Movement o the Desinstitucionalization proposal. The goals and the indication of the halfway house are recovered placing them in the context of the Brazilian Reform. The proposals and studies of the Psychiatric Reform in Brazil began in the 80s, becoming enhanced at the First National Conference of Mental Health held in 1987 with the bill 3657/89 presented by Paulo Delgado disposing the progressive extinction of the Brazilian psychiatric hospital. Among other things, the proposal suggests internal democracy of the services and institutions, including new standards of services that have the patient's citizenship as its fundamental premise, involving the rupture with the institutionalization paradigm. The project indicates the halfway house, among others, for the chronic patients. As a result, we decided to investigate the experience of interns at the halfway-house with the following goals: 1) to obtain references about the experience of the interns in a halfway-house; 2) to collect from the declarations the aspects that reveal this as being an opportunity to practice the rights and citizenship of a mentally disturbed person; 3) the analysis of the aspects within the context of the Psychiatric Reform Proposal. Methodology: Sample: Nine (9) ex- patients living in Two Halfway-house. Focusing interview: focusing on the experience of living in the halfway house guided by a guidebook consisting of five (5) straight questions to obtain the reports. Analysis: with the material at hand we proceeded with the process of Thematic Categorization. Results: The subjects were satisfied with the halfway house. They accuse the hospital assistance for the lack of freedom, respect, slavery and stern discipline. They consider the halfway house a pleasant place where they are free and respected as people. Conclusion: The halfway-house is an appropriate place to practice freedom, individuality, and independence, where the mentally disabled can fight for their rights and citizenship.

Introduction

Nowadays in Brazil and in the whole world we have noticed a new act of criticism to the asylum and hospital centered model for treatment of the mentally ill person, considered a hectic and old-fashioned system as it has justified segregation, prejudice, disrespect to the rights of citizenship of those who suffer from mental disorders, or even those who vary from the behavior considered normal.

Deinstitutionalization certainly is a process to be started irreversibly in the whole world and must be properly replaced by more human, less humiliating, less violent, more therapeutic alternative institutions.

In the rest of the world theories and alternative practices for the asylums have been happening mainly after the Second World War as show the following acts: Therapeutic Community, Community Psychiatry (in the USA), Anti-psychiatry (England), Sector Psychiatry (France), Democratic Psychiatry (Italy); in Brazil these acts have just become outstanding after the democratization of the country and the reformation in Italy.

The act for reformation organized by BASAGLIA supported by the Radical Party in Italy promoted the complete revocation of the psychiatric legislation in force, assuring the absolute suspension of every form of institutional control over the insane people and insanity. This act had effects on politics on in May 13, 1978 the law 180 is approved and is named after Basaglia.

In Brazil, at the second half of the 70’s, the effects and announcement of these experiences are noticed and a time of intense accusation about the anti therapeutic and harmful conditions of the psychiatric hospitals. Reflection and consequent awareness about the psychiatric issue is started as part of the national issue. In 1984 Basaglia was in Brazil making some conferences about Alternative Psychiatry. New acts arise with professional, social and political mobilization. From 1987, debates about the situation of the psychiatric hospitals and mentally ill people interned in them increase and the movement becomes stronger and reaches the political milieu in an effective way.

In this context, the bill 3657/89 by the congressman Paulo Delgado comes forth suggesting the gradual extinction of psychiatric hospital like asylum and their replacement for other alternative social resources such as halfway houses, shelters, leisure centers, community centers, day hospital, night hospital, psychiatric units in general hospital and psychiatric emergency units. This bill is going through the proper procedures in the National Assembly and has been arousing warm debates of the Brazilian society on the character of the intended changes. It brings themes about the citizenship of the mentally ill people, limits of legal reformation and new models of care to the mentally ill person including the Halfway House which we will discuss in this study.

Halfway House according to OLIVEIRA (1989) is a human and efficient alternative to the treatment of the chronic patient for the following reasons: 1) It is a small institution which takes the patient from the anonymity of the hospital; 2) It replaces the Medical model by the family model, propitiating a better appreciation of the healthy part of personality; 3) It is a proper place for every chronically ill person where he can make use of his righteous areas; 4) It represents an opportunity of approaching the patient with his family and community through a comprehensive and cooperative approach which promotes the family interest in the patients.

DESCRIPTION OF THE SETTING

The halfway houses in this study take part of a project created by a governmental psychiatric hospital in the region of Ribeirão Preto.

This project comes from the unfolding of a rehabilitation program called Therapeutic. Village whose patients, besides owning acceptable conditions of independence and self-administration, show the desire of breaking the bond with the institution.

Thus, the halfway houses model was created for, these patients in discharge conditions (and) who stayed in the hospital due to essentially non-clinical reasons but due to sequels of mistaken policies, whatever their reason is (lack of social and economic resources, social abandon and compromise of their productive capacity).

It is expect to offer ex-patients of the institution through the halfway house their real social integration and recovery of citizenship which would set them free from the State custody.

Nowadays there are three units like this two units for women and one for men, and the first one was opened in September, 1992.

This project counts on the effective participation of community since the halfway houses are managed by entities with funds from the government which are given to a civil organization hired by the government through selling or bidding at auction process.

Besides managing funds for the halfway houses, the institution which provides services is responsible for keeping an advisor whose responsibilities are: coordinate meetings with the residents; be an element of linkage between residents and hospital supervision staff; take part in periodic meetings to assess the staff and facilitate the development and maintenance of an environment which makes possible a good relation between residents and community.

The Psychiatric Hospital is responsible for offering technical support to the halfway houses which is made by a staff formed by the technical director, management director, nurse, social worker and therapist.

The social worker and the nurse make periodic visits to the halfway houses as well as take over the supervision of the advisor's work.

The halfway houses work in private properties located in a middle-class neighborhood of town, with complete substructure.

The houses are simple, of changeable size depending on the number of residents- about three to five residents. They are furnished end there are household appliances which enable their normal functioning. They are also provided with food and consumption materials for both residents and their maintenance.

It is important to emphasize that the residents receive a retirement income from the Benefit Program of Continued Assistance and the amount of money earned is managed by the resident and is used exclusively for personal expenses.

According to what was said before we chose the following **objectives** to develop the present study:

1) Obtain testimony of grasp of life experiences from the residents in a Halfway House.

2) Take aspects from the declarations which reveal the rescue of rights and citizenship of the mentally ill person.

3) Analyze these aspects in the context of alternative model of Halfway House.

Methodology:

Sample: Nine (9) ex-patients living in two Halfway Houses.

Method and instrument: Focused Interview: focusing on the experience of living in the halfway house guided by a **guidebook** consisting of five (5) straight questions to obtain the reports.

Procedure: After permission of the institution, some visits were carried out in the halfway house in order to establish a friendly relation between the research worker and the residents. A previous meeting was done in every halfway house to explain the objectives of the interviews. It was informed that the participation would be voluntary and secrets would be kept. The research worker stayed in the halfway houses part time for a week to obtain the reports. The halfway house advisor’s room was used. The research worker was at the residents’ disposal in order to interview them whether they accepted to take part in the research. All the residents (9) - four (4) from one halfway house and five (5) from the other - showed up to be interviewed using a guidebook consisting of five (5) straight questions regarding to their lives in the halfway house. The interviews were recorded with the residents’ permission aiming to obtain accuracy of results. The reports were classified according to the steps suggested by GIORGI (1985) adjusted by Vietta (1995) as follow: 1 - Careful reading of the overall content expressed by the patient in his report in order to understand its meaning in the global structure; 2 - Texts reexamination aiming to identify units of speaking, understood as locutions of effect on the thematic context; 3- Description and classification of aspects which show contents agreement from several reports expressed by different subjects and looking for what seems to be constant in everyone’s speech; 4 - Organization of locutions or their meanings in categories; 5 - Thematic analysis of these groups and general contents.

Analysis of reports

The question **"How do you like living in the Halfway House"**. For the residents the halfway house is an excellent, calm and peaceful place. They hope they can get over this situation and they state that,

"It is gook and much better. Here we are fine, we can work peacefully and happily".

"It is peaceful, a harmony, I am happy now, I think I can get better here".

The residents feel free and get more autonomy and freedom with responsibility.

"It is good to live here, we have freedom, I do my laundry, everybody does his laundry, Graça makes the meals, cleans the house and I walk freely on the street".

"It is calmer and free, it is funnier and better. We can walk around and nobody annoys us".

The residents express satisfaction when their individuality is respected and their feelings of ownership are protected.

"It is peaceful, everybody has his stuff, we get by more freely".

"It is very good. I am learning how to take care of what belongs to me".

Being allowed to get out of the halfway house for a day makes the residents foresee a future life and look for financial stability.

"We have retirement income, we will get a minimum wage, but I am thinking of getting a job, making more money and live with my girlfriend".

"It is very good, I would like to meet any relative of mine one day, but not to live with him, just as a friend, but I don't want to keep on living here".

According to the Universal Declaration of Human Rights, article 13 "Everyone has the right to freedom of movement and residence within the borders of each state". In the Citizen's Manual the practice and delight of all the social, political and civil rights of people are protected including the right to come and go (movement) guaranteed to everyone in the whole national during peace time, since there is no strict prosecution against them or they are in the act of crime. The problem of the mentally ill person in Brazil is the disrespect to his legal condition of citizenship. The word which we use to express citizenship is entirely impressed by the universal rational tradition that identifies citizenship as the complete practice and possession of what every man would have in common: rationality. That is why the mentally ill person, seen as insane, is excluded from citizenship. Actually the citizenship condition of the mentally ill person is impressed by the paradox written in the citizenship statute of the mentally disturbed person indicating that the negative influence of this social condition does not involve the faculty due to political and care or merely conjuncture reasons, but due to structural reasons established during the historical organization of the mental disorder figure. Based on the terms used in the mental disorder, the social removal of the mentally ill people was authorized as well as deprivation of the other social rights, that is, his entire citizenship condition. The Halfway House rises at the moment of proposals of changes with an alternative of rescue of this condition.

The reply to the question **"How does the Halfway House work?"** makes clear that the environment of this community is designed in order to help the development of the residents' potentialities, that these residents are stimulated to try increasing responsibilities, try new attitudes and behaviors and develop their social relationship.

It is obvious, through the reports that every resident is reliable and they are aware of the task to keep the community environment. It is also obvious that the local community starts contributing to the support of the Halfway House.

"Everybody does a kind of housework, everybody helps because the house belongs to everybody".

"Everybody does a kind of housework, Graça prepares the meals. The remaining people help do the cleaning".

"Everybody feels free, Dalva does the shopping, the Spiritual Center based on Allan Kardec in front of here helps with the remaining chores".

"Everybody is responsible for something. Dalva does the shopping, takes care of the rent and gets nervous about the mess. We have meetings for explanation on what we are supposed to do and to reprove the residents who do not accomplish their duties or scream".

In response to the question **"Do you have any complaint about the Halfway House?"** if so **"Have you ever thought of going back to hospital?"**

"No, only if I have any problem (crisis) and they take me there by force".

"No, I have no complaint about here, I want to stay here until I die (this patient does not have family)".

"No, Heavens forbid. I want to stay here until I can go out and live with somebody else or by myself in a house".

"Heaven forbid, I'd better die. It is a mess in there. Anyway, nobody can control the insane people".

"I don't want to go back to the hospital anymore. We couldn't even talk. There is no use complaining. Here it is different, when we don't like anything the only thing we have to do is speak during the meeting".

The article 10 of the Universal Declaration of Human Rights states that "Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him". The speeches of the residents are affirmative regarding to the disrespect of this right in the psychiatric hospital. The major complaint of ex-patients related to the hospital is the lack of freedom, oppression, abuse of authority and lack of rest.

"We are not free to do anything there, you have to do everything they order. You can't rest. We can't do what we want".

"We work like slaves there and we can't complain, sometimes we even starve because we can't eat out of the meal time".

"The only thing we do is work, we do not take a rest, we may rest only away from them. It is very bad for we can't run away".

"We can't even open our mouth to speak, we only work as slaves. The food is terrible".

It is obvious that the mentally sick person is disregarded in his rights, forced to do what he does not feel like and work when he is not up to. They complain about injustice and not having anybody to turn to.

In the Citizen’s Manual, it is obvious the Right of doing or not anything, except when the law determines it in a different way. In the State of Right, every person is free to do or not to do or quit doing something if the law does not demand different form, ability or duties. Any act which forces somebody to do or quit doing anything when the law does not demand is considered illegal constraint. Hindering somebody to do something when it is allowed or ordered by law is an illegal constraint as well. Somebody who forces somebody or quit doing anything, if not by virtue of law, must be immediately arrested in the Act of Crime. If the co-author is an authority, "Habeas Corpus" would be appropriate.

Another right of the citizen is the respect to his body privacy. The patient’s need for rest by the administration of medication and opposition to rest is an infraction of this right. Nobody can be subjected to torture or degrading treatment. It is know that mentally ill people take medicine which makes them sleepy and if they are hindered to sleep or rest, it is considered a torture. When an authority disobeys the body safety of a person it is considered abuse of authority. No member of a staff can take advantage of his position to torture, assault or force a person to go through a degrading treatment. The article 5 of the Universal Declaration of Human Rights states that, **"No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment".**

It is noticed that the halfway house shelters few residents, therefore, the staff can control more efficiently the medicine schedule which improves the conditions of the residents making the environment more therapeutic and manageable.

When asked **"Has was your condition before coming to the Halfway House?"** the residents answered that they got bad in hospital, abandoned and neglected, with proper medicine control.

"I went insane, I had dizziness, I felt lonely, I saw things. Here we have attention from the doctor, nurse, social worker and Dalva. Here I take my medicine at the right time. I don’t feel dizzy and I don’t see things".

"I heard voices, I walked around, I saw things, I couldn’t work. Now the doctor has changed my medication and I take it according to his schedule. I am much better. In hospital I got worse because of the medicine. There I couldn’t talk to the doctors".

"I really went insane, depressed, I didn’t feel like doing anything. I just wanted to be lying, but they didn’t allow us to lie down at daylight. I wanted to be alone, but they bothered me. Now I am better, sometimes I go insane, but when I am fine I help with the cleaning and I go for a stroll with Graça".

Dalva likes me, Graça likes me, Bertinília likes me. Do you like me?"

Most of the patients are psychotic who have been in hospital for over 25 years. Most of them have already been submitted to somatic therapies like electro convulsive therapy, with traumatic experiences of treatment.

"I had a good mental health, I worked at the Mercy Hospital, I took care of sick people, I gave injections, then I started getting worse, I ended up in a mental institution. I was submitted at least to 30 shocks. I have suffered a lot. Thanks be to God I am happy now. I am not complete treated but I can work and take care of my life. I ran away from my family. My father wanted to kill me. My father wanted to have sex with me. He had intercourse with me. I grew up and I was very ashamed of it. I didn't tell anybody. When I became a young lady I warned him I would tell what he did (she shows the scars on her breast). He attacked me with a knife. He was arrested. I became a whore and started taking drugs. I was arrested and taken to the hospital where I have been since then. I was submitted to many electro shock therapy sessions. My father hurt me so much. I think he is already dead. I feel protected here".

The responses to the question **"What is a Halfway House?"** the expropriation of the minimum rights and survival of the patients in this kind of institution is a confirmed.

"It is good because we have our house. We have arguments but we love each other".

"It is good here, everybody does what they are supposed to do, we go out together and we come back whenever we want to".

"Well, we weren't well treated in hospital. The other patients were nervous and had arguments with us. I helped with the cleaning. When I moved here everything has changed. I can sleep well and eat whenever I want to".

"We had no freedom and rest in hospital. We couldn't eat when we felt like eating let alone sleep well. Here everybody has his stuff, takes care of his things and everything is clean".

"We were in hospital, we worked like slave there and we didn't have anything. We got depressed. Here we do some job here or there and I already have money in the bank".

When you are not feeling well in the halfway house, you may rest. There is total freedom to do that. Dalva explains that it is not good to be in bed all the time, we must stay in bed only when we are not feeling well or when we are tired, sleeping too much is not healthy.

It is noticed that the awareness of citizenship, of being treated as person with respect is gradually conquered.

"We do some job here and there, I have already saved some money in the bank, the Spiritual Center helps us with the supplies. The only problem is that there are arguments among the women".

Problems are common, but they may be solved or worked out with a good conversation on behalf of the individual and group development.

"It is good, but some of us are not mature enough. Here there are arguments, lack of organization, but it is much better than in hospital. There are discussions because we can protect ourselves here. Once in a while Dalva (advisor) also helps us organize the house".

"It is good, it is like I was in my house. Our lives are calmer. It is different from the hospital. Here we can go out alone and make friends".

On being asked about **"What has changed in your life after you came to the Halfway House?"**

"Here I have a bed, a house, food, in the hospital I had them but it was confusing, nothing belonged to us. Here I feel that the house is mine and I can struggle for it and other things which belong to me".

"We have freedom, our lives have changed. When I was in hospital, I worked but I didn't earn any money. Now I already have some money in a savings account. I want to get a stable job".

"It was very good to come here. Everything has changed. I have another life. I was dead in that hospital".

"I got my freedom. I go to the primary care center by myself to receive the insulin injection and I take advantage of it to go for a walk, see people on the streets and talk to normal people. There we lived in dirty places, it was no use cleaning, it was a sty".

"We lived like slaves and even starved. It is different here. When we want to eat something we fix it ourselves. It is good to take care of everything".

In terms of the question **"What are your expectations for the future?"** the residents stated: assets, partner, job, occupation, money, peace and find their family.

"Have a house to live with my girlfriend, but just live, work and get a better life".

"Get a good job and work. I want to get money. I want to be respected in life".

"Live with my partner, alone with him, he doesn't want to get married. I want to have my belongings".

"Have a house, a telephone, money in the bank to live in Petrolina forever. I would like them to find he family in Petrolina. Poor, she cries a lot".

Conclusion

The Halfway House is an alternative of care that works as a resource designed to help the development of potentialities of ex-patients in a democratic and therapeutic environment where there is respect and accomplishment of human rights, as a result, the Articles of the Universal Declaration of Human Rights, respect to life, freedom and safety; some residents, besides their tasks, have already had a retirement income, fair conditions and protection against unemployment. As members of a society, they have social security and satisfaction regarding to social, economic rights which essential to their dignity and free development of their personality.

The Halfway House meets the several articles of the Universal Declaration of Human Rights because it does not hold its residents in slavery or servitude; the residents are not subjected to torture or to cruel, inhuman or degrading treatment or punishment; everyone has the right to recognition everywhere as a person before the law; everyone has the right to own property alone as well as in association with others; no one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed no shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed (that is, educational and therapeutic conversation); everyone has the right to freedom of opinion and expression; everyone has the right to rest and leisure and make proper use of spare time.

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BUPRENORPHINE-KETOROLAC vs. CLONIDINE-NAPROXEN IN THE WITHDRAWAL FROM OPIOIDS.

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Abstract
The authors analyzed the comparative results of two groups of patients undergoing detoxification from opiates: one group received a Clonidine-Naproxen protocol, and the other received Buprenorphine-Ketorolac. Success rate of Clonidine-Naproxen (CN) was 81%. and success rate of Buprenorphine-Ketorolac (B-K) was 73%, success defined as patients who finished detoxification procedures and were drug-free at the end.

Despite the better results for the CN group, BK was much better accepted by patients. One of the advantages of the Buprenorphine protocol was that it did not require close supervision and monitoring, thus abating the costs significantly.Buprenorphine doses used were lower than average reported in literature, and the authors attribute this to the concomitant use of Ketorolac.

The authors recommend the use of BK in order to increase the number of patients asking for treatment. The addictive potential of Buprenorphine is emphasized but also the misuse of Clonidine by patients attempting at self detoxification is brought to attention.

Introduction

The need for an effective and accepted method of opioid withdrawal is ever increasing. Different methods have been tried, but none has proven to be perfect (1), (2). One of the principal problems of most methods is that they require hospitalization, and are consequently expensive. Other, less expensive methods are not easily accepted by patients asking for withdrawal, either because they are painful or because the side effects are undesirable.

Classical maintenance-detoxification methods, such as methadone detoxification, are not accepted by both public and some institutions, due to the preconcepts about methadone, although methadone detoxification seems to be the most effective and less troublesome method for ambulatory detoxification (3).

A new concept on opiate detoxification with Clonidine has been developed in Israel, called "house detoxification" (4). In this method, the patient receives instructions about the use of Clonidine, and performs the detoxification at home, under family surveillance.

Two varieties of this procedure are used: in the first, the family receives specific instructions about the use of a digital sphygmomanometer and about Clonidine doses the patient has to receive, and about blood pressure monitoring which permits or does not permit to administer the Clonidine. At the end of the procedure (usually from 7 to 10 days) the patient returns to the clinic for final check-up and directions for continuation of psychosocial treatment.

In the second variety, a team composed of a doctor and/or nurse, social worker and counselor visit the patient at home, check blood pressure and advise about continuation of medication, while at the same time starting the psychosocial intervention, which is later continued.

We developed a different protocol for ambulatory detoxification, using a combination of Buprenorphine and Ketorolac, to be used as the first variety described above, and which was well accepted by patients.

MATERIAL AND METHODS

In an attempt to establish the comparative efficacy of two relatively inexpensive ambulatory methods, we studied the results of 32 patients who were given a Clonidine-Naproxen protocol according to the first variety described, and 81 who were given a Buprenorphine-Ketorolac protocol, also on an ambulatory basis. Patients on B-K did not have to be monitored, and consequently the cost of the treatment was considerably lower. The treatments were carried out at a private clinic in Tel Aviv.

Initial daily doses of Buprenorphine were in average lower than generally recommended, (5), (6), (7), and, in our opinion, this was possible due to the use of Ketorolac.

The use of Ketorolac together with Buprenorphine was suggested by the paper by CANADEL.-CARAFI. J. et al. (8). and it was based upon the rationale that providing the patient with two different analgesics: an opioid one (Buprenorphine). and a non-opioid one (Ketorolac) would greatly improve the degree of analgesia, thus making the treatment more symptom-free.

RESULTS

Data for the two groups was as follows:

GROUP 1 (BUPRENORPHINE-KETOROLAC, BK)
N = 82

Average age: 32 (range: 22-47)

Reported average daily use of Heroin: 0.84 grams

Average length of treatment: 9.75 days

Average initial dosage of Buprenorphine: 1.80 mgs/day

Succeeded: 60 (73%) (*)

GROUP 2 (CLONIDINE-NAPROXEN, CN)
N = 32

Average age: 32 (range: 24-49)

Reported average daily use of Heroin: 1.18 grams.

Average length of treatment: 9.5 days

Average initial dosage of Clonidine: 900 micgr/day

Succeeded : 26 (81%) (*)

* - Success defined as percentage of patients who finished treatment and were detoxified at the end.

Table 1

	Buprenorphine - Ketorolac	clonidine - naproxen
Number	82	32
Average age	32 (22-47)	32 (24-49)
Daily use of Heroin	0.84 grams	1.18 grams
Average length of treatment	9.75 days	9.5 days
Average initial medication dose	1.80 mgs./day	900 micgr/day
Succeeded (% of patients who finished treatment successfully)	N = 60 (73%)	N = 26 (81%)

DISCUSSION

From the above it seems clear that success rate of Clonidine-Naproxen (CN) is higher than that of Buprenorphine-Ketorolac (BK).

Nevertheless, there are other considerations to the problem:

First of all, we should consider the problem of logistics. The use of Clonidine requires frequent blood-pressure check-ups, which are not easily carried out at home. There is usually a need to either send a nurse home to check blood pressure, or to provide the patients and/or their families with a digital sphygmomanometer for self use. Not every patient can afford a digital sphygmomanometer. Sphygmomanometers, when given to take home, have a tendency to disappear or malfunction. With this method, families are required to cooperate in a degree higher than generally accepted by them, and not all families are ready to provide such a degree of cooperation. Consequently not all patients may use this method.

In second place, we have to consider that CN has good, but not excellent results in preventing the symptoms of withdrawal (9, 10), and patients more often than not complain of pain and other symptoms of the withdrawal syndrome, not entirely suppressed by either Clonidine or Naproxen. Many patients refuse to start this method, because they have heard, or know from previous experience, that symptoms are not totally avoided.

In third place there is the fact that in the first few days of CN patients are usually unable to function properly, they have to lose working days and give explanations as to why they were absent. In the cases when the patient was working despite the addiction, this is undesirable.

Using BK allowed the patients to function normally since the first day of treatment, thus avoiding social and labor problems.

This condition apparently enticed many addicts to come for treatment who had never dared to do so before.

CONCLUSIONS

Although the Clonidine-Naproxen protocol was more effective than the Buprenorphine-Ketorolac one, the authors are of the idea that the Buprenorphine-Ketorolac protocol is more attractive for the patients, and entices them to come for treatment more often and more willingly than the Clonidine-Naproxen protocol.

In places where the problem is to make treatment attractive, so as to reach more potential patients and bring them forward, the use of the Buprenorphine-Ketorolac protocol is advisable.

Nevertheless, it must always be taken into consideration that Buprenorphine poses a risk for addiction, although lower than Morphine (11), (12), and the use of Buprenorphine has to follow all the restrictions concerning the use of any other addictive substance.

Clonidine, on the other hand, is not considered addictive in itself. The authors could not find literature concerning the illegal or irrestricted use of clonidine.

Despite the lack of literature on the subject, though, many patients report having used Clonidine freely and without medical supervision, in attempts at self-medicated withdrawal from opioids.

The irrestricted use of Clonidine seems to have been connected with some deaths among the drug-addicted population in Israel, and consequently also Clonidine use should be closely supervised and restricted.

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Earning Money via the Internet: Perceptions of Women with Schizophrenia of In-Home Computer Work

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ABSTRACT
Objective: The aim of this inquiry was to find out whether women attending an outpatient clinic for schizophrenia had an interest in part time work from home using the Internet. Background: The literature suggests that in-home work on a part time basis suits the needs of many individuals recovering from schizophrenia, particularly women. Method: Thirty-two women attending an outpatient clinic during one week in June, 2000 were asked whether or not they had a computer at home and whether they would be interested in earning money doing part time work over the Internet. Results: Five women were interested and capable. One, with the help of a boyfriend, was already earning money via the Internet. Conclusion: By side-stepping some of the disabilities inherent in this psychiatric condition, training patients with schizophrenia to work from home to earn money via the Internet may be a realistic way of increasing both finances and self-esteem.

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Work plays a central role in most people's lives. Those who do not work suffer because of it - economically, socially, and personally. The experience of clients of a Canadian clinic for women with schizophrenia (1) provide glimpses into the challenges of finding appropriate gainful employment. These women speak of the futility of seeking work, even after full recovery, once a disabling illness has struck. Part of the problem is that, paradoxically, work can jeopardize earnings. Beyond a small permissible amount, provincial disability entitlements in Canada subtract all earned income from the monthly government subsidy. Moreover, provincial plans insist that individuals with a history of once having worked (those who, among this population, are the most likely to find employment after recovery from an episode of psychotic illness) apply to the Canada Pension Disability Plan at the same time as they submit their disability claim to the province. The federal disability pension, if granted, disallows all remunerative work. Most individuals with a psychiatric disability realize that illness can recur unexpectedly and are reluctant to abandon the security of pension benefits (which include health and drug coverage) to venture into the uncertainty of the job market. They are, therefore, not interested in full-time work because it automatically cuts off government support. And full time employers, looking for long term commitment from employees, have little interest in ex-psychiatric patients.

Most of the women in the clinic lean toward the part-time or temporary job market (2). Because there is no permanent commitment on the part of the employer, he or she is more likely than the full time employer to take a chance on hiring individuals with a history of mental illness. This market usually demands few skills, but the pay is low and there are no associated unemployment or other benefits. Although such part-time jobs may not interfere with pension benefits, they nonetheless exact a heavy price. Required tasks are frequently routine, unhygienic, and sometimes unsafe (3). Such low level, occasional work means always being on the bottom of a hierarchy, playing a submissive role vis à vis co-workers, having little access to collegial support and no assurance of job continuity. Occasional workers are told what to do and how to do it; they have no decisional authority or latitude. They are never allowed the autonomy to arrange individual time schedules and have no privacy in their work space, all of which results in stimulus overload. These are the very conditions that are known to promote job stress (3-8) and that, from a rehabilitative point of view, should be avoided by individuals vulnerable to recurrences of serious psychiatric illness. Unhealthy work conditions have been suspected risk factors for episodes of schizophrenia (9). At the same time, it is known that individuals prone to schizophrenia, in order to avoid competition, undue expectation, or social interaction, seek out low level jobs where work conditions, almost by definition, are unhealthy (10).

When questioned, the women in the clinic endorse the opinion that a major source of job stress for women in general, and particularly for women with a history of psychiatric illness, is the conflict between obligations of work and home (11-15). Already feeling guilty that episodes of illness have involved absences from home and from the continuity of marital and mother-child relationships, women in the schizophrenia clinic express ambivalence about joining the work force. On one hand, they want the pride of achievement, the salary, the identity, the collegiality that comes with a job; on the other hand, the guilt of less time spent with children, with necessarily lowered domestic standards of cleanliness and nutrition and the burden of organizing complicated schedules of delivering children to school and picking them up, plus arranging a back-up system when children are ill, is viewed as overwhelmingly stressful.

Many clients of the clinic are single parents living in poverty. They frequently have no one to whom they can safely entrust the care of their children. They may be alienated from parents or other family members. These women want occasional work that is not demeaning, that can be done in the privacy of their own living space, during times that are convenient to them. They prefer not to interact with others face-to-face and they prefer not to be placed n a position which allows comparison to others. They do not think, for the most part, that they are well-groomed enough or well-dressed enough to work in an office with other women. Elsewhere, employment specialists have been successful in placing similar clients in individualized job settings suited to their needs (16-19).

Since recent economic shifts have highlighted the potential of the work-from-home advantages of Internet companies, we asked all the women attending the clinic during one week in June, 2000 whether they knew anything about Internet work , whether it would interest them, whether they owned a computer with Internet access, and whether they knew how they might go about inquiring into such jobs which might entail reading and email response to customer/corporate enquiries or complaints, carrying out online research, doing web design and layout or digital art work, copy writing, or transcribing and proofing voice dictation.

Of the 32 women we talked to, 8 were students, 3 had full time jobs, 3 worked part-time, 1 was currently looking for work, and 7 had child care responsibility. The remaining ten did not have a definable occupation.

One of the women with a full time job was on a disability leave from work and, as part of her retraining, was taking a computer course. She knew about jobs that could be done from home for Internet companies and had actually had an offer from an acquaintance to work for him. She stated: "I was somewhat tempted, but not seriously so. I don't want to go back to my regular job but, at the same time, I don't want to lose the benefits that come with it. I don't want to go back because they watch me and read my email and tap my phone. And I don't like meeting face-to-face with customers, which is part of my job, and I absolutely hate my boss." On the face of it, this woman seemed like an ideal candidate for a part time Internet job once her employee medical disability ran out and she was on government assistance. "No," she said to my direct question about the new possibilities, "I can't get away from the surveillance. They'd follow me home. I'd have no peace working from home. I wouldn't be able to get away from it."

The other two women who were already working full time could not see an advantage to workingfrom home. Both said they would miss the socialization of work. "Though it's sometimes hard to get up in the morning, I'm glad to have something to get out of the house for." One woman lived with her retired father and didn't like "the idea of spending all day in his company." The other one was married and felt she had to "pull her share of the load" by maintaining her present job until she could claim retirement benefits. Neither owned a computer nor were interested in the concept of working for a "virtual" firm.

The six students were taking courses in philosophy, environmental studies, English literature, art, cosmetics, and computer science. Some had interrupted their studies for the time being, but were intending to return. None of the six expressed any interest in working from home after graduation except the English literature student who was considering a job writing web pages. She owned a computer and thought she knew how she could obtain work in this field. She thought her father and her brother could help her. Interestingly, she felt that, since interpersonal relating was a problem for her, the experience of being in an interpersonal environment would be good training so she did not think a 'from home' job was the right way for her to go. The art student was just starting art school and could foresee no difficulty in finding full time work after graduation. Optimism about eventual employment characterized all the six students. They were relatively young compared to the other women in the clinic and had suffered from schizophrenia for a shorter period.

Of the seven women with children, four did not currently live with their children. Two women had children in foster care; the other two women's children had been placed with relatives by Children's Aid. I first asked these four whether they could see themselves doing work part-time from home via computer. Only one expressed interest in a job but was unable to say what kind of job might be suitable for her. The others all felt they were busy enough as it was trying to extend visiting time with their children and attending parenting classes. The three women whose children were at home were more interested. One was sharing custody of her two children with her ex-husband and was already having trouble organizing her time around the children's schedule so that her interest did not seem realistic. The other two both had child-help from mothers and mothers-in-law and both had had recent work experience.They were interested and quite knowledgeable about what they would need to do to inquire further into job possibilities.For these two women, from home part-time Internet work seemed realistic and manageable.

Five women suffered from severe symptoms that remained uncontrolled by treatment. One also abused drugs. The idea of work was not at all attractive although one of these women had worked most of her life and was, even in her very ill state, doing several volunteer jobs and taking part in a number of organizations and clubs.

Eleven women without children said they wanted to find work. E. has worked in the past but was now having trouble concentrating and had been unable to complete an entry level computer course. C. is actively seeking work but wants nothing to do with computers. J. wants to do something "physical" like teaching yoga and cannot see herself sitting at a desk. Z. is quite proficient on the computer, very well educated, and had held a number of jobs in the past. Nevertheless, she said: "I do not approve of computer companies and only want to work at something which has meaning and purpose." L. has teaching qualifications and speaks several languages. Realistically, she could easily do computer work from home but would need to be trained and is, at present, lacking the confidence to try something new. A. has just completed a vocational rehabilitation course where she learned basic computer skills. She is currently on a job placement in an office and may continue in that job. She lives with her parents; her mother works and her father is usually at home. "Being alone in the house with him would not be easy," was her response. S. abuses alcohol and has been unable recently to keep any job she attempts - although she attempts many. If her alcohol problem were solved, she would probably be able to work from home very well. Her boyfriend works with computers and would be able to help. K. is recovering from cancer treatment but is otherwise very interested. She and her roommate have bought a computer and she likes the idea of working from home because she considers herself "too fat to apply for an outside job." R. has worked until recently and is now volunteering in a library, so is exposed to computers and Internet. But she is easily stressed and easily confused and says "computers scare me." B. is a younger woman but also gets confused easily and would probably not be self-directed enough to do computer work from home. She currently works as a volunteer. O. lives with a boyfriend and, together, they collect antiques and sell them successfully at auction sites over the Internet. They have registered several domain names and hope to sell these as well. O. is an example of how, with the help of an enterprising colleague, someone with a moderately serious form of schizophrenia can be gainfully and creatively occupied from home.

For a variety of reasons, most of the women questioned would not be interested or would not be able to attain sufficient skills to work from home on the Internet but 5 of the 32 or 1/6 of those questioned seem to be likely candidates for this form of training. Patient O. is a good example of how well this can work if circumstances are right.

We need to foster conditions which allow individuals with schizophrenia to work at their own pace, from the security of their own home, away from the gaze of others, and yet to obtain both job satisfaction and good pay. Specialized training programs have proven effective (16-19). The Internet in this new century has opened up opportunities which overcome the weaknesses of people with severe psychiatric disorders and draw, instead, on their strengths.A variety of personal service exchanges such as smarterwork.com and eFrenzy.com which are already in existence could be helpful to psychiatric patients..

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ARE TENS OF THOUSANDS OF THE MENTALLY ILL BEING MISDIAGNOSED?

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ADDITIONAL INFORMATION ON SDIP: www.rust.net/~norman/

Citation:

Part 1

I have been working to establish the new diagnosis of substance dependency-induced psychosis (SDIP) for the past six years. It is a important and very common diagnosis, with likely half of all cases diagnosed as schizophrenic really being that of a SDIP. They are both functional psychoses and their signs and symptoms are quite similar. I serendipitously first used the diagnosis on a patient 26 years ago. He was a 45 year-old auto executive 3 months into his recovery from admitted alcoholism, with AA attendance as his only treatment. He had no other history for psychiatric problems and was doing well when an older brother unexpectedly died. The next morning he was confused and told his wife he "was afraid his car would tell his employer that he wanted to drink." (It was a company car and his company didn't want him to drink.) He had already been given the diagnosis of schizophrenia by another psychiatrist. I took over his case in the hospital about 3 weeks after the start of his illness, because of my position as consulting psychiatrist at the substance dependency treatment center where he had recently been treated for uncomplicated alcoholism. I shortly informed him of my very unofficial diagnostic impression. He largely accepted it, and this helped to further motivate him for lasting sobriety. After a year of often irregular outpatient treatment, he was able to safely get off all medication. For the remaining 15 years of his life, he functioned well and never drank again.

Academic psychiatry hasn't liked this diagnosis because it clashes with its 'biological ideology.'

To summarize the support for the diagnosis, there have been three nationally known psychiatric experts in substance dependency who have supported further investigation of the diagnosis. The National Council on Alcohol and Drug Dependence (NCADD) added its support almost a year ago. Quite recently, the California Mental Health Dept. took the public-spirited, open-minded and even courageous action of informing all of its psychiatrists about the diagnosis. The "courageous" aspect of this action is that academic psychiatry "hasn't liked" this diagnosis because it clashes with its "biological ideology." It has largely dealt with the diagnosis by simply "stonewalling it." Biological psychiatry greatly emphasizes the role of genetics and "biochemical imbalances" in the origin of serious psychiatric illness. In doing so it is often guilty of overly reductionistic and simplistic thinking. Its very name represents a distortion of the dictionary meaning of the legitimate term, "biological." Its influence has had the very unfortunate effect of eliminating any training in ("unbiological") psychotherapy at many psychiatric training programs. At my web site www.rust.net/~norman is a very worthwhile and critical essay on "Biological Psychiatry" by psychiatrist David Kaiser, which is entitled: "Not By Chemicals Alone: A Hard Look At Psychiatric Medicine."

The head of the addictive section of an eastern medical school psychiatric department was seriously planning to organize a clinical trial on the diagnosis two years ago. But this was largely prior to his assuming the post. Subsequently, he soon lost almost all of his interest and initiative regarding the diagnosis. I could only assume that he had underestimated the resistance of the psychiatric department to the diagnosis, and didn't want to deal with the inevitable hassle it represented.

I recently learned with some difficulty from the University of Melbourne (only) that it is currently conducting a clinical trial on what captures much of the essence of the SDIP diagnosis. This knowledge came about because a father from Australia had emailed me after having accessed my web site on the diagnosis. His 15 year old son had became mentally ill after abusing drugs during his parent's recent divorce, and was not doing well. He remarked that reading about the diagnosis was "like a breath of fresh air for him." I agreed with him that the diagnosis likely applied to his son. A few months, later I learned that his son was responding very well to treatment being offered at an outpatient treatment program, and that it was "much like I had recommended for SDIP patients." It was this knowledge that led me to learning that the son was a participant in a clinical trial. He was exceedingly fortunate to have such a concerned father, and to have lived near the only appropriate treatment program for him in the world. The father didn't want to reveal where his son was being treated- but I later learned that it was at the EPPIC (Early Psychosis Prevention Intervention Centre) program in Melbourne- which is aimed at young people.

I will be candid about this article. It is intended to inform- but also to motivate its readers to do whatever they can to support adequate media exposure of this diagnosis. I am convinced that the public has a right to know about this diagnosis, and that enough exposure will inevitably result in some medical school organizing a critically-needed clinical trial. I live in Michigan and the medical writer for the Detroit Free Press expressed real interest in reporting on the diagnosis earlier this year. Then about a month later, she mysteriously lost all her interest- and never would explain herself. I am convinced she belatedly learned of the "politically incorrect status" of the diagnosis. It is absolutely inevitable that the SDIP diagnosis will eventually become officially established. I would like this to happen sooner than later to avoid the preventable and very considerable suffering on the part of so many SDIP-afflicted persons.

The diagnosis of a SDIP is predicated on the pre-existence of a substance dependency, for which a variety of evidences point to its crucial role in the genesis of the psychosis. These include the timing of the illness, the nature of its symptoms, and the response to treatment. (One patient suffered his last auditory hallucination when he finally fully admitted to himself that he was alcoholic. This occurred six weeks into an outpatient substance dependency treatment program. A "voice" then said to kill himself. It was his first "voice" in months, and the first ever involving any suicidal ideas.) My executive patient likely would never have suffered a psychosis if he hadn't first become alcoholic. He also probably wouldn't suffered a psychosis if his brother had died several months later, when his alcoholic recovery would likely have been better consolidated. The first psychotic symptoms often develop during regular practice of the dependency. But they also often occur during periods of reducing or attempting to cease use of the substance because of increasing problems with its use. Probably the strongest evidence for the diagnosis is when a person first experiences symptoms very shortly after a return to (usually moderate) substance use- following a significant period of abstinence.

Part 2

Alcohol, tobacco, cocaine and marijuana

The most common substances involved are alcohol, tobacco, cocaine and marijuana (though tobacco only rarely by itself). The more substances involved and the greater the chronicity of the dependency, the greater is the likelihood of a psychosis later developing. Its first appearance is unlikely beyond a six month period from the last use of the substance. Its duration may be brief or it can last a lifetime. The latter can even be the case if the person never uses the substance again. Abstinence from all addictive substances (except nicotine and caffeine) is crucial- but often not sufficient by itself for recovery from the psychosis. It is abstinence, in the context of the person knowing he or she has a dependency, and learning about the vital causal role of the dependency in the psychosis which are the cornerstones of effective therapy for the SDIP patient. There are some state mental hospitals which have mental illness/substance dependency or dual diagnosis wards. These are a step in the right direction, and include some education on addiction. But the emphasis of treatment is on the need for abstinence because of the interference that any substance use has on the medication treatment of the psychoses. Of course, this is true as far as it goes- it just doesn't go far enough. The great majority of these patients do go back to some substance use. Knowledge of the causal role of the dependency doesn't automatically provide enough motivation for abstinence- but it helps.

It has been my experience that nearly all of the cooperative patients I have treated with a SDIP diagnosis have experienced considerable improvement over that of their previous psychotic diagnoses. Treatment has been mainly outpatient on a weekly basis for 3-12 months. It is of a individualized, educative, and insight-producing type- with the emphasis being placed on the dependency, its meanings and consequences of its practice for them. Fully a third have experienced full remissions, meaning no more medication is needed and that they have enjoyed a good return of function. The chances for the remission being permanent are good, providing they stay abstinent and otherwise maintain a good recovery from both the dependency and the psychosis. Either AA or NA attendance is a good idea for many of these persons. The average SDIP patient is less ill than the average schizophrenic patient to start with, and the treatment advantages of correctly making the diagnosis further improves the prognosis for these persons.

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Exploring Hope in Individuals with Schizophrenia

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Abstract

The purpose of this study was to assess the stability of hope, measured over a three-month period and to assess the effectiveness of a short-term intervention for individuals with long-standing schizophrenia. A before-after study design was used. The level of hopefulness was measured in thirty subjects, using the Miller Hope Scale. Eleven subjects self-selected to attend an inspirational lecture delivered by an individual who was coping well with schizophrenia. All 30 were tested again 2 and 6 weeks after the lecture. Subject bias was tested on each occasion using the Social Desirability Scale. The entire group had no significant change in hopefulness over time (F=1.86, df=2, p=.165). At the two post-test times, no significant difference was found between attenders and non-attenders on their level of hopefulness (F=.03, df=2, p=.968). The study group (x=142.30, SD=26.74) was 20 points lower on the Miller Hope Scale than the norms for healthy, normal adults (x=164.46, SD=17.65), but with larger variation in scores. This pilot study found that hope is a relatively stable phenomenon in individuals with long-standing schizophrenia. The relatively large variations in hopefulness indicates the need for future studies examining factors that influence this variation. The evaluation of the one time inspirational lecture found no long-term effect on hopefulness.

Introduction

The outlook for individuals with schizophrenia has changed dramatically over the years, partially due to changes in diagnostic criteria (Hegerty, Baldessarini, Tohen, Waternaux, & Oepen, 1994). It has also changed as a result of the findings of very long-term follow-up studies which demonstrate better outcomes than were previously thought possible (Harding, Zubin, & Strauss, 1987). However, the new view of prognosis is not necessarily communicated in the treatment settings of individuals with schizophrenia (Deegan, 1988; Harding & Zahniser, 1994; Leete, 1993).

Psychosocial rehabilitation is an approach aimed at improving the outcome (or induction of recovery) for individuals with schizophrenia. Promoting a hopeful attitude is one of its basic principles (Anthony, Cohen & Farkas, 1990). Some first person accounts of schizophrenia describe regaining hope as a turning point in recovery (see for example, Deegan, 1988 and Lovejoy, 1984).

The past decade has witnessed a dramatic rise in the number of individuals with schizophrenia coming forward to share their stories. Consumers and professionals alike have been inspired by the stories of individuals reclaiming their lives despite serious obstacles (Hatfield & Lefley, 1993). What is the actual impact of this increased openness? Many believe that it challenges the conventional wisdom of the outcomes of schizophrenia and brings hope to individuals living with the illness.

Most of the research on hope in various populations has been cross sectional in nature (Farran, Herth, & Popovich, 1995; Fehring, Miller, & Shaw, 1997) and there has been virtually no research on the natural variance of hope over time in individuals with schizophrenia. Existing literature on hope suggests that supportive relationships and positive role models could serve as hope-inspiring interventions (Farran, Herth, & Popovich, 1995; Dufault & Martocchio, 1985; Kirkpatrick, et al., 1995). One study of homeless veterans found increased levels of hope among participants following a hope-inspiring group strategy when compared to a control group (Tollett & Thomas, 1995).

There is limited research on hope and individuals with schizophrenia. Hopelessness, conceptualized as low self-concept, depression and external locus of control, was associated with poor rehabilitation outcome in a study of 46 individuals with schizophrenia (Hoffmann, Kupper, & Kunz, 2000). A study on hope in individuals who were hospitalized for schizophrenia demonstrated that hope improved in 14 suicidal individuals using a combination of medication and psychosocial treatment (Littrell, Herth, & Hinte, 1996). In a cross-sectional study of individuals with schizophrenia, Landeen, Pawlick, Woodside, Kirkpatrick, and Byrne (2000) found significant correlations between hopefulness and a subjective sense of health. To date, there has also been virtually no research into the effectiveness of particular hope-inspiring strategies in schizophrenia.

While definitions of hope vary, nearly all include the idea of a positive, future orientation. For the purposes of this study, Miller's (1986) operational definition of hope has been used:

> Hope is a state of being characterized by an anticipation for a continued good state, an improved state or a release from a perceived entrapment. The anticipation may or may not be founded on concrete, real world evidence. Hope is an anticipation of a future which is good and based upon: mutuality (relationships with others), a sense of personal competence, coping ability, psychological well-being, purpose and meaning in life, as well as a sense of 'the possible' (p. 52).

The purpose of this pilot project is to determine the stability of hope in individuals with long-standing schizophrenia over a three-month time period and to assess the effectiveness of a short-term intervention of their levels of hopefulness.

Operating hypotheses are as follows. 1) Levels of hope in individuals with long-standing schizophrenia, as measured by the Miller Hope Scale (MHS) (Miller & Powers, 1988), will differ significantly over time. 2) Individuals with schizophrenia who self-select to attend an inspirational speech given by an individual who is coping well with schizophrenia are more hopeful at baseline than their non-attending counter-parts. 3) A positive change on the MHS will be related to attendance at an inspirational speech and this change will be sustained over time. 4) Individuals who are more hopeful are no more likely than the general public to answer questionnaires in a manner they think the researchers expect, as measured by the Social Desirability Scale (SDS) (Crowne & Marlowe, 1960).

Methods

The study uses a before-after design, with subjects completing questionnaires prior to the lecture and at two follow-ups, approximately one month apart. One of the researchers was present during test administration to ensure that participants answered all questions thoughtfully. The study received Ethics approval from the Review Committee on the Use of Human Subjects, University of Toronto.

Sample

Individuals who were clients of the Continuing Care Division of Centre for Addictions and Mental Health, Clarke Site were invited to participate in the study. Inclusion criteria were: a diagnosis of schizophrenia as defined by a SCID-determined DSM-IV diagnosis of schizophrenia (American Psychiatric Association, 1994) and the ability to read and understand English at a Grade 5 level or higher.

The Intervention

The existing research and theoretical literatures on hope identify relationships as being key ingredients in promoting hopefulness (eg. Farran, Herth, & Popovich, 1995; Dufault, & Martocchio, 1985; Byrne, et al., 1994; Frank, 1968). Many authors discuss the contagious effects of both hopefulness and hopelessness (Farran, Herth, & Popovich, 1995; Landeen, et al., 1996). Schizophrenia can challenge the individual's ability to form and maintain reality-based, hopeful relationships both due to the illness itself (Seeman & Greben, 1990) and to the isolating stigma, which occurs in relation to the illness (Deegan, 1988; Leete, 1993). As identified earlier, one strategy that has been identified by staff working with individuals with schizophrenia for enhancing or supporting hope is connecting individuals to positive role models (Kirkpatrick, et al., 1995). One way to facilitate this connection is through a one-time lecture delivered by an individual who is coping well with schizophrenia.

Mr. William McPhee, publisher of Schizophrenia Digest and the 1997 recipient of a Schizophrenia Society of Canada award, is a Canadian consumer who gives public addresses about his personal experiences of schizophrenia and his story of recovery. He has talked to family and consumer groups and is currently being sponsored to deliver talks across Canada. Mr. McPhee was a Bertha Rosenstadt Lecturer at the Clarke on March 6, 1996. Consumers, family, and staff were invited to attend the lecture. Notices were posted and included in publications consumers were likely to read. Pizza was served after the lecture to encourage attendance. Staff at the Day Centre, from which most of the study participants had been recruited, encouraged members to attend the lecture. However, neither staff nor consumers knew that the lecture was part of the research design.

Measurement

All subjects were aware that they were volunteering in a study that measures hope, and this, in itself, might have influenced the level of hopefulness of the subjects. However, subjects were blind to the inclusion of the inspirational talk as part of the study, thus reducing the sampling bias for impact of the intervention. In addition, all subjects completed the Marlowe-Crowne Social Desirability Scale (SDS) to determine if the subject group is more likely than the general public to respond in a manner they believe the researchers want (Crowne & Marlowe, 1960). The SDS has established reliability and validity and is used extensively in research.

All subjects completed a Miller Hope Scale (MHS), which measures multidimensional aspects of hope, and has established reliability and validity in handicapped and non-handicapped samples (Miller & Powers, 1988) and has been used in psychiatrically ill populations (Holdcraft & Williamson, 1991; Landeen, et al., 2000).

Data were analyzed using repeated measures ANOVA to test for variability over three points in time and to compare the attenders and non-attenders. Z tests were used to compare the means of the subjects to published norms for healthy adults on the two scales (MHS and SDS). Pearson correlations were used to analyze the relationship between subjects' scores on the two scales (MHS and SDS).

Results

Forty five individuals volunteered to participate in the study. Six subjects were excluded because they did not meet a DSM-IV criteria for schizophrenia as measured by the SCID. Nine individuals dropped out of the study. A comparison at baseline of included and excluded subjects and drop-outs using two-way ANOVA did not reveal statistically significance differences on either measure (Miller Hope=F Ratio 2.380, p =.11 and Social Desirability=F Ratio .089, p=.915). However, the differences approached significance for level of hope, with the drop-outs being least hopeful.

A total of 30 subjects met all of the inclusion criteria and completed all of the measures. The average age of the group was 38, with 73% of the sample being male. (See Figure 1.)

Figure 1

Demographics for Total Group (n=30)

Gender		
	Male	22 (73.3%)
	Female	8 (26.7%)
Age		x =38.47
		SD = 8.73
Marital Status		
	Single	25 (83.3%)
	Married	2 (6.7%)
	Sep/Div	3 (10%)
Years Ill		x = 17.03
		SD = 8.51

The entire group had no significant change in hopefulness over time (F=1.86, df=2, p=.165) using repeated measures ANOVA. This pilot study found that hope is a relatively stable phenomenon in individuals with schizophrenia.

No significant differences were found from published scores of healthy, normal adults on either scale (p = .20 for MHS and p >.20 on SDS) using two-tailed t-tests. The study group (x=142.30, SD=26.74) was 20 points lower on the Miller Hope Scale than the norms (x=164.46, SD=17.65) which would lead one to suspect significance. This was not achieved probably due to the large variation in individuals with schizophrenia. This high degree of variability is, in itself, an interesting finding as the fluctuations in hope among individuals with schizophrenia has not been established. The lack of difference on the Social Desirability Scale was in the predicted direction, indicating that study subjects were no more likely than the general public to tell the researchers what they wanted to hear.

Both the MHS and SDS were administered at each testing point. On the first occasion there was a moderate correlation (r=.365) using Pearson correlation. This correlation disappeared by the second testing point (Time 2 r=.160 and Time 3 r=.269).

No statistically significant differences were found between the attenders (n=11) and non-attenders (n=19) on demographic data or on the level of hopefulness or desire to please the researchers at baseline using t-tests. (See Figure 2). At the two post-test times, no significant difference was found between attenders and non-attenders on their level of hopefulness (F=.03, df=2, p=.968) using repeated measures ANOVA. Thus, this pilot study found no effect of the inspirational talk on level of hopefulness.

Figure 2

Comparison of Attenders and Non-Attenders

		Attenders **n=11**	**Non-Attenders** **n=19**	**Total** **n=30**
Gender	Male	7 (63.6%)	15 (78.9%)	22 (73.3%)
	Female	4 (36.4%)	4 (21.1%)	8 (26.7%)
Age		x = 41.36 SD = 8.21	x = 36.79 SD = 8.79	x = 38.47 SD = 8.73
Marital Status	Single	9 (81.8%)	16 (84.2%)	25 (83.3%)
	Married	0	2 (10.5%)	2 (6.7%)
	Sep/Div	2 (18.2%)	1 (5.3%)	3 (10%)
Years Ill		x = 20.36 SD = 8.95	x = 15.11 SD = 7.84	x = 17.03 SD = 8.51
Baseline Comparisons	Hope	x = 140.53 SD = 28.28	x = 138.36 SD = 28.84	p=.51
	Social Desirability	x = 14.91 SD = 4.23	x = 17.53 SD = 4.93	p=.66

Discussion

There was no significant change in hope over time for the entire group, with all of the multivariate tests of significance producing the same results. The time period of approximately three months may have been insufficient for there to be any change, indicating that levels of hope are relatively enduring in individuals with long-standing schizophrenia. Alternately, the instrument may be insensitive to minor fluctuations in hopefulness, although minor fluctuations would be of little clinical significance.

The relatively large variation in hope in the group with schizophrenia (x=142.30, SD=26.74) compared to the published norms (x=164.46, SD=17.65) indicates that there is more to uncover in investigating hope in individuals with schizophrenia. Identifying factors that influence that large variation is of great clinical significance, particularly because the suicide rate is approximately 10% among individuals with schizophrenia (Seeman & Greben, 1990) and hopelessness and depressions have been previously correlated with higher rates of suicide in individuals with schizophrenia (Caldwell & Gottesman, 1990; Tanney, 1992).

The lack of a demonstrated effect of the lecture on the attenders' levels of hope was disappointing. This may be due to a number of factors. First, it was projected that a minimum sample size of 16 per group was required to allow for statistical significance using a standard formula for calculation (Streiner, 1990) and projecting an effect size of 1 standard deviation on the Miller Hope Scale (MHS) following attendance at the inspirational lecture. This projected effect size on the MHS is consistent with the findings of Holdcraft and Williamson (1991) for a mentally ill population comparing initial and post hospitalization rates. Despite an original sample size of 45 and aggressive advertising of the lecture, only 11 study participants attended the lecture. Thus, the impact of the lecture would have had to been quite large for statistical significance to be reached. The very nature of any one-time lecture would be unlikely to produce such dramatic effects given the complex nature of hope. Also, this research was conducted with subjects with long-standing schizophrenia (x=17.03 years). These individuals may have reached a level of acceptance of their illness, or at a minimum, have developed a relatively stable coping pattern, which includes their levels of hopefulness. Future research on hope in schizophrenia should explore variations in hope in individuals with differing durations of illness in order to explore the stability of hope and to identify optimal timing for interventions. It makes clinical sense that individuals with different illness trajectories will require interventions of varying lengths and strategies, of which a hope-inspiring lecture might be one component.

The timing of the follow-ups was designed to capture long-term effects of attending an inspirational speech, and no attempt was made to evaluate hopefulness immediately following the lecture. It may be that the effects of such an intervention are short term and that there may be a short-term window of opportunity in which to clinically intervene to bolster the effect of such a speaker. Thus, the future research should include immediate as well as longer-term follow-ups.

The low correlations between the MHS and the SDS and the similarity of the participants scores with those of healthy adults indicate that there were no discernable patterns between level of hopefulness and desire to tell the researchers what they thought the researchers wanted to hear. Thus, future research evaluating hope-inspiring interventions can have a more open design, allowing for evaluation of hopefulness immediately following interventions.

Conclusion

This pilot study demonstrated that hope is relatively stable in individuals with long-standing schizophrenia. A direction for future research is to establish the stability of hope in populations with differing durations of illness. The study also found relatively large variations in hopefulness among the participants, indicating the need for future studies examining factors that influence this variation. The evaluation of the inspirational lecture found no long-term effect on hopefulness. However, this type of intervention remains promising for inclusion in longer-term, hope-inspiring interventions that are tailored to individuals with varying degrees of experience in living with schizophrenia. This pilot study does begin to unravel some of the basic understanding of hope in individuals with schizophrenia.

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DEVELOPMENTS IN PSYCHIATRIC REHABILITATION: A THERAPEUTIC TRIP

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Abstract
The paper describes the process of preparation of inpatients to be discharged from a psychiatric facility to live in sheltered quarters in the community. The results of a two-year follow-up seem to indicate that this preparation greatly enhanced the ability of the patients to stay in the community, specially those patients who were referred to half-way houses. The paper also describes the efforts of the patients to improve their life style, and engage in activities which are normal for the rest of the population, like planning and taking a vacation trip abroad. The groupal procedure used to improve the patients' social skills is also described.

Introduction

In the last decade there has been a general impulse all over the world to desinstitutionalize mental patients (1). The movement, which started in the USA and in Italy, mostly due to economic reasons, has spread to most advanced countries (2).

Nevertheless, the practical difficulties, the lack of knowledge and experience, and the lack of uniformity in the goals to be achieved in different countries, have created much controversy, and many attempts at desinstitutionalization failed, due to lack of adequate preparation, both in the community facilities aimed at receiving the patients once desinstitutionalized, and in the patients themselves, before being moved from hospital beds to more open facilities.

The Mental Health Center Beer Sheva (MHC) has developed a system of preparation which, according to results, seems appropriate for Israel. It is possible that the system cannot be exactly adapted to other countries, but some of the techniques which were developed may certainly be replicated elsewhere.

1) - Antecedents

The Rehabilitation department of the MHC organized, starting in 1995, a rehabilitation school which provided a series of courses in order to prepare chronic schizophrenics to leave the hospital where they had been admitted for the last average 14 years, and pass to live in new facilities, called Hostels, or Half-Way Houses, being developed in the community. The school provided courses on very basic elements of independent living:

- Personal Hygiene;
- Mental illness and the effects of medication (why is it advisable to continue complying with medication);
- Basic cooking;
- Creating and managing a shoe-string budget;
- Applying to organisms in the community (such as the Municipality, gas and electric companies, etc.)
- Free community resources available and not-generally-known;
- What to do with your spare time without getting bored.

Courses were provided by members of the staff of the Rehabilitation Department, and did not require additional funding.

Those courses covered the four basic elements enunciated by Hersen & Bellack (4,see below). Some other elements of resocialization (5) were covered by other activities carried out in the ward: Group activities on news read in the newspapers or heard in the radio or television, with the dual purpose of 1) Keeping the patients in contact with the surrounding reality of the external world, and 2) To promote dialogue and communication among the patients (6); active intervention of the patients in preparing some of the collective activities, like cleaning the ward (there are no cleaning personnel in the ward); preparing religious or national festivities (which in Israel are the same thing); collective visits to a social club for mentally ill people which functions outside the hospital walls; encouragement of some “normal” social activities which are generally not considered in hospitals, like ordering a pizza on the phone and sharing it with friends (7).

The Outpatient Department, which had to receive those patients for follow up treatment, developed a day-care unit. The liaison unit at the Outpatient Department created a special day-care unit for the management of some 40 to 50 patients, who were engaged in the re-entry process, and who were discharged from the Rehabilitation Department to the Hostels (three of them have been created so far, with different degrees of autonomy for the inhabitants, and a fourth is in the process of being opened).

The day care unit, comprising a doctor, a nurse and a social worker, provides the patients with occupation in the Occupational Therapy department of the MHC or as assistants in the Maintenance and Cleaning department, for a very low salary. Patients are also provided with lunch in the premises of the MHC. This salary, although very low, together with the hot meal provided, assist the patients to square their budgets.

The day-care unit provides placements in the different working areas, including some in the community or in sheltered workshops outside the MHC. It also provides the patients with medical follow-up, including application of injectable medication, social worker services and house visiting when necessary. General medical needs are covered by one of the medical insurance companies existing in the community, which are paid for by a special tax applied to every citizen in Israel.

To assist patients to comply with medication, a nurse provides them with special weekly pill containers (8), and patients take their medication by themselves, although the containers are periodically checked.

In the period 1997-1998, the Rehabilitation Department passed to the care of the day-care unit of the Outpatient Department 48 patients, of which 40 were referred to hostels, and the other 8 preferred to live either by themselves or with their families. 85% of the patients had diagnosis of schizophrenia or schizoaffective disorder, the others had diagnosis of affective disorder. They had been admitted in different hospitals for an average of 14 years.

Of the 40 patients placed in Hostels, 32 (80%) were still doing well at two year follow-up. The eight patients who preferred to dwell with their families had a much higher relapse rate, in excess of 50% (9). 8 patients living in the hostels had to be readmitted, of whom, 7 were readmitted for only a few days, and only one patient had to be readmitted for a long time. The 23 patients admitted in one of the hostels, including 3 patients who had undergone a brief readmission, decided that they had the same rights as everybody else, and that if it is normal in Israel to take a vacation trip abroad, they would also take one of those trips, just like the rest of the population.

In order to assist them fulfill their wish, the day-care unit of the Outpatient Department had to undertake special tasks to insure adequate preparation of the patients.

2) Material and Methods

The principal task for the staff was to ensure that compliance with medication should be total, if relapses or any other mishaps were to be avoided during the trip.

In order to enhance compliance, the nurse of the day-care unit organized a course(10) (11) (12), which in part reinforced the material the patients had learned in the previous course at the Rehabilitation Department, and in part introduced new elements, which were thought to be important for the new goal (13).

The principal points thought to be in need of stressing during the course were (14):

- - That patients understood that their disease was chronic, and that they would need medication for most or all of their lives;

2) - That patients understood that there was a connection between taking medication and avoiding symptomatology and improving functioning;

3) - That patients understood that they should not stop medication even if they felt better or well;

4) - That patients understood and knew the side effects of medication, and the ways to cope with them.

5) - That patients understood that it was within their reach to comply with medication;

6) - That most patients understood that they could be helped by relatives or staff when they had some problem with compliance;

7) - That patients developed sufficient confidence in their doctor or nurse as to be able to ask for help when needed;

8) - That patients would comply with their medication during the three months that the preparation program went on.

These points were chosen based on the theoretical framework on which the program was based. The theoretical framework was provided by the psychodidactic approach of Hersen and Bellack (4), and the work of Liberman (14, 15) on social skills training. Hersen and Bellack remark several issues in the psycho-social approach to the treatment of mental patients:

- - This approach cares of the social aspects which are an important component in the life of mental patients.
- - The approach considers that mental patients profit from the learning process.

3) - The approach tries to provide the same education to dysfunctional patients by the use of limited goals and systems.

4) - The approach supposes a positive result from treatment irrespective of diagnosis and chronicity of the illness.

The goal of the approach is to change the social behavior of the patients without changing their other aspects. The higher the social skills of the patient, he becomes less anxious and depressed, and feels less incapacitated and more self-confident.

Wilkinson & Canter (16) propose some definitions of social skills: Some people define them as the possibility of using behaviors which receive a positive reinforcement, and to avoid behaviors which receive negative reinforcement or punishment. Efficiency of the individual from the social standpoint depends on what he proposes to achieve in determinate circumstances. A behavior which may be appropriate in some circumstances may be inappropriate in different circumstances. The individual brings to every situation his own set of values, ideas and beliefs, and his personal style.

Fundamentally, social skills training, according to Liberman (15), was divided in the following stages:

- - Problem definition: training the patient to identify his deficitarian behavior in order to recognize areas where behavior should and could be improved;

2) - Inventory of assets: This most important item aims at allowing the patient, who usually suffers from a very poor self image, that he has a series of assets he may use and develop in order to improve his problem solving capacity;

3) - Establish a reinforcing therapeutic alliance: This permits to improve the patient's self-image and also permits the positive therapist to bring forth some negative elements without hurting the patient's fragile self-image. This requires establishing rapport, showing concern, expressing empathy, and demonstrating competence;

4) - Goal setting: this requires the patient to focus his attention on specific areas and not to disperse in the pursuit of sometimes unachievable expectations. Setting specific and concrete interpersonal goals is perhaps the most challenging step in the behavioral procedures comprising social skills training;

5) - Behavioral rehearsal: Patients usually do not achieve a high degree of proficiency in their skills from the beginning, the task requires lengthy rehearsal, usually by means of role playing;

6) - Shaping: Shaping is the building of complex sequences and chains of social behavior through successively reinforcing small steps along the way;

7) - Prompting (or cueing): is a technique which enables us to reinforce positive elements even before such elements actually occurred, or when those elements appear only seldom in everyday life in the therapeutic milieu. The therapist must be very active;

8) - Modeling: demonstrating to the patient a determinate behavior or skill as an example, in such a form that the patient may understand it and rehearse it;

9) - Homework and practice in vivo: homework assignments are regularly given to the patients in order to control their compliance with the treatment and to ensure that they acquire sufficient skills in each of the topics.

Development of the training course:
Patients were divided into two groups, one with fourteen patients, and the other with nine. Each group participated in ten two-hour meetings (with a fifteen minute interval). Patients were taught to speak freely and to explain their feelings about the disease. For example: when asked what was the disease they suffered from, some of the patients explained that schizophrenia was like the flu, other explained that they felt depression, or heard voices, others stated that they had fear, others that they had strange thoughts.

When asked about what it was to have a mental disease, they explained that it was to have something wrong in the brain, some bad materials in the brain. Others said that something bad was running after them to hurt them, or that the person who was sick from mental disorders was a person who did not catch reality as it is. In their opinion, mental patients stop functioning, do not want to get up in the morning, detach themselves from the environment and the surroundings.

In the second and third meetings, they spoke about their medicines. The patients explained that their medicines affected and improved their thoughts, their behavior, but complained seriously about the side effects of medication, in their words, “You better don’t try them, they make you extremely tired”.

When asked about why they had to take drugs, they answered that “because they were sick”

When asked about what makes them feel well, they answered: “Adequate treatment, motivation for something, will power, treatment of the personal problems of the patient, self-understanding, to go out to have fun, to take the pills on time, to be in touch with people".

In the fourth and fifth meetings they spoke about side effects of medication. They first received careful explanation about their medications and about the side effects, and then each one spoke about what side effects made him/her feel. After each one had spoken, they received instruction about how to identify side effects, and what to do to avoid them or to reduce them.

Sixth, seventh and eight meeting were devoted to role playing of the effects of medication and of its side effects. In these meetings patients also received instruction through role-playing about the different situations a trip may entail, like arriving to the airport, speaking with the immigration officers, show the passports, and the like.

The last two meetings were devoted to rehearsal of all the material seen in the course, strengthening of points identified as weak, and, very important, distributing to each participant their certificates of completion of the course, a very important point according to previous experiences.

Results

The patients effectively took their trip to Turkey. They 23 of them were accompanied by a nurse and two instructors who worked in the hostel with them.

During the trip there were absolutely no incidents, the patients behaved just like anybody else. Some of them, who were flying for the first time in their lives, were slightly apprehensive, but all in all there were no problems. Once in Turkey, they arrived in the hotel, received their rooms, shared the lives of all the other guests at the hotel, took guided and unguided tours around, with no special difficulties or signs that they were a group of mental patients.

The nurse had taken along great amounts of medication, and was prepared to cope with almost any eventuality, but there was not even need to open the medication case, each patient had been provided with their weekly medication containers, and that was all they needed.

Discussion

From the above mentioned we may conclude that the social impairment of mentally ill people may be overcome, at least partially, by intensive training and dedicated cooperation of the staff (17).

The work made with this particular group of patients may be divided into three stages: a first stage, accomplished during their period of hospital admission, which enabled them to abandon the hospital and pass to live in the hostel; a second period in which they acclimatized to life in the hostel, and in which they decided that they could do just like anybody else, and decided to take the trip to Turkey; and a third stage in which they prepared this trip.

The first stage, accomplished in the Rehabilitation Department in the hospital, started the process of rehabilitation which would lead the patients to eventually return to the life in the community. This stage may in itself be divided into two periods: in the first, the patients were trained in basic socialization skills, and understanding of their disease (18). The second of these periods, the passage to the hostel itself, required the corporate efforts of the staff of the Rehabilitation Department and the staff of the Outpatient Department, with a very gradual transition from one to the other, and with a deep understanding, on the part of the second personnel, of the needs of the patients and of the direction of the efforts made by the first team.

The second stage required a great involvement on the part of the relatively small staff provided by the Outpatient Department, because the patients were very active, and engaged in new activities almost every week, and they often had to be redirected on the positive goals previously fixed, without letting them wander at will.

The third stage required the cooperative effort of the Outpatient Department staff and of the staff of the hostel, in order to make sure that training was continuous and with an adequate rhythm. The repetition of the subjects already covered in the Rehabilitation Department in this stage was of course only a practical application of the principle of reinforcement of behavioral therapy.

The good results obtained during the trip itself were surprising even for members of the staff involved, and only showed that with the adequate amount of effort (19), much can be achieved in the process of rehabilitation. The good results also triggered the will to repeat the experience. The same group is already planning another trip, and the patients of another of the hostels are beginning to prepare their own vacation trip.

The trip also became an important topic of conversation for the patients, among themselves, but also with other people, thus contributing to their resocialization.
It is important to stress that the process of training created a very strong bond between the patients and the staff, which, in all probability, aided to the success of the process (20).

The fact that a group of those desinstitutionalized patients were able to organize themselves, both economically and logistically, to take a leisure trip abroad, indicates that the quality of life (3) of those persons may be dramatically improved, and that our suppositions concerning the ability of chronic schizophrenics to improve their situation must be seriously reconsidered.

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An Overview of Substance Dependency

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The general issue of substance dependency is best exemplified by the problem of alcoholism. There is actually still some controversy as to whether it should be considered as a disease or not. I strongly believe that it is a disease- but just not the usual type. It can't be diagnosed by a physical exam, imaging techniques, or any blood tests. But it ruins lives and kills people. Most psychiatrists and psychologists see alcoholism as mainly a genetic/biochemical type of disease. Then there are those who consider it as only a irresponsible behavior. My understanding of alcoholism agrees with neither of these positions. Both of them fail to look at the great importance of the functioning of the unconscious mind in dependencies. (Specific insight about this involvement for any given individual is usually not needed. What is needed for significant change in the unconscious mind regarding the dependency to somehow occur.) The idea of all substance dependencies as basically being of a "straightforward" genetic/biological nature can be comfortable for many substance dependent individuals and support groups. But regardless of what the understanding of the basic nature of a dependency is- there is still always the need for afflicted persons to take personal responsibility for their dependencies, and for making basic changes in themselves and their behavior.

Substance (or chemical) dependency is what is commonly thought of when "addiction" is mentioned. Unfortunately, it has lost much of its association with the more general concept of addiction. It also includes non-substance addictive practices- or dry addictions." For example, there is a frequent association between alcoholism and compulsive gambling. Not only are they found frequently in the same person, but the alcoholic person may occasionally switch completely from alcohol to compulsive gambling- or visa versa. Both substance dependency and compulsive gambling are addictive practices. The former just happens to also involve the ingestion of addictive substances. Of course, the psychopharmacological properties of the addictive substance are important- but substance dependency is much more than the sum of these effects. At one time, cocaine addiction wasn't thought to really exist, because there weren't any pronounced withdrawal effects upon cessation of its regular use. Substance dependency represents a group of very complex behavioral disorders. The addictive process in all addictions is mainly a learning one. It follows that the value of animal experimentation to better understand human substance dependency is very limited. A rat who is experimentally addicted to alcohol and then withdrawn from it won't later get depressed, obsess about it, crave it, perhaps develop panic reactions, etc. The difference is that, unlike persons, rats don't have complex and symbolizing minds

It has recently reported that cigarette dependencies can occur very quickly in people (largely referring to teenagers) and that even several smoking occasions over a period of a couple weeks can sometimes suffice. Cigarette smoking is extremely addictive, and anybody who gives himself half a chance will soon become addicted- even if it is the person’s first dependency. The important message that this finding strongly suggests is that, theoretically, anybody is capable of becoming addicted to any addictive drug. There are many diverse factors, including a few genetic ones, that determine if any particular person will ever be exposed to any particular addictive substance to start with- and then what further exposure would be needed for a dependency to develop. The rapidity and ease of the cigarette addictive process is involved with more than just nicotine alone. I’m quite sure that studies would find that it takes longer for most people to get addicted to chewing tobacco. A very recent finding indicates that teenage cigarette smokers are four times more likely than their nonsmoking counterparts to develop depression.

The particular substance involved in a dependency plays a strong role in its potential psychopathological effects and consequences- which often can be quite subtle. Nicotine is quite low in this regard, and alcohol is on the high side. One woman was a long time smoker and was divorcing her husband for obscure reasons. They were still getting along well, and shortly before they separated, they were planning to see a movie together. Just before leaving, she impulsively went back in the house to make sure that her cigarette was completely out in the ashtray. It was out, and without any animals or children in the house, it wouldn’t have mattered if it weren’t. She changed her mind about the divorce a few months later. I was then able to explain to her that her unusual behavior regarding the cigarette had been an unconscious expression of concern about the divorce action. Her cigarette addiction both symbolized and facilitated the more neurotic and immature part of her personality that wanted the divorce. Her checking on the cigarette had expressed her concern about her dependency’s potential destructive ("inflammatory") effects on that part of herself- including the risk of its gaining a dangerous degree of power within herself.

There is a great deal of ignorance about substance dependency by even mental health professionals. Additionally, the current and predominant "biological psychiatric" thinking operates as an effective obstacle to its better understanding. (I use quotation marks here because of the misuse of the legitimate term "biological," as defined in the dictionary.) Unfortunately, many psychiatric training programs have dropped any training in psychotherapy, due to the influence of "biological psychiatry." It is a sad irony that "biological psychiatry," in its efforts to make psychiatry more scientific, has actually succeeded in some ways of making it less so. There is a long-known and somewhat "tongue in cheek" "Four, Two, and Zero Rule" in the field of substance dependency- and it still has much truth to it. It concerns the matter of substance dependency education in medical schools and refers, respectively, to the number of years of medical school, the number of hours of lecture on the subject, and finally- the amount learned. Psychiatric training programs are little better in this area.

Only the very obvious psychiatric organic diseases like Alzheimer's and Huntington's fit the traditional (biomedical) disease model fairly well. That model is based on infectious diseases like tuberculosis where the cause is obviously the tubercle bacillus. It has been criticized because disease effects are often being confused with disease origins- with neglect of the latter. "Disease effects" refer to symptom-producing physiological mechanisms ("chemical imbalances"), as for example, acute anxiety in response to unconscious emotional conflict in panic reactions. Psychiatric diagnostic entities, in particular, don't fit this model very well, and substance dependency probably fits worst of all. There have been many "Procrustean Bed" (in Greek mythology, a bed for which, if necessary for a good fit, a person's legs would be partially cut off) efforts made to have substance dependency appear to fit the traditional disease model. There is a book by Stanford neuroscientist Robert Sapolski by the amusing title of "The Trouble With Testosterone." The "trouble" is for "biological psychiatric ideology-" that assumes the reverse of the finding of an animal experiment dealing with animal aggressiveness. It found that animals first showed signs of increased aggressiveness- and only then developed a higher level of testosterone.

In the relatively recent book, "Understanding Alcohol," its councilor authors were obviously writing from their knowledge of the general understanding of substance dependency at most substance dependency treatment centers. In their chapter on psychiatric illnesses, they state: "Alcoholics do have psychiatric illnesses in approximately the same proportion as the nonalcoholic population." This is an obviously incorrect statement. I think there is a strong, but hidden wish here not to acknowledge any strong associations between substance dependency and other psychiatric disorders. Psychiatrist Mark Gold of the University of Florida cited a 37% incidence for such an association- and I think it is a bit higher than that. These disorders are depression, anxiety states, panic reactions, manic-like disorders, obsessive states, post-traumatic stress disorders and functional psychoses. .

A "biological understanding" of substance dependency requires that many important aspects of it be largely ignored- like placebo effect. The great importance of the placebo-affecting "set and setting" in addictive drug use is well exemplified by the case of the proverbial alcoholic man who responds so differently at times to the same amount of alcohol in regard to different situations. He may be: somnolent in a library; tearful at a sentimental movie; belligerent at a bar; the life of a party; sexually passionate in the back seat of a car. The general (collective) concept of substance dependency is critically important to understanding any individual substance dependency. A basic tenet of the concept is that one dependency can, and often does completely substitute for another. The use of multiple substances in dependencies is very common, and they tend to be a greater problem than single ones. A cocaine addict can switch completely to alcohol- or visa versa. Yet these two substances are in completely different chemical classes- with alcohol being a depressant type drug- and cocaine a stimulant. It is a fairly well-known fact that developing a first dependency facilitates the addition of additional substance dependencies. The most common example of this is that the large majority of alcoholic persons were first addicted to cigarettes- and many of them would have not become alcoholic without that facilitation. The influence of "biological psychiatry" has kept this risk of cigarette smoking from being used in the battle against smoking. From a "biological theorizing standpoint," substance dependency is actually rather messy!

It is the development of the irrational and narcissistically-driven overvaluation of the substance by the dependent which is really the "heart and soul" of the addictive process. I once made a "hypothetical offer" to an alcoholic man who had to attend an outpatient substance abuse treatment program because of a couple of DWI offenses. He was in denial for his alcoholism, and wanted to convince me that he wasn't alcoholic. I asked him to imagine I was an eccentric millionaire who was offering him in good faith the sum of $50,000 for his right or opportunity to ever drink any more alcohol- no matter what. His very interesting response was an immediate refusal of the offer, and the comment that accepting it would be "like selling my soul." He was smart enough to know that the best "denial answer" would be to accept the money- whether or not he really felt that way. In effect, this option was overruled by his strong unconscious need "not to deny alcohol." I then knew beyond any doubt that he was alcoholic.

There has been a general trend in the field of substance dependency to get away from the early emphasis on the importance of withdrawal symptoms and signs, and to look more for the "benefits" of substance use. Because something is very obvious about a problem doesn't necessarily mean that it is given adequate scrutiny. The irrational degree of overvaluation by the alcoholic person for alcohol is a given- and this is no less the case with other substance dependencies. I am convinced that it is vital to look for the "likely mechanisms" for this importance. It is fairly easy to adequately explain the nature of an organic psychosis like Huntington's disease as being due to straightforward biochemical/genetic factors. But it would be very difficult, if not impossible, to attribute the irrational and great importance that the substance dependent person has developed for the addictive substance to these factors.

From a logical standpoint, it is hard to explain substance dependency as being other than chiefly a learned sort of behavior- since the addiction itself is irreversible. Only its practice is reversible. Before I really knew much about addiction, I treated a man in his early fifties who had started to show (non-psychotic) paranoid thinking. I didn't use any medication, and weekly outpatient therapy for about 10 months was successful. It wasn't until after therapy was over that I belatedly realized that his paranoia was related to his approaching 25 year anniversary of recovery from alcoholism. He denied any temptation to drink, and I think he was being honest with me. His paranoia was symptomatic of- but also a defense of sorts against an unconscious rationalization that, after 25 years of sobriety, it should be okay to have a drink or two.

In his presidential address to the Society For Biological Psychiatry, Wagner Bridger went so far as to declare that personality is in no way affected by childhood. In a report in the July 1989 "Clinical Psychiatry News" he declared, "There seems to be no relationship between early experience and adult outcome in the human life cycle." He then added: "Even a horrible parentless or institutionalized childhood has 'no effect on later personality development. All that matter is genetic predisposition and current life influences." Apparently he believes that the past isn't prologue; rather it is nothing! Let me invite the reader to read the essay by psychiatrist David Kaiser that is critical of "biological psychiatry," which is also on this web site. It is entitled: "Not By Chemicals Alone: A Hard Look At Psychiatric Medicine." I am not at all against the use of psychoactive medications. I just don't believe that there is now, or ever will be a pill or pills to fully treat every, or even most psychiatric problems.

There was a psychological experiment carried out on volunteer alcoholic persons who were recent dropouts from treatment programs. They were truthfully told that (a randomly chosen) half of their group would receive a placebo beverage, and the other half would receive a alcoholic one. The placebo drink was pure tonic water, and the experimental one contained tonic water and vodka at a ratio of five parts to one. Essentially, the two beverages looked, smelled and tasted the same. Each group were given subtle, but misleading clues as to which beverage they were actually receiving. Each person was given an amount of beverage, which if it were the alcoholic one, would yield a blood alcohol level of 0.10%. After drinking the beverages, the volunteers were then subjected to some relatively minor provocative behavior of a negative type. The individual responses could be objectively evaluated and the results were very interesting. They showed that "typical alcoholic behavior" was elicited much more by what the person thought he or she was receiving- as opposed to what actually was received.

There was another experiment in which three heroin addicts in a hospital treatment program for the dependency were falsely told (on the quiet) that they alone among a group of other actively addicted persons would not receive gradual withdrawal from heroin. They were to serve as a "control" among the group who would receive at least daily injections at an unknown schedule of a decreasing amount of heroin.The subjects would receive the same amount of liquid injection until the withdrawal was completed. None of the group experienced withdrawal symptoms. Then the three subjects were finally told the truth- that they had also been withdrawn from heroin. They then suddenly exhibited signs and symptoms, which were typical of acute heroin withdrawal. Though their withdrawal was no doubt less severe and protracted than a "true withdrawal," they were certainly not "play-acting."

Psychiatrist Robert DuPont is a former White Chief of Drugs and author of the excellent book entitled "Getting Tough on Gateway Drugs." He wrote that "getting addicted to drugs is a lot like falling in love." He has also had some very interesting things to say about social drinking. He feels it isn’t definable scientifically, and that the majority of persons thought of as "true social drinkers" are actually "only a short step or two from active alcoholism." Some of them will inevitably eventually take those steps, and some of the others will just be potential victims of fate. He cited the matter of consumption and problem curves of drinkers not being bimodal. This means that they describe just one population of drinkers, not one healthy and the other of sick alcoholics. In practice, the person considered to be "just a problem drinker" is almost always alcoholic. Along the same line of thinking, in their book "Alcoholism And Substance Abuse," Bratter and Forrest always referred jointly to "substance abusers/dependents." It is an interesting finding that, not infrequently, some persons, who are properly diagnosed as "alcohol abusers" (by current official diagnostic criteria), are actually more strongly addicted than some other persons who are diagnosed as "alcohol dependents."

There are many good reasons to advocate complete abstinence in the treatment of any substance dependency. Although, for example, there are certainly some alcoholics who manage to control their drinking and its consequences quite well, this always represents a somewhat unstable situation. Though most alcoholics will experience progression of their disease- this is not always the case. There is the recent and tragic example of Audrey Kishline, the woman who championed "moderation management" for "problem drinkers." She was responsible for the death of two people in an auto accident she caused, and was found to have had a high alcohol blood level. Even when she was managing to drink a moderate amount of alcohol, her drinking couldn't be considered as "truly moderate," or normal, as the "true social drinker" doesn't overvalue alcohol as she obviously did. She had acknowledged that her program wasn't for alcoholics- but only for "problem drinkers," like herself. (She now admits that she is and was alcoholic.) There is a recent book by psychologist Jeffrey Schaler by the title of "Addiction Is A Choice." He feels that few people who use addictive drugs get addicted, and those who do use them heavily will "mature out of it" in time and without any treatment- which is a waste of time." In his book (written before her accident), he was critical of her view that there even was such a disease as alcoholism- and mentioned that he had withdrawn from the Board of Directors of Moderation Management.

The mention of "love" in connection with any conceptualization of the nature of substance dependency must create shivers among "biological psychiatrists-" but there is no shortage of such mentions. Peele and Brodsky are the psychologist authors of the classic book on addiction entitled "Love and Addiction." In a more recent book they developed a list of five attributes of any addiction (substance or not):

> ***"1) It organizes, structures, and fills time: without it your day is formless and barren.***
>
> ***2) It provides regular rewards: the activity is the major reward in your day.***
>
> ***3) It makes you feel accepted, worthwhile: your sense of yourself depends upon the activity or the habit.***
>
> ***4) It erases negative moods such as anxiety, depression, boredom: It makes you forget, 'gets you through the night,' creates a soothing oblivion.***
>
> ***5) It extracts, as a cost of the rewards it provides, penalties that make the person more dependent on it;"***

The authors don't think alcohol or drug dependency should be considered as a disease- but rather an unfortunate, disordered behavior. I strongly disagree with them about substance dependency not representing a true disease. Nonetheless, I think that they made some very good points in their two books.

The psychologist husband and wife team of the McAuliffes operated a training center for substance dependency councilors in Minneapolis for many years. Their book, "The Essentials of Chemical Dependency" stated at the very beginning that chemical (substance) dependency was "essentially

a pathological or sick relationship of a person with a mood-altering chemical substance, a psychoactive substance, in expectation of a rewarding experience." They developed this understanding on an intuitive basis in their work with substance dependent persons- and were "innocent" of any psychoanalytic understanding or background. They helped to found the American Chemical Dependency Society whose motto is "Love Heals."

The alcoholic's essential error is poetically, but still well stated in a revealing statement by psychologist Charles Hampden-Turner in his book "Maps of The Mind:"

"Much as wine symbolizes communion, the alcoholic has taken the symbol for the reality and uses

drinking as a substitute for the relaxation, fusion, surrender and security of deep personal relationships."

In Smokey Robinson's lyrics to a song, it is unclear whether he was referring to a woman or an addictive

drug. Most likely, he was consciously referring to both:

"I don't like you but I love you, Seems I'm always thinking of you, Though you treat me badly, I love

you madly, You really have a hold on me."

I am a firm supporter of substance dependency treatment programs- even though their results often don't look that encouraging. There are no easy answers to treating substance dependency, and likely there never will be. Prevention, of course, is the best treatment- but that isn't easy either. Twelve-step programs such as AA and NA can be very valuable. Biologically-oriented psychiatrists give lip service to their importance. But they certainly are not aware that, for some of their members, these organizations are capable of giving more than simple supportive treatment. Their altruistic-oriented and structured programs can actually give specific treatment that is aimed at the excessive narcissism of the addictions (which is not synonymous with the dependent person being narcissistic) .

There is a place for the individual psychotherapy of some substance dependency patients. I treated a middle-aged successful business man for depression with psychotherapy alone. At the first meeting I surprised him by telling him he was very likely alcoholic. He had been a six beer a day drinker before undergoing neurosurgery for a cerebral aneurysm. (His wife didn't even think he had a drinking problem.) Though the surgery was successful, and there was no residual impairment or symptoms, he became depressed for the first time in his life. The onset was almost immediately post-operative, and I first saw him six months later. With his depression was an almost complete loss of desire for alcohol, and a decrease in intake to about one drink daily. I gradually managed to erode his denial for alcoholism by a variety of means. The Marty Mann Test is a functional test for alcoholism which calls for the person to drink from one to three standard drinks daily for 30 days. (I have added the proviso that the person also not experience any unusual emotional reaction to taking the test.) He twice flunked it in short order by going over the daily limit. As his denial weakened, his drinking increased and his depression lessened.

Despite there having been a good patient-doctor relationship, I wasn't surprised when he abruptly quit therapy after about five months. He was feeling good, and apparently didn't want his denial for his alcoholism weakened any further. A few months later, I called to see how he was doing and talked to his wife. I found out he was recovering from a broken leg suffered in a drunken auto accident- and she now wanted him to see me again. I never did see him again, or learned what happened to him. But I think the chances were good that he eventually got sober with the help of AA. I never had the chance to fully deal with his very interesting family history. His mother had become disabled from neurosyphilis at his age of two- though she lived for ten more years. He likely wouldn't have suffered a depression if he had developed some other serious medical problem. Unconsciously, his suffering from a "brain disorder," like his mother, had been a great stress for him. It seems likely that, in a "repetition of the past" manner, there had been a switch from a "good parent meaning" of alcohol for him to a "bad one" (like the "good mother" before she became disabled, and the "bad one" afterwards). This psychodynamic understanding correlated well with both his depression and the loss of desire for alcohol.

Placebo response is a phenomenon that is very basic to substance dependency. The term "placebo" derives from the Latin word meaning "to please"- though negative placebo response is always a good possibility too. Most people don't recognize the term- but are still somewhat familiar with the idea of the "fake sugar pill" and its ability to help some people some of the time. Most typically it is a pill, liquid or shot that enters the body and its effect is not (directly) related to any pharmacological properties- if present. A procedure, belief, situation, another person or a thing can also elicit placebo effect. In short, a placebo can be anything that invites the unconscious mind to react strongly in some manner. Placebo effect is always inherently unstable and unreliable. It wasn't until the turn of the century that there were literally more than a handful of drugs being used by physicians that possessed any intrinsic worth. Providing that neither the dose or the type of drug used was toxic (which unfortunately it often was), any therapeutic effect from the great majority of drugs used then could result only by eliciting a positive placebo effect. With the right placebo response, a sleeping pill can act like a stimulant- if a person is in the right "set and setting." The sedative effects are simply overwhelmed by the placebo response.

A man with advanced cancer was near death, but then enjoyed a "miraculous therapeutic response" to a worthless cancer drug which was being given a therapeutic trial at his hospital. This positive placebo response was possible via his emotion-sensitive immune system's better functioning. It had been stimulated enough to do this simply by the hope he had associated with this new medication. He was continuing to improve until about three months later when he read in the newspaper that the AMA had gone on record in labeling this drug for what it was. All of his symptoms and signs quickly returned after learning of this negative evaluation, and in a few weeks he was dead. His problem, like that of many people, was in learning how to access his own self-healing potentialities.

Andrew Weil is the psychiatrist author of the "Natural Mind," in which he referred to all psychoactive drugs as being "active placebos." He meant by this that their pharmacological effects were more likely to elicit placebo effect than other drugs or medications. Addictive drugs are simply that class of psychoactive drugs whose pharamacological properties are such as to produce quite pleasurable effects in most people. This factor then invites additional pleasure from their use- secondary to frequently experienced positive placebo response. Learning to really enjoy an addictive drug is the same thing as becoming addicted to it. For example, marijuana, usually requires a fair amount of practice before a sufficiently strong positive placebo response results. Nicotinic acid is often added to inert placebo pills. It is a form of "B" vitamin and has the effect of causing slight flushing of the skin at a relatively low dosage. This addition has the subtle effect of inviting placebo effect because of this limited pharmacological property- as if the volunteer actually had gotten the real experimental drug. The reason for the use of this type of active placebo is to increase the reliability of double blind tests of new drugs. The only way to scientifically explain the results of acupuncture is to posit a positive placebo effect. Not surprisingly, variations on acupuncture using pressure seem to work as well.

70 years ago some medical investigators found that the same post-surgical patients who experienced a fairly good pain relief to a placebo "pain shot," also responded more strongly to actual injections of morphine. This was in contrast to non-placebo responders. Furthermore, on psychological testing and interviews, the placebo responders showed similar psychological test profiles to those of addicts. The strong placebo responders were described as being more anxious and more emotionally volatile, and had less control over the expression of their instinctual needs. They were also more dependent on outside stimulation than their own mental processes, which were not as mature as those of the non-responders. This study correlates well with the finding that substance dependent persons are invariably strong placebo responders- which can complicate the use of psychoactive medication for them.

Some recovering alcoholic persons will state that, in retrospect, they realized that they were alcoholic from the very first drink because they liked alcohol's effects so much. This type of statement has been incorrectly thought to support a strong genetic-biochemical nature for alcoholism. But these are actually persons who were already fully primed (for example, by having a parent or step-parent who drank a lot) to react to alcohol with a strong and positive placebo response. There is still some truth in what they say. The process of addiction always requires a time factor for the learning of the addiction to occur. But these persons have shown by their initial response that they are "fast learners." Therefore, barring unusual circumstances arising, an addiction develops rather quickly because the person is very likely to start drinking at a frequency and quantity that he or she will almost certainly shortly become alcoholic.

The psychologists Firestone and Catlett, in their excellent book "The Truth- an Approach to a Psychological Cure" use the metaphor of an "emotional bond." It is also an "attachment-behavioral bond," and can seem to be located in other persons, things and even some ideas. This is obviously the psychological phenomenon of "transference"- although they never did name it as such. Their treatment of the concept is particularly helpful in gaining an understanding of the crucial role of transference in substance dependency. They first defined their meaning of "emotional bonds" and then commented on what can be the problems of breaking one of these bonds:

"By taking in the rejecting attitudes of the parents and identifying with them through imitation and preserving them through the inner voice, the child forms a fantasy of being self-sufficient, of having everything he needs within himself. This is the first bond, so to speak, a kind of close tie with his parents within himself- in effect, a self-bond...A bond is an imaginary connection with another person and is used to allay pain and anxiety. When a bond is broken, the underlying pain surfaces. People from tremendous resistance to the truth to ward of the pain of breaking a bond. They will literally destroy themselves to hold on to their bonds, imagining that they are holding on to people."

The unconscious parental ties or meanings of the substance in a "substance dependency" are particularly meaningful in a linguistic sense because they automatically repeat, in a way, a person's experience of early "parental dependency." But transference developing toward a thing like alcohol is obviously much more irrational than that toward another person- which need not be at all pathological. In combination with splitting (into "good and bad aspects of the object"), it always represents the basic core of any addiction (substance or not), and is always ultimately at least a little harmful to the person. The addict always experiences a very strong need to highly repress his or her self-knowledge of this source of artificial self-love and illusory power from any conscious awareness- and for a number of reasons. And the obvious first line of defense against such knowledge is the denial of the addiction itself. There is an inevitable increase in narcissism that occurs in the origin and practicing of a substance dependency. This is intimately associated with the ego-regressive effects of a dependency.

The progression of a substance dependency with the increasing negative consequences of its practice sorely threatens the very important initial "good parent" symbolizing or labeling of alcohol for the alcoholic person- and thus also lessens the pleasure of drinking. To counter this, some alcoholic persons will "act out" this internalized splitting in a creative way by creating an outward denial/defensive "good alcohol/bad alcohol split." The person will maintain that he or she can handle beer or wine ("good alcohol") as well as ever. Its the "hard stuff," or liquor ("bad alcohol") that causes them all the trouble. This choice of beverages is made less because of the matter of its greater alcohol concentration, than stereotypes about it. But the person will always occasionally use the "bad alcohol" anyway. Seldom, if ever, is the person wrong in his or her negative expectations of its use. Inevitably, some negative (placebo) responses to the "good alcohol" also occur as the addiction progresses.

Dr. Weil also observed that the use of any consistent set of rules which apply to the times, occasions and amounts of addictive substance use has some protective effect against a dependency occurring. If one already exists, it limits its negative behavioral effects. The source of these rules could be anywhere, including the person himself- though they would have more force if socially imposed. He didn't explain how or why this effect should occur. I am convinced that the reason is the narcissistic-limiting effects of following any rules. Obviously, using the addictive substance whenever, and to whatever extent that the person feels like at the moment is a more narcissistic position to take. A businesswoman had a strict policy of having six drinks daily- two at lunch, dinner and in the evening. She often had the evening drinks in a bar, and one evening she gave into the temptation to have a third drink. The next morning, she was surprised and upset when she woke up in a strange bed with a strange man. This was the first time this had ever happened- but not the last!

An understanding of narcissism ("self-centeredness") is important to a good understanding of any type of addiction. Everybody has a narcissistic side to their personality. Hopefully, the more mature, adult, and altruistic side of a person's personality and character will be able to play the role of "good parent" to the vulnerable "inner child" to safely control its immature and narcissistic tendencies. Narcissistic satisfaction and power is the all-important common denominator in substance and non-substance addictions. One way to understand a strong and progressed substance dependency is to see that it both represents and fuels an unconscious, compulsive, and destructive quest for "unconditional love." For example, in an abusive marriage the desire for illusionary evidence of such may paradoxically be partially satisfied merely by the mistreated partner not leaving the mistreating partner. The person who later becomes an addict doesn't necessarily initially have a greater amount of narcissism than the average person. But the process of becoming an addict and, especially, the practice of an addiction always increases the person's narcissism, or potential for same. This doesn't mean the person necessarily becomes a "narcissistic person." Such implies that a person's narcissistic tendencies exceeds their altruistic ones. A recovering alcoholic person, for example, may become quite a mature and altruistic person. Cessation of the practice of the dependency is usually, but not always, associated with a decrease in a person's narcissism and a healthier adjustment in general.

It is fairly well-known fact that the use of heavy doses of opiate-type drugs for the relief of chronic and severe pain seldom results in an opiate addiction. I think the explanation for this phenomenon is inextricably linked to the issue of narcissism. The conditions of this strongly utilitarian use of opiates precludes enough narcissistic leeway for an addiction to develop. The psychologist Gary Forrest, in his book "Alcoholism, Narcissism, and Psychopathology," reported an interesting finding involving a relatively small number of alcoholics. They are true sociopaths, who fail to show any compulsion to drink. Should the results of their alcohol use become too painful, they simply stop drinking quite easily- at least for awhile. I think the reason for this is that, in these alcoholics (who are definitely not AA types), there is no inner conflict between the altruistic and narcissistic aspects of the self to fuel the compulsion to drink This is because the former is essentially absent. Therefore, unlike the case for most alcoholic persons, the person's narcissistic values aren't put at any risk by not drinking

The practice of any addiction is an exercise in narcissism. Dr. Aaron Stern, in his book about narcissism, made the wise comment that "all addictions were a narcissistic force." Psychological regression is intimately associated with sufficient narcissistic power. Regression, or the potential for same, is an integral part of any addiction. Sexual enjoyment has been characterized as a "regression in the service of the ego," and ideally, this will continue to be the case for any given person. But like the enjoyment of alcohol, the issue/practice of sex involves some finite risk of addiction. Substance dependency entails a greater risk of regression than for non-substance addictions. This is largely because there is the added pharmacological effect of the substance to stimulate narcissism. In turn, this invites unconscious and irrational fantasy related to its ingestion and, therefore, its becoming "part of the self." The psychological meaning of "regression" is that of a return to earlier and immature modes of thinking, feeling and functioning. The phenomenon of regression is very important to understanding substance dependency.

By definition, enough regression can result in a psychosis. This actually happens somewhat frequently in what I have termed "substance dependency-induced psychoses" (SDIP). It is a new diagnosis that I am working to establish. A university psychiatrist reported an association of the diagnosis of substance dependency in 80% of state hospital cases of schizophrenia. Unfortunately, he erroneously assumed that the mental illness comes first in these cases. His assumption wasn't based on the patient histories regarding the respective sequences of the dependencies and psychoses. Rather it was based on the "biological theory" that genetic factors cause both the mental illness and the dependency. But a substance dependency therapist on a dual diagnosis ward (schizophrenia and substance dependency) reported that, in over half of these cases, it was clear that the dependency came first. Its further investigation has been supported by the National Council on Alcohol and Drug Dependence. There is a link to an article on the diagnosis at the Mentalhealth.about.com web site on the menu list. Unlike this article which is aimed at general edification about substance dependency, it endeavors to help this very clinically important diagnosis to overcome its "political/biological incorrectness." This has caused academic psychiatry to almost unanimously "stonewall" the diagnosis, which has a critical need for a clinical trial to be organized by a medical school.

There is a substance abuse-related psychosis diagnosis which was established several years ago at the last revision of the DSM (the psychiatric diagnostic bible), which is entitled "substance-induced psychosis." Its ("very biological") criteria require that it be a "direct result of the physical effects of the substance-" which explains its two rather arbitrary 30 day time limits. It can’t persist, or have its onset from the last use of the substance beyond that period of time. Although nearly all of the uses of the diagnosis involve addictive substances, its criteria completely ignore the issue of substance dependency. Its clinical value is minimal, except when non-addictive substances are involved.

Some years ago George Weinberg wrote a best-selling book entitled "Self-Creation," which was chiefly about making good habits and unmaking bad habits to better "create oneself." Is alcoholism a bad habit? It most certainly is- but it is no ordinary habit. Habits in general can be considered as usually having biological survival value for man and animals. The stronger the habit has become, the stronger is the sometimes irrational accompanying unconscious idea that it is dangerous not to practice the habit. In other words, the alcoholic person unconsciously (and often also consciously) has some fear of recovery. He writes

"The whole book is about habits because our convictions are not created by a single act. You have to reinforce them constantly by acting. The jealous person habitually reproduces his jealousy. The confident person makes confident choices and thereby regenerates confidence. We all repeat the same kinds of acts, and the underlying premise- jealousy or confidence, whatever- is reinforced in our minds. Every feeling, attitude, or belief that stays with you is being retained, reinforced, by strands that your choices weave. Choices you make constantly, habitually. This is the basic principle at work every day of your life behind the creation of your personality:

> ***EVERY TIME YOU ACT, YOU ADD STRENGTH TO THE MOTIVATING IDEA BEHIND WHAT YOU HAVE DONE… IT’S AS THOUGH THE ACT RETYPES THE MOTIVATING MESSAGE IN YOUR MIND. WHEN IT’S ACTED ON, THE MESSAGE BECOMES BRIGHTER, LOUDER, RECHARGED, PROMPTING STILL MORE OF THE SAME ACTS."***

The last sentence vividly depicts the nature of the risk of the "first drink" for an alcoholic after a period of recovery. It helps to make clear its importance- beyond the common sense fact that there can't be a second without a first and so on. The basic motivating idea (or world view) behind any substance dependency is that of narcissism- which is not the case with good habits: Richard Stiller in his book "Habits" wrote about habituation as a process by which an animal or person automatically continues to accept and practice a behavior- because of its being old, and thus also "safe. Therefore, it can be more or less ignored so as to be better able to concentrate upon that which is new and potentially dangerous. In substance dependency, the "logic of the habit" is, of course, very misleading.

It is falsely assumed by not only the general public, but also by the psychiatric profession, that alcoholism has a strong genetic or biological element. This understanding supports biological theorizing- because genes control the basic biochemical make-up of the organism. It also fosters hope that eventually a medication will be found to neutralize or eliminate the harmful effects of an alcohol dependency by getting at the inner-most source or workings of the disorder. But the reality is that no such possibility exists (like insulin for diabetes). Furthermore, David Lester, a prominent biological researcher recently concluded after a lengthy review of the pertinent literature that the evidence for genetic involvement in alcoholism was "weak at best." He explained that the popularity and persistence of the idea of a strong genetic factor had much to do with its "conformity to ideological norms." The famous Danish genetic study so often cited to prove a strong genetic element applied only to men (a sex-linked disease)?? This is despite the fact that women were also included in the study. Most importantly, the use of identical and fraternal twin comparison studies has never supported a genetic etiology for alcoholism. And such a study is the most reliable genetic investigating tool available. Psychiatrist George Vailant, in his acclaimed book, "The Natural History of Alcoholism" commented succinctly on the matter: "A person had as much chance of inheriting alcoholism as of inheriting the skill of being a good basketball player."

A particularly unfortunate, yet very common example of "biological psychiatric thinking" really having gone wrong is the use of lithium, or its equivalents, to "biologically treat" that which is too often only a bogus case of "bipolar illness." This happens much too often in the presence of a substance dependency- which may or may not also be diagnosed. The real diagnosis is usually one of a somewhat atypical substance dependency- with or without various psychiatric complications. It should be remembered that substance dependency doesn't usually respond well to medication as the main or only therapy. Some psychiatrists actually make a practice of diagnosing any substance dependent person who comes their way as also having the "more important" diagnosis of bipolar illness. But the majority of substance dependents don't need any medication- apart from detoxification therapy when needed. And the use of not-indicated medication in their treatment is at best a needless risk and a waste of money- and too often acts as a direct hindrance.

Very much contrary to current psychiatric understanding and practice, George Vailant wrote that bipolar illness is not more common in alcoholics than in the general population. (He also commented that there have been many "metabolic theories" proposed for alcoholism- but none have held up to scrutiny.) Once under-diagnosed, bipolar illness has become greatly over-diagnosed due to the subtle, but still seductive expectation of being able to effectively and easily treat it with medication. (It also enjoys good "P-R.") And biopsychiatrists do know that substance dependency isn't at all easy to treat "biologically." The major inpatient substance dependency treatment centers often initially discontinue medication used to treat this disorder- as not having been indicated to start with. Here we have a sorry situation where a non-existent disease is being treated- while the actual disease was likely largely being ignored. Probably the worst thing about this type of false diagnosis is that it offers substance dependents a dangerous, though subtle rationalization to de-emphasize their need for complete abstinence from the substance. For alcoholics, this tendency can be greatly aggravated if the person is told that his or her excessive drinking was "merely symptomatic" of their "bipolar illness." If the person does use the addictive substance, his or her condition usually deteriorates. And then the non-existent bipolar illness is simply considered to have gotten worse.

There obviously is no intrinsic reason why an interest in biochemistry has to result in the antipsychological, mechanistic, and overly simplistic thinking of mainstream psychiatry. A very positive example that biological psychiatry should learn from are the ideas of two biochemically-oriented psychologist authors who are interested in such "non-biological issues" as love, fantasy, self-identity, security, etc. Milkman and Sunderwirth are these authors, and they have recently written an excellent book entitled "Craving For Ecstasy" and subtitled "The Consciousness And Chemistry Of Escape." They demonstrate the necessary interrelatedness and interdependency between thoughts, feelings, behavior and biochemistry. In other words, they realize that these factors represent a "seamless whole." This is in stark contrast to biopsychiatrists who greatly emphasize biochemistry at the expense of the other three. (Nature [genetics/biochemistry] and nurture [the environment] don’t represent a true dichotomy- and the mind and body don’t represent separate worlds.) Their work has obvious relevance for substance dependency and SDIPs. They wrote that "love is the ‘piece de resistance’ of addictions." This is because it manifests quite strongly the three ingredients of any type of addiction- which are arousal, satiation, and illusion. They write:

"Are criminals, cocaine users, sky divers, police, and lovers motivated by a similar adrenaline rush? Are comparable needs being met through alcoholism, overeating, and membership in a spiritually oriented group? The term 'addiction' was once reserved for dependence on drugs. Today it is applied to a range of compulsive behaviors as disparate as working too hard and eating too much chocolate. In fact, there are essential biological, psychological and social common denominators between drug use and other habitual behaviors. Whether your pleasure is meditation or mescaline, cocaine or cults, you are addicted if you cannot control when you start or stop an activity.

In this book we examine the age-old search for pleasure, finally from a new perspective. We transcend the inconclusive debate that surrounds substance abuse and focus instead on more basic issues of human compulsion and loss of control. The enslaving drive to feel good is inadequately explained as a function of a weakness of character, chemical imbalance, or spiritual defect...

From a psychological perspective, voluntary courtship of any drug or activity depends on how well it 'fits' with one's usual style of coping. The drug of choice is actually a pharmacological defense mechanism; it bolsters already established patterns for managing psychological threat. People do not become addicted to drugs or mood-altering behaviors as such, but rather to the sensations of pleasure that can be achieved through them. We repeatedly rely on three distinct types of experience to achieve feelings of well-being; relaxation, excitement, and fantasy; these are the underpinnings of human compulsion. As they say in show business, 'you've gotta feed em, shock 'em or amuse'em.'

Addiction: self-induced changes in neurotransmission that result in behavior problems. This new definition encompasses a multi-disciplinary understanding of compulsive problem behaviors that involves the concepts of personal responsibility (the behaviors are self-induced); biochemical effects (the body's neurotransmission changes); and social reactions (society absorbs the costs and consequences of problem behaviors)...

Given that we may voluntarily alter our neurotransmission to achieve a desired feeling, why do only some of us become compulsively involved in the pursuit? After all, most people can have a drink or occasionally rage at the race track without going off the deep end. Most addictionologists- even those who disagree about other matters of causation and treatment- agree that low self-regard is a crucial factor in all forms of addiction. The chronic absence of good feelings about oneself provokes a dependence on mood-changing activity. Manifest or masked, feelings of low self-worth are basic to most dysfunctional life-styles.

One way of coping with disquieting factors is to immerse oneself in an activity without serious self-evaluation. The climber, clinging to a mountain face with only a rope, pitons, and a tenuous foothold, has few moments to spare on self-derogation. The risk taker may figuratively bridge the crevasse of his or her sense of inadequacy by temporary surrender to something outside the self. A 32 year-old cocaine user reported a particularly vivid dream that illustrates this point: 'I recall seeing my personality as a huge concave surface. It looked like a great ceramic bowl with irregularly spaced craters on an otherwise smooth surface. Somehow I could patch the holes with an ultra fine paste made of cocaine. The new shimmering surface appeared nearly unmarred.'" This addict's dream imagery is a perfect visual metaphor, regarding the importance of cocaine in his inner and outer life

Biological psychiatrists consider dreams as neurological trash- meaningless. A better understanding is to compare dreams to "off-line computer time" where the person is unconsciously attempting to do problem solving in the form of trying to more fully integrate his experience. I think this man was correct about the meaning of his dream. One of the traits of many substance dependents is that of perfectionism. This is a reaction against feelings of low self-esteem- however, realistic or unrealistic these feelings may be. One writer referred to the "hero-zero split" of the perfectionist (and many alcoholics, in particular, are perfectionists). This metaphor says a lot. Obviously the "higher the zero," the "lower must also be the accompanying zero." Both images lie! Here is another view of the basic" good/bad" duality of any addiction. It also clearly indicates the plight of the addict. One recovering drug addict commented poetically about his personal growth in recovery from his addiction. He learned that: "I'm neither the giant of my dreams nor the midget of my fears."

From their chapter entitled 'Unreal Worlds':

"People frequently experience problems in living, and they may develop eccentric beliefs as highly personal and specialized coping devices. Clearly drug toxicity or internal biochemical imbalances are involved in much of the personality disorganization we describe as emotional disturbance. Yet the ability of many who have psychotic thoughts to function with great rationality stimulates a fascinating question. Are some 'crazy' people compulsively dependent on fantasy, as drug addicts may be to heroin or alcohol? Certainly there are some intriguing parallels, as the list of schizophrenics' characteristics reveals: DENIAL. Schizophrenics often deny that there is anything wrong with them or that their perceptions are inaccurate. COMPULSION. Schizophrenics often will choose not to take antipsychotic medications, which when properly administered, serve to reduce fantasy productions. LOSS OF CONTROL. Schizophrenics may suffer great damage to social, economic and health functions in relation to their uncompromising belief in the importance and authenticity of their delusions and hallucinations. RELAPSE RATES. For schizophrenics, drug addicts and alcoholics, recidivism is roughly the same, about 60-80% after 6-8 months of abstinence.."

Relative to this issue, one of my alcoholic patients had multiple and relatively brief SDIP episodes which ended only when he finally got serious about recovery from his alcoholism. On one occasion he made a very interesting and insightful observation: "One similarity about drinking alcohol or being psychotic is that either one is capable of making me feel powerful and important." That quote reminded me of the title of the book by psychologist Edward Podvol- "The Seduction of Madness." Certainly "feeling powerful and important" is seductive. He cited the four causes of functional psychoses as being schizophrenia, bipolar illness, personality disorders and substance abuse.

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Psychoeducational Group Therapy for the dually diagnosed

Arthur J. Anderson, Ph.D.

Sylvia Boris, Ph.D.

Julia Kleckham, D.Clin.Psych.

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- teach you some new information.
- give you a new skill and role in dealing with patients.
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We'd like to acknowledge the considerable contribution of Dr. Hugo Franco, Dr. Sylvia Boris, Dr. Samuel Alverez, Mr. Martin Rodriguez and Mr. Roger Evans for their dedication to the various drafts and pilots of this project.

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Rehabilitation and Social Insertion of the Homeless Chronically Mentally Ill

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Abstract:
Rehabilitation and social insertion of the homeless chronically mentally ill. Homelessness is undoubtedly the most serious and dramatic expression of all social exclusion phenomena. It affects a growing number of people suffering severe poverty, marginality and abandonment. Serious mental illness shows up within the group of homeless that survive on the streets or live in shelters. The severe mentally ill, which constitute an especially marginal group, have raised much social concern. In Spain there are precious few initiatives aimed at the care and rehabilitation of the homeless mentally ill. One particularly notable intervention took place in Madrid in 1991, the "Project for the Rehabilitation and Social Insertion of the Homeless Chronically Mentally Ill", funded by the Health and Social Services Committee of the Madrid Regional Council, with support from the Social Services Department of the Madrid City Council. This article reviews problems of homelessness with special reference to the above-mentioned project, whose structure, organisation, main actions, intervention strategies, results and impact will be described. Finally, future perspectives and recommendations concerning the care of the homeless are discussed.

La Marginación sin Hogar es, sin duda, la expresión más grave y dramática de los fenómenos de exclusión social. Afecta a un número cada vez mayor de personas y grupos que sufren condiciones muy graves de pobreza severa, marginación y abandono. Dentro del colectivo de las "Personas sin Hogar" que malviven en las calles o son acogidas en Albergues, se ha hecho patente la presencia de trastornos graves de salud mental. Los enfermos mentales graves sin hogar constituyen un grupo especialmente marginado y han generado una importante preocupación social. Son muy escasas las iniciativas especificas que se están desarrollando en España en relación con la atención y rehabilitación de los enfermos mentales en situación de marginación sin hogar En este sentido merece especial mención una actuación específica que se viene desarrollando en Madrid desde 1991: se trata del `Proyecto, de Rehabilitación e Inserción Social de Enfermos Mentales Crónicos Sin Hogar" que depende de la Consejería de Sanidad y Servicios Sociales de la Comunidad de Madrid y cuenta con el apoyo del área de Servicios Sociales del Ayuntamiento de Madrid. En este artículo se repasará la problemática de este colectivo y especialmente se expondrá la experiencia del `Proyecto, de Rehabilitación e Inserción Social de Enfermos Mentales Crónicos sin Hogar" Se describirán la estructura y organización del Proyecto así como sus principales acciones y estrategias de intervención, los resultados del mismo y su impacto. Para terminar sintetizaremos el balance y las perspectivas que se plantea el Proyecto y ofrecemos como conclusión algunas recomendación generales para mejorar la situación y atención a este colectivo.

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INTRODUCTION:

The fundamental objective of the present article is to consider the situation of a group –the homeless chronic mentally ill– about which little is known and to which scant attention is paid, and which involves a combination of two dimensions, those of mental health and social exclusion. In addition, and especially, it aims to describe a project designed specifically to aid the rehabilitation and social reintegration of people in this situation: the "**Project for the Rehabilitation and Social Insertion of the Homeless Chronically Mentally Ill"**, developed initially as a "New Initiative" within the framework of the European Commission’s POVERTY 3 Programme (1990-1994), and that continued to function after the termination of Poverty 3 in 1994. This Project is the responsibility of the Health and Social Services Committee of the Madrid Regional Council, and is supported by the Social Services Department of the Madrid City Council. During its stage as a "New Initiative" of Poverty 3 it also enjoyed the support and co-funding of the then General Directorate of Social Action of the Ministry of Social Affairs, and of the European Commission.

Its essential purpose was (and continues to be) that of developing innovative strategies that aid the rehabilitation and progressive social reintegration of the homeless chronically mentally ill, a much-neglected population that has emerged over recent years as part of the complex phenomenon of "homelessness".

We shall describe the structure and organisation of the Project, together with its principal actions and intervention strategies, its results and its impact. Finally, we shall draw some conclusions about its effectiveness and future perspectives, and offer some general recommendations for improving the situation of this community and the attention it receives.

MENTAL HEALTH AND SOCIAL EXCLUSION: The homeless chronically mentally ill

Homelessness is, without doubt, the most serious and dramatic expression of the phenomenon of social exclusion (Cáritas, 1996). It affects an ever-increasing number of persons and groups that suffer serious conditions of poverty, marginalisation and abandonment.

The term "homeless persons" refers to a group and a social problem with varied and heterogeneous characteristics, profiles and necessities, but with a series of common dimensions: severe poverty, social isolation, rootlessness, breakdown of social and family bonds, personal deterioration and lack of a place (a home) to cover needs of accommodation and social support. The phenomenon is a highly urban one, characteristic of large cities in which problems of poverty, rootlessness and isolation are exacerbated, and lead to exclusion processes (which form the basis of the problem) being expressed in the most extreme and inhuman way in situations of homelessness (Rodriguez Díaz, 1987).

Homeless persons do not constitute a homogeneous group; on the contrary, this is a group with diffuse boundaries and heterogeneous composition and characteristics. In contrast to the typical profile of the "tramp" or "vagrant" of 20 years ago (male, aged around 40, with no profession or trade, working sporadically or marginally, itinerant for reasons of seasonal employment and due to a reliance on hostels and shelters, with problems of alcoholism, etc.), today’s profile is new, differentiated and multiple (women, one-parent families, young people, long-term unemployed) and with new problems (drug-dependence, mental illness, disorders such as tuberculosis or AIDS, etc.). The phenomenon of homelessness is clearly of considerable magnitude, as evidenced by the different annual reports drawn up by the European Observatory for the Homeless and co-ordinated by FEANTSA (European Federation of Services for Homeless Persons) (Daly, 1993; Drake, 1994; Avramov, 1996). Nevertheless, it is difficult to quantify this problem due to the absence –at either national or European level– of a universal definition of "Homeless Persons" (HPs) and the extreme scarcity of epidemiological statistics or studies on the phenomenon.

Within the community of HPs living in the streets or in hostels and shelters, cases of severe mental illness have been detected. The homeless seriously mentally ill constitute an especially marginalised group, and have given rise to considerable social concern. This situation is particularly serious in the large cities of the United States. Diverse studies carried out in that country estimate that between 25% and 50% of adult homeless suffer from severe or chronic mental illness (Lamb, 1984; Arce and Vergare, 1984; Bassuk, 1984 and 1986; U.S. GAO, 1988). However, many of the early studies presented various methodological difficulties related to sampling biases, failure to use standardised procedures, lack of a consistent definition of "mental illness", etc., which led to overestimations of the prevalence of these disorders among the homeless population. In recent years, several studies have been carried out using improved sampling systems and more appropriate diagnoses based on structured interviews such as the DIS or the CIDI (Composite International Diagnostic Interview). These studies indicate that between 25% and 35% of HPs present some kind of serious mental disorder (such as schizophrenia, severe depression, dysthimia or cognitive deterioration), and that 30% to 50% abuse alcohol or drugs. A summary of the most relevant data found in these studies is presented in Box 1.

Box 1. Data on lifetime prevalence of DSM-III mental disorders from various epidemiological studies carried out on homeless in the U.S.A. compared with the ECA study on the general population

Until quite recently, there was scarcely any reliable data on the Spanish homeless population in general, and still less on the problem of their mental health. Some of the data was based on estimations, or on the records of centres for the homeless. For example, Solé (1994) estimated that among

Barcelona's homeless population approximately 1 in 3 suffered from some kind of mental disorder according to the DSM III-R or CIE-10, in the following proportions: 5% organic mental disorders, 10% schizophrenia or delirium, and 20% depression. Fortunately, some specific and rigorous epidemiological studies have recently been carried out in this area. Two of these deserve special attention: that carried out in Madrid by Manuel Muñoz, Carmelo Vázquez and Juan Antonio Cruzado (1995), and that carried out in Gijón by Luis Santiago Vega (1996).

An analysis of the data from these studies clearly reveals that there is a higher incidence of schizophrenia among the homeless population than in the normal population (see data from the ECA study in Box 1); it is also clear, however, that in no way does the problem involve a majority, as some would argue, stating that "the streets are full of mentally ill people". Depressive disorders are more frequent (as they are among the general population), which seems reasonable if we take into account the lamentable conditions in which HPs live.

In the mentioned studies from Spain, more than 50% of the interviewees presented none of the serious mental disorders assessed. The available data would therefore appear not to corroborate the hypothesis of homelessness being caused by mental illness. This should by no means, however, lead us to minimise the importance of the problem of mental health among the homeless; rather, on the basis of this type of study, appropriate measures of prevention, attention and rehabilitation should be promoted.

As we have indicated, the problem of homelessness is complex, and multidimensional in its causes, processes and results. It is therefore difficult to establish with any kind of rigour causal and temporal relationships between mental illness and homelessness. From the existing data it would not appear very likely that mental disorders constitute the main cause of homelessness, nor that severe psychiatric problems have a majority presence among homeless persons; nor can it be maintained, especially in the case of Spain, that the processes of psychiatric reform and disinstitutionalisation (Desviat, 1996) have had a decisive influence on the increased numbers of mentally ill in situations of homelessness.

Evidently, the conditions in which homeless people live and the isolation and social rejection they suffer are factors that can precipitate or facilitate the appearance of psychiatric disorders. Moreover, it should not be forgotten that the presence of serious mental illnesses may constitute an element that aggravates social exclusion situations, and helps to maintain them if the appropriate treatment and support is not provided.

Specific attention to the homeless chronically mentally ill in our country is scarce and inadequate. Networks of attention resources for the homeless (Institute of Spanish Public

Opinion Studies, 1990), already limited, often find themselves overloaded and overwhelmed due to the psychiatric and psychosocial problems of the severely and chronically mentally ill.

Given their situation and condition of severe social exclusion, many of the homeless mentally ill do not regularly use or take full advantage of mental health services –and the situation is much more serious among those living rough in the streets, who do not use hostels or support centres at all.

It is fundamental for mental health services to prioritise the development of more responsive and flexible programmes that can be adapted to the peculiarities and characteristics of this group, and can offer them the treatment and attention they need. Furthermore, the serious inadequacy of community social resources for rehabilitation, residential attention and support for the chronically mentally ill population is exacerbating and maintaining the situation of exclusion and marginalisation of many homeless mentally ill.

In sum, it is clear that attention to this community is negative and deficient. There are few specific initiatives being developed in Spain in relation to the homeless mentally ill. It is for this reason that special mention should be made of a project under way in Madrid since 1990: the "Project for the Rehabilitation and Social Insertion of the Homeless Chronically Mentally Ill", run by the Health and Social Services Committee of the Madrid Regional Council (through the Programme of Social Services Alternative to Psychiatric Institutionalisation) and developed with the collaboration of Madrid City Council’s Social Services Department and San Isidro Shelter.

This project began in 1990, and from then until 1994 it formed part –as a "New Initiative"– of the European Commission’s POVERTY 3 Programme. It continuous to function. The objective of the Project is to attend to people with serious psychiatric disorders that are using or in contact with the San Isidro Municipal Shelter, and to offer them there, through a team of specialists, individualised programmes of psychosocial rehabilitation and community support in order to increase their personal and social autonomy and improve their chances of social reintegration. The work is carried out in close collaboration with the local mental health services. The Project also has 4 supervised flats, capable of accommodating up to 18 people, which serve as back-up resources for the rehabilitation and social reintegration of those attended.

This project does not pretend to be a panacea, nor the solution for all Madrid’s homeless mentally ill; rather, it is a specific experience that has demonstrated that the homeless chronically mentally ill in situations of serious psychosocial deterioration and social exclusion can live a normal and dignified life in the community if they are offered appropriate and flexible attention and support. We have seen the success of a methodology of rehabilitation and support, based on a responsive and individualised style of attention, that has made possible the active involvement of service users, and contributed to a substantial improvement in their quality of life and increased their independence and possibilities of social reintegration. This experience might serve as a basis for improving programmes of attention, rehabilitation and reinsertion aimed at the homeless chronically mentally ill. In the following sections we shall describe the main characteristics, activities and results of the Project (for a more detailed review, see the Reports of 1988/93 and 1994/96 of the Programme of Social Services Alternative to Psychiatric Institutionalisation (PSSAPI), of which the Project forms a part).

A PSYCHOSOCIAL INTERVENTION IN THE MADRID AUTONOMOUS REGION: The Project for the Rehabilitation and Social Insertion of the Homeless Chronically Mentally Ill (PRISEMI)

Antecedents and context of the project

The Project for the Rehabilitation and Social Insertion of the Homeless Chronically Mentally Ill (hereinafter referred to as "the Project" or "PRISEMI") was developed in 1989 in a context in which two factors were prominent:

> a) the transformation and increase of the homeless and marginalised population, and especially the existence of a group of people with serious and chronic mental disorders in situations of homelessness.
>
> b) The development in the Madrid Autonomous Region of a model of community attention, committed to the attention to and maintenance of the chronically mentally ill in their social environment via a set of treatment, rehabilitation and support services.

The former Social Reintegration Committee (now the Health and Social Services Committee), through the Programme of Social Services Alternative to Psychiatric Institutionalisation (PSSAPI), has been working since 1988 toward favouring the rehabilitation and integration in the community of the chronically mentally ill population. For this purpose it has developed specific social resources of psychosocial rehabilitation, employment rehabilitation, residential attention and community support. The PSSAPI Programme and its different material resources (Psychosocial Rehabilitation Centres (PSRC), Employment Rehabilitation Centres (ERC), Mini-Residences, Supervised Flats and Supervised Approved Boarding Houses) function in close co-ordination and collaboration with the mental health services of the Madrid Autonomous Region.

In developing and extending community attention to the chronically mentally ill, the presence was detected of homeless people with mental disorders. During the 1980s, there was a notable increase in the homeless population of Madrid. 1988 data indicated the network of services for the homeless had attended to a total of 10,628 persons, over half of them for the first time. At the same time as this increase in numbers, a qualitative change had occurred in the composition and problems of this population. Thus, according to figures from the Madrid City Council, which estimated that 28% of people using the services of the San Isidro Municipal Shelter in 1988 suffered from serious mental health problems, an increase was recorded in the number of persons among this group with psychiatric disorders.

This apparent increase of the number of mentally ill in marginal situations constitutes a new and complex social phenomenon, as yet barely known and little researched. It has arisen in recent years in a context of crisis and economic and social transformation, in which new forms of poverty and social exclusion have been generated and the number of homeless people has increased.

The appearance and apparent increase in the number of "mentally ill in the streets", persons living in poverty and without a home, must be understood within this context of "the new poor"; these people constitute one of the groups in which homelessness and social exclusion are combined in a serious way. Marginal lifestyles, isolation, lack of family and social support, lack of economic resources, psychiatric disorders, personal and social deterioration –these are some of the elements that converge in this group, forming a vicious circle of poor conditions, marginality and exclusion. This situation is worsened by the fact that many of these people do not use the social and health services available, and tend to be reluctant to become properly involved in attention programmes.

The appearance, then, of the new phenomenon of the so-called "mentally ill in the streets", with their special characteristics, represents an important challenge for social and health services in general, who must try to adjust to their peculiarities and respond to their needs, making possible an improvement in their quality of life and their gradual social insertion.

Given this situation, it became necessary to design specific measures oriented to this group in order to understand their problem and its extent and to develop actions designed to improve attention to them and facilitate their progressive social reintegration. Furthermore, it was (and is) fundamental to promote the development of a comprehensive network of resources for attention to, and the rehabilitation/social reinsertion of those with serious and chronic mental illnesses to prevent their becoming marginalised and facilitate the normalisation of attention to the specific treatment, rehabilitation and residential support needs of the homeless chronically mentally ill.

In this line, the Programme of Social Services Alternative to Psychiatric Institutionalisation, developed by (as it was then called) the Social Reintegration Committee of the Madrid Autonomous Region, targeted the specific social needs of the chronically mentally ill, taking advantage of the European Commission’s "Poverty 3" programme of 1990. In collaboration with the Social Services Department of the Madrid City Council, a project was designed with the aim of organising and putting into practice specific actions designed to approach this group, understand its problems and, through better attention, improve its situation.

Thus emerged the **"Project for the Rehabilitation and Social Insertion of the Homeless Chronically Mentally Ill"** as a "New Initiative" within the Poverty 3 programme (1990-1994). The organisational structure of the Project was framed within a model of co-operation and collaboration among various public bodies (Madrid Autonomous Region, Madrid City Council, Ministry of Social Affairs and the European Commission):

- **The Madrid Autonomous Region**, through the former Social Integration Committee (currently Health and Social Services Committee), as the body promoting the Project, was responsible for its overall management and supervision via the Programme of Social Services Alternative to Psychiatric Institutionalisation (PSSAPI). Its duties included appointing the team of Project Co-ordinator, 2 Psychologists and 8

Instructors) and the organization and maintenance of the supervised flats. It provided most of the funding for the Project during its stage as a New Initiative within Poverty 3, and from 1994 it took on total responsibility for funding, management and co-ordination.

- **The Madrid City Council**, through its Social Services Department, and specifically the Section of Attention to the Homeless and the San Isidro Municipal Shelter, is the body whose collaboration and participation was essential for the planning, development and follow-up of the Project. Its collaboration was (and continues to be) particularly helpful with regard to the provision of work spaces at the San Isidro Municipal Shelter and the participation of its professionals in the development of the psychosocial rehabilitation and community support activities organised by the Project in its work with the chronically mentally ill using the Shelter.
- **The Ministry of Social Affairs**, through the General Directorate of Social Action, provided funding and technical support for the Project.
- **The European Commission**, through the administration and coordination structures of the Poverty 3 programme, gave support and technical advice, as well as the funding it provided until the end of the programme in 1994.

Although Poverty 3 concluded in June 1994, the Project continues to function, promoted, directed and funded by the General Directorate of Social Action of the Health and Social Services Committee, within its Special Programme Service via the Programme of Social Services Alternative to Psychiatric Institutionalisation, and with the support of the Madrid City Council.

The following sections are devoted to a description of its main characteristics, actions and results.

General description and principal features

The Project for the Rehabilitation and Social Insertion of the Homeless Chronically Mentally Ill emerged, then, as an attempt to develop innovative measures of social intervention with the chronically mentally ill, who had begun to become visible among the homeless population. Little was known about this new type of homeless person, and data from studies on the extent and characteristics of the problem was scarce.

Its aim was to carry out positive interventions with respect to this socially excluded group, offering them attention programmes, psychosocial rehabilitation and community support, together with housing alternatives that would help to increase their independence and quality of life and make possible their progressive social reintegration.

As already stated, the Project’s target population is that living in Madrid (permanently or temporarily), homeless, and suffering from chronic mental illness, and therefore suffering from the effects of two adverse situations and their interaction.

Those included in the category of the chronically mentally ill are characterised by the following features (Talbott, 1984; Liberman 1988/1993):

- Severe psychiatric disorders, such as schizophrenia, manic-depressive illness, recurrent serious depressive disorders, paranoid disorders and other psychoses, and organic brain syndromes.
- Psychosocial deterioration with regard to three or more aspects of everyday life, including personal hygiene, self-care, interpersonal relationships, social skills, etc., which hinders the development or maintenance of their economic self-sufficiency and their independent coping in the community.
- A history of psychiatric attention, with hospitalisation that may be long-term (one year or more in the last five years), medium-term (ninety days to a year in the last year) or short-term (less than ninety days). This feature is not common to all chronically mentally ill, some of whom may simply have attended local medical centres, or even received no type of attention at all.

To respond to this two-sided problem of homelessness and mental illness, exacerbating one another mutually, it is necessary to develop an integrated system of services that can, in a flexible and coordinated fashion, cover the different needs involved:

- Basic needs: food, lodging/housing, clothes and hygiene.
- Medical attention: this is crucial, since, due to the poor diet, hygiene and self-care conditions of this group, its mortality and morbidity rates are higher than those of the rest of the population.
- Psychiatric attention: diagnosis, psychopharmacological treatment, crisis intervention and hospitalisation where necessary.
- Psychosocial rehabilitation: training in self-care, social skills and adaptation to the community; support for integration and maintenance in the community.
- Employment rehabilitation: prevocational, vocational and occupational training, and support for finding employment and adaptation to work.
- Residential support in the community: graded residential services according to the different levels of independence and following the principle of the least restrictive alternative.
- Economic support.

This does not imply that it is necessary to create specific services for the homeless chronically mentally ill with regard to each one of their different needs (treatment, rehabilitation, residential attention, support, etc.). In many cases the services exist, both at a general level: health centres, social services centres, hospitals, hostels, etc., and at level of specific services: mental health services, psychosocial rehabilitation centres, etc.

The problem is to create a situation whereby this group is able to accede to and benefit from these services in an appropriate way. It is therefore necessary to develop active, search-based formulas that allow us to reach this population wherever they are, to understand their problems and to put them in touch with the network of services; at the same time, there is a need to work towards improving their capacities and increasing their independence, so that they are able to take advantage of the services they need, and can gradually progress in the direction of social reintegration.

FEATURES OF THE PROJECT

With the above in mind, the Project was designed with the following characteristics or defining elements:

1) To adopt a search-based intervention style, that is, approaching the target population *in situ*. Given the characteristics of this group, which normally fails to use services or does so in an inadequate way, we decided, in accordance with this "search-based" style, to develop the project in the San Isidro Municipal Shelter, as a resource catering for marginalised persons, as well as working in close collaboration with the Social Emergency Mobile Units working in the streets of Madrid, detecting, assisting and advising people in situations of need.

2) To make more dynamic and strengthen coordination between the existing social/health services in order to favour integral attention to this population. This project neither should nor could pretend to cover all the multiple and varied needs of the homeless chronically mentally ill, but rather it is necessary to develop coordination among the different services already in place, especially those of mental health and general social services, with the aim of promoting their involvement in attention to the psychiatric and social needs of these people and in supporting their access to and use of these services.

3) To make accessible to the reference population programmes of psychosocial rehabilitation, aimed at increasing their independence and preparing them for integration in the community. Such programmes, which do not normally reach this group, were to be run at the San Isidro Municipal Shelter. Moreover, and with a view to creating opportunities to break away from the circuit of homelessness and marginalisation, 4 supervised flats, catering for up to 18 people, were made available.

4) To frame the project in an environment of inter-institutional collaboration (Madrid Regional Council, Madrid City Council and Ministry of Social Affairs), thus permitting access to considerable technical and financial resources, and the promotion of the Project as a measure for improving the quality of life and possibilities of social insertion of this group.

5) To design a dynamic and flexible project, capable of being readjusted as better knowledge of the realities and needs of this group and the experience and results themselves allow an assessment of the effectiveness and relevance of the actions carried out, so that the possibilities of its rehabilitation and social reintegration can be maximised. This means that the Project was conceived as a kind of "bank of tests", allowing not only better knowledge of the problems and situation of this group, but also the type of resources, actions and programmes necessary for adapting and complementing the existing services, including the Project itself.

The Project's aim was, therefore, to approach and work with the homeless chronically mentally ill in the context of two complementary dimensions:

- On the one hand, a Research-Assessment dimension, which would allow, in an overall way, a fuller knowledge of the reality of this group, and enable the filling of some informational gaps with regard to its numbers, its situation, its main characteristics and its needs.

To this end, the Project proposed the development of a rigorous epidemiological study for the analysis and detection of the quantity, psychiatric and psychosocial problems and characteristics of those with serious and chronic mental disorders in situations of homelessness. Likewise, it sought to advance the study of the factors that led to their becoming homeless.

- On the other hand, an Intervention-Specific Action dimension aimed at the group of chronically mentally ill (around 60) using or in contact with Madrid City Council's San Isidro Municipal Shelter, the principal public resource providing attention to homeless persons.

The Project aimed to offer this group active strategies of psychosocial rehabilitation and community support that would improve their level of psychosocial autonomy, promote their integration in the network of mental health, social and other community services, provide community housing (supervised flats), facilitate their leaving the Shelter and, in sum, favour their progressive normalisation, improve their quality of life and promote their gradual social reintegration.

Given the philosophy of rehabilitation underlying the Project, the participation of users in their rehabilitation process and in the control of their own lives is an objective and an instrument essential to the intervention. Thus, in a gradual but continuous way, those making up the target population of the Project were encouraged to become involved in the planning of their own process of reinsertion, and in the definition of their objectives. After all, the ultimate aim of rehabilitation is to help these people to overcome their problems and recover their capacity to make decisions and move away from exclusion and deterioration towards normalisation and integration.

For this purpose, the Project had the support of the following team:

- 1 Co-ordinator-Psychologist
- 1 Psychologist
- 6 Instructors

The Project was directed by the Committee and carried out by a company, working under contract, with expertise in the rehabilitation and support of this type of population.

Actions

In summary, the main actions and intervention strategies of the Project are:

Programmes of psychosocial rehabilitation and community support

The Project aimed, as a basic pillar of the intervention, to reach the group of homeless chronically mentally ill using the San Isidro Municipal Shelter and to offer them individualised programmes of psychosocial rehabilitation and community support (Rodríguez, 1997), with the purpose of:

- Helping them to recover the set of personal skills and abilities necessary for living as independently as possible in the community environment.
- Supporting and strengthening their links with the existing social and health services, especially with mental health services, attending to their needs for psychiatric treatment, but also with general social services and other specific services for the chronically mentally ill, as well as other socio-community resources, in order to increase their possibilities of social integration.

- Preparing, facilitating and supporting their progressive social reinsertion.

The following section offers a more detailed account of the main data on attention provided between 1990 and 1996. As a general summary of the results of this intervention strategy we can adduce the positive effects of these individualised programmes of psychosocial rehabilitation and community support: those attended have improved in terms of personal and social autonomy, their quality of life has improved during their stay at the Shelter, they have become more involved with mental health services and other community resources, psychiatric relapses and hospital admittances have decreased, and in sum, effective possibilities for reintegration in the community have been opened up.

However, in spite of these positive effects, the Project's potential for facilitating the social reinsertion of many of the target population is limited by the insufficiency of residential alternatives and social support in the community.

Residential alternatives in the community

In order to facilitate leaving the San Isidro Municipal Shelter and to favour the social reintegration of the mentally ill using its services and reached by the Project, four supervised flats (18 places) were made available, to serve as housing alternatives and support, and as a context for favouring the process of rehabilitation and social reintegration.

These flats received support that was flexible and adapted to the needs of users by the Project team.

The flats have been seen to work well and constitute a positive element of the Project, as a flexible residential alternative, providing an opportunity to live in a normal community and enjoy its support, and thus as a context for moving towards social reintegration. Those benefiting form them have experienced a radical improvement in quality of life: having a home of their own has made it possible for them to recover their dignity and self-esteem, and to change their role of marginalised persons or patients for those of active, normal people. Functioning at an internal level has been interesting, with the achievement of high levels of independence and self-organisation in everyday life, as well as normalisation of the users' current situation and perspectives for integration.

Training

The Project was responsible for organising various training and technical support programmes with the following personnel:

- Those working with Madrid City Council's Social Emergency Mobile Units (UMES), in order to improve capacity for the detection of and attention to the mentally ill living on the streets.
- The auxiliary staff of the San Isidro Municipal Shelter, with the aim of increasing their knowledge of the chronically mentally ill population and providing them with strategies for improving rehabilitatory attention to chronically mentally ill persons using the Shelter.

Research

As already explained, the aim of the Project was to develop an epidemiological study that would provide rigorous, valid and reliable data on the number, social and demographic characteristics, and types of psychiatric problem of the homeless mentally ill, and to make progress in the analysis of the factors that have influenced their becoming marginalised.

This research was carried out by the Psychology Faculty of Madrid's Complutense University under the direction of Manuel Muñoz, Carmelo Vázquez and Juan Antonio Cruzado, and in accordance with an agreement with the Committee. It concluded in 1994 and was published the following year, by the Regional Council of Madrid, as a book entitled: "Homeless Persons in Madrid: A Psychosocial and Epidemiological Report."

Its main results have already been presented, and have also been summarised by Muñoz and Vázquez in other studies.

Sumary of attention provided by the proyect 1990-1996

We shall continue by offering a summary of the development of the Project and the attention provided during the period 1990-1996 (see PSSAPI reports of 88/93 and 94/96).

The following table presents the main data referring to attention provided by the project from its inception in 1990 until 31st December, 1996.

During this period a total of 109 persons were attended. As can be observed in Table 1 and Graph 1, the project's attention capacity increased continuously, reaching a maximum of 83 users, with figures of around 70 simultaneous users. The rate of new users, after reaching figures of up to 22 per year in the early years, stabilised in the last three years at a mean of 14 users/year.

Table 1. Evolution of Attention in the PRISEMI Project

Graph 1. Basic descriptive statistics of effect size

From the opening of the Project's first two supervised flats, in 1992, up to the present, with 4 flats available, the team has made a considerable effort, in collaboration with the professionals at the San Isidro Municipal Shelter (SIMS), to offer users living in the SIMS more normal alternatives –not only their own flats, but also boarding houses or flats shared among several SIMS users. Supervision in these other residential alternatives has also been carried out by the Project team, and always in accordance with the circumstances of each case.

Openings for returning to the family environment continue to be limited, given the lengthy periods of separation usually involved in these cases and the mutual difficulty of adaptation, but those that have occurred have been aided by a previous stage of living in the supervised flats.

The result of the team’s work, as observed in Table 2, is that by 31st December 1996, only 48.5% of users attended by the Project were living in the SIMS. The remainder, i.e., 51.4%, were living in more normal alternative accommodation: boarding houses, shared flats and Project flats. All of those attaining these alternatives had come from the San Isidro Municipal Shelter.

Table 2. Place of residence of Project users

The total number of places in supervised flats currently managed by the Project is 18. On 31st December 1996, 17 were occupied. The remaining place became vacant on its occupant moving to another normal housing alternative, and the place was kept free while the person’s adaptation to the new environment was assessed.

In general, as can be seen from Table 3, the level of continuity in the flats is high. Since 1992, 5 persons have left (without moving to alternative accommodation), but of these five, the team continues to help or to maintain contact with four. Only one of them has decided to separate from the Project completely.

Table 3. Evolution of stay in supervised project flats

The number of those leaving the flats for a positive alternative is also low (3). Although users’ contacts with their families increase significantly on moving to a more normalised environment, such as a supervised flat, this proximity rarely leads to a return to the family home. Other alternatives for positive moves, such as renting flats, are beyond the economic possibilities of the users, whose opportunities for integration in the world of work (with mean ages of 40 years and little training or work experience) are scarce.

In total, throughout the history of the Project, 18 people have made positive moves (3 of them, as indicated, from the supervised flats). The residential destination of these 18 users is shown in Table 4:

Table 4. Evolution of Positive Moves from the Project

The total number of those moving to more positive alternatives represents 16.5% of those attended, and has mainly occurred since 1993, one year after the team began to intensify its work of enabling people to leave the Municipal Shelter and move to alternative accommodation. As it can be seen, the majority of these cases (two-thirds) involved moves to shared flats or homes (Senior Citizen’s Residences or Instituto José Germain).

Table 5 shows the data on the use of other resources of the PSSAPI Programme in which the Project is included and of other community resources by users of the Project (those living in the SIMS and in other residential alternatives) between 1993 and 1996.

Table 5. Use of other socio-community resources

Graphic 2. Use of community resources 1993-1996

Despite the fact that the use of other resources of the PSSAPI is not particularly high, since the weight of rehabilitation falls mainly on the Project, considerable efforts have been made to encourage users to take advantage of community resources of all kinds. Figures for the last two years show that 70% of Project users benefit to some extent from employment and leisure services. These figures represent an increase with respect to those of previous years.

The sociodemographic data that characterises those attended by the Project are, in summary, as follows (for further details see the PSSAPI Report 1994/1996): with regard to sex, approximately 60% of those attended are women and 40% are men; mean age is 43 years; the vast majority (63%) are unmarried; schizophrenia is the most common disorder; there is a low educational level, with 53% having only elementary education and 20% education to age 15; they are unemployed and not receiving benefit (42%), or receiving a pension (55%), in the majority of cases a non-contributory disability pension; the vast majority (79%) have no criminal record; since being attended by the Project 83% have not been admitted to hospital due to psychiatric crisis.

Summary and perspectives

Let us consider the main conclusions reached by the Project, which form the basis of experience on which its work can be continued:

- The first and soundest conclusion reached is that it has been demonstrated that the homeless in situations of serious psychosocial deterioration and marginalisation can live in a normal and dignified way in the community if they are given the appropriate attention and flexible support.

- We have moved much closer to the problems, needs and characteristics of the homeless chronically mentally ill, and gained a much better and more comprehensive knowledge of their situation.

- A methodology of psychosocial rehabilitation and flexible community support, adapted to the needs of this population, has been successfully used. This has made possible their active involvement and contributed to an improvement in their situation and quality of life and an increase in their autonomy and possibilities of social reintegration.

- The suitability of the accommodation alternatives (supervised flats) developed by the Project has been demonstrated: these normalised and normalising alternatives have made possible a substantial improvement in the quality of life of the target group and increased their chances of social reintegration.

- Involvement and coordination with mental health services and other socio-community services in attending to this group have been strengthened and improved.

- A model of inter-institutional co-operation has been developed through the Project. This is an essential condition for comprehensive attention to the population in question and in general in the fight against the exclusion and in favour of the integration of the homeless.

In sum, the Project has provided a wealth of experience and practical knowledge with regard to a marginalised group about which little is known, that of the homeless chronically mentally ill. This experience should serve as the basis for improving attention to this group and their quality of life and providing more effective support for their progressive social reintegration.

CONCLUSIONS AND RECOMMENDATIONS

We should like to conclude this work by considering a series of recommendations (among many others) that we feel to be pertinent, with a view to improving the situation of the homeless mentally ill and offering them the integral attention they need:

- It is fundamental to increase the priority currently given, in general, to "homeless persons", and specifically to the homeless chronically mentally ill, at both a political-institutional level and a social level. This necessity is evident if we consider the serious problems of social exclusion suffered by this group and the need to offer these people –citizens with full rights– the possibility of leading a dignified life as part of society.

- Given the characteristics of this population it is necessary to continue developing specific actions aimed at them that will serve as a basis for attention to them and their rehabilitation. These actions should complement the efforts of the general systems of social protection and those of specific social and health networks for giving attention to, rehabilitating and providing community support for the mentally ill.

- It is highly important to plan and develop integral programmes and projects for attending to the entire homeless chronically mentally ill population in the large cities in Spain, including not only those attended by or in contact with the various shelters and hostels, but also those living rough on the streets.

- The programmes and interventions to be developed should be based on the appropriate studies and research that permit the detection of the population to be attended and provide reliable quantitative and qualitative data on their situation, characteristics and problems.

- These interventions, although necessarily specific, should be integrated and/or coordinated in a coherent and synergic way with general planning of attention to the homeless population, and with planning or systems of mental health and social services for community attention to the population with chronic mental illnesses.

- Measures taken should cover the different levels involved: prevention, attention, rehabilitation and social reintegration.

- From the logic of the principle of multidimensionality, all the different needs and problems of this population (detection and reach, basic needs, accommodation, psychiatric treatment and follow-up, psychosocial rehabilitation, community support, economic self-sufficiency, etc.) should be covered in a comprehensive way, with the overall objective of facilitating their integration and maintenance in the community in the best possible conditions of autonomy, quality of life and normalisation.

- Both the organisation and development of the necessary specific resources and programmes and the involvement and adjustment of the various existing networks of community services (mental health, general and specialized rehabilitation and social support, hospitals, etc.) should be taken into account in the planning of integral attention to this population, avoiding the creation of parallel networks or unnecessary duplication that may lead to marginalisation. Likewise, it is essential that the network of attention, rehabilitation and social support for the chronically mentally ill be endowed with sufficient resources to be able to include the homeless.

- As specific and priority measures to be developed with the homeless mentally ill, intensive actions should be designed –from a "search-based" perspective– that aim to detect and reach this group (specialised teams for attention and advice in the street, flexible "bridges" adapted to their characteristics –day centres, "no questions asked" accommodation, etc.–, rehabilitation and follow-up programmes for those living rough) and aid their progressive involvement in more normalised attention programmes and resources. Also, efforts should be made by mental health services to offer, in a flexible and responsive way, the psychiatric help this population requires.

- With regard to the group of chronically mentally ill attended by or in contact with the shelters, the development of flexible and individualised programmes of psychosocial rehabilitation and community support, together with the launching of an adequate range of supervised accommodation resources in the community, should constitute one of the main pillars of the intervention.

- These programmes and interventions should be structured by promoting the involvement in planning and management, not only of health and social service administrations at their various levels (central, regional and municipal), but also of all the social bodies and organisations that work with the homeless, and whose coordinated collaboration is fundamental for the optimum and effective development of the plan and its different strategies.

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Dual Diagnosis

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Definition of Dual Diagnosis

The whole issue of "Dual Diagnosis" is rather conflictive, and it has been addressed from different points of view in literature.

The definition causing some problem is "Dual diagnosis" itself. The term refers of course to the situation in which the same person suffers from more than one condition. But we could say that somebody who has the flu and at the same time suffers from gastroenteritis has "Dual diagnosis".

In more common use, Dual Diagnosis refers to the situation in which somebody suffers from a mental disorder and is also dependent or addicted to some substance.

When the term "Dual Diagnosis" is used in the USA, it often refers to *any* mental disorder plus some substance abuse.

In Israel, we prefer to use the term "Dual Diagnosis" to refer to a person who suffers from a condition determined under Axis I of the DSM IV classification (1), which refers to Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention. The diagnosis specifically omits Personality Disorders and Mental Retardation.

The difference of conception between the USA and Israel is based mostly on economic reasons. Insurance companies pay for the treatments in the USA, and they have decided that the treatment for Substance Abuse or Dependence should be one week, which is obviously only enough for, in the best of cases, completing the physical withdrawal period, but not for the rest of the treatment. As a result, therapeutic sources have decided to treat the (usually) accompanying Personality Disorder as an entity separated from the addictive disorder, in order to justify the extension of time used for the treatment, and the use of the term "Dual Diagnosis" has become much more common.

In Israel, the treatment of addictions is paid by the State, and it is substantially more comprehensive than the current approach accepted in the USA, and consequently, we can spare the term Dual Diagnosis for cases in which an Axis I diagnosis other than the addictive disorder is found. These patients are treated separately from either psychiatric or addictive patients, as will be described further on.

We have been using the term "Addiction" in the old sense, we should mark that a distinction is now made between two terms which were used rather indistinctly until a few years ago: Addiction and Dependence. The difference, as seen now, consists of the following:

1. Addiction (Drug addiction)

The term is often used indistinctly with "Dependence", but the meanings, and even the anatomical location of the two conditions, are different. Addiction means that the person continues using the substance he/she likes the effect produced by the substance. The anatomical location is in the Ventral Tegmental Area.

2. Dependence (Substance Dependence)

The term means that the person continues using the substance because he/she fears the consequences of the abstinence syndrome produced by the sudden cessation of the use. The anatomical location is in the Hypocampus.

It is useful to remember that the distinction between Addiction and Dependence, recently elucidated, may help explain the controversies respect to some substances like THC (cannabinoids), which were considered by some as "Addictive" and by others as "Non (or Almost Non) Addictive", before the distinction was noted.

Incidence

The incidence of Dual Diagnosis is very difficult to determine, specially if we take into consideration that nobody can really tell what is the incidence of Addiction or Dependence in the population.

Some figures have been advanced (2):

-1) - About 20% of the adult population of the USA suffer from some form of addictive disorder throughout their lives;

-2) - Approximately 25% of the adult population in the ECA study had some form of Axis I diagnosis besides the addictive problem;

-3) - Of this 25%, about half (12.6%) suffered from major depression and about 5% could be diagnosed with psychotic, bipolar and other disorders;

-4) - Women substance abusers show a high incidence of PTSD as comorbidity (3).

-5) – About 30% to 50% of schizophrenic patients may meet the diagnostic criteria for alcohol abuse or alcohol dependence; the two most commonly used other substances are: cannabis (15 to 25%) and cocaine (5 to 10%) (4).

-5) – Every fifth psychiatric inpatient abuses opiates or cocaine; every fourth one abuses some illegal substance; every third one abuses alcohol (5).

-6) – About 60% of patients with schizophrenia, and about 58% of all psychiatric inpatients abuse or are dependent of at least one substance (6,7).

American statistics do not match well with Israeli population, but we can assume that a high proportion of substance abusers in Israel have another form of Axis I diagnosis as comorbidity.

We should note here that Heroin abuse is, at least by the time being, more common in Israel than Cocaine abuse, consequently, some of the references found in American literature should be adapted when referred to Israel. Alcohol abuse, which receives in Israel much less attention than Heroin abuse, is increasing, and some statistics place the number of people dependent from alcohol at about 60.000. (8)

Order of appearance

The question of what disorder appears first is often raised. The answer is not simple. Alcohol abuse was found to be prior to first admission in 24% of cases (9, 10), and other substance abuse in 14%, which is double the rates in the general population.

The same source states that there is some evidence that alcohol abuse precedes schizophrenia, while it is possible that the first hospitalization due to schizophrenia is more or less coincident with the beginning of opiate abuse.

Practical problems in the management of dually-diagnosed patients

Although it is generally accepted that addictions are part of the Psychiatric field, in practical terms psychiatrists do not like addicts, and addiction treatment centers do not like mental patients.

As a result, patients presenting the comorbidity of addictive disorders and mental disorders are underdiagnosed and receive very little treatment.

Most psychiatric hospitals will admit addicts for very short periods when there is a significant psychotic decompensation, but will discharge them as soon as the acute phase of the disease is over, or, sometimes, as soon as the dual diagnosis is discovered.

Addiction treatment centers usually do not admit patients who are overtly disarrayed from the psychiatric point of view. Those patients are referred to psychiatric facilities, and the procedure starts all over again. Some attempts are being made to improve the situation (11, 12).

The situation in Israel

Until 1993 there were no services specialized in the treatment of dual diagnosis in Israel. At the beginning of 1994 the first beds for these patients were open at the Mental Health Center Beer-Sheva's Rehabilitation Department.

In that opportunity the patients were chosen from the Negev area, in cooperation with the addiction-treatment facilities existing in Beer-Sheva. The degree of cooperation between the teams in the two areas made it possible to start a program specifically aimed at patients who suffered from dual diagnosis with the characteristics mentioned above: An Axis I diagnosis besides the addictive problem. Inter-team cooperation was assured by inserting some members of the Mental Health Center staff into the addiction-treatment facilities.

It soon became evident that, although the teams were cooperating and trying to provide the best possible set of treatments under the circumstances, patients and their families were not so cooperative.

The Israeli society is quite different from the American, and family ties in Israel are much stronger than in the USA.

The majority of addicts in Israel still is from North African origin, and they consider as "family" the extensive family. It is customary to visit relatives, who are unwell, especially if they are admitted in hospitals.

Since the rehabilitation department is an open ward, where patients can enter and leave at will, it was very difficult to control the visits of families and friends of the patients. The families and friends often felt obliged to bring those addicted patients something with what to feel better, including of course their favorite substances of abuse.

At the same time, it soon became evident that visitors were profiting from their visits to sell drugs to other patients, and sometimes even to abuse male and female psychiatric patients.

The management of the Mental Health Center then decided that, although it was very meritorious to treat dually diagnosed patients, and although the management was much interested in continuing the treatment, a drastic change in procedures had to be implemented in order to permit the adequate functioning of the institution and at the same time treat the dual diagnosis patients.

It was decided that a new kind of unit, of the closed type, had to be created.

The search for the means with which to build the facility started. At the same time, when the word spread in Israel that there was an interest to open a dual-diagnosis unit, some other psychiatric facilities started to study the possibility to open that kind of unit.

Administrative and logistic problems of many kinds started to appear.

One of the psychiatric facilities, located in a general hospital in the North of Israel decided to use a few empty rooms they had to start a dual diagnosis unit. The project had to be abandoned when the nursing staff of the hospital menaced to collectively abandon their jobs if addicts were admitted in the facility.

A psychiatric hospital succeeded in opening a detoxification unit for dually diagnosed patients, but with very limited objectives: a very short admission period, only for male adult patients, very few beds, no after-care.

The funding for our facility was difficult to find, and it was made available mostly due to a specific interest in the subject that could be elicited at the Anti Drug Authority. The Authority finally came up with a substantial part of the building cost, and the Ministry of Health made the rest available.

Finding the personnel to staff the unit was not simple. Most nursing staff refused to work in a unit where addicts would be admitted, because they feared the violence usually accompanying the admission of addicts. It took several months of training the staff to lower the degree of anxiety that the presence of addicts produced. Finally, when the facility started functioning, and the patients showed absolutely no degree of violence, the personnel started to relax and cooperated fully with the treatment.

After solving some other minor administrative problems, the new unit was finally open in June 1999.

The facility

The unit has capacity for 15 inpatients, and it also comprises facilities for occupational therapy and sport, as well as the usual dinning-room and nursing facilities.

The unit is of the one-way closed type, that meaning that visitors are not allowed, and patients cannot leave on vacations. On the other hand, every patient may ask for discharge at any time, but once he/she leaves the facility, he/she cannot return until after five years.

The selection program established requires that patients, who are referred from all over Israel, sign an agreement to cooperate with their treatment.

Referrals are accepted only from institutions and not from patients themselves or their families. The reason for this is that institutions which refer patients to the unit have to sign an agreement to receive the patients back and continue treatment in their own facilities, or in other facilities which they have to look for, after the patients are discharged from the dual diagnosis unit.

This agreement serves two purposes: On one side, nobody wants Beer-Sheva to become the national concentration point of every dual-diagnosis patient in Israel, so they have to return to their place of origin. On the other side, and most important, those patients who are re-placed in other institutions, are usually receiving antipsychotic medication. When they are re-placed in other institutions, they have to continue taking their medication, which forces the institutions which previously refused to accept patients taking medication to accept them.

In this way, it is hoped that, in a few years, a great part of the present rejection of patients taking medication will disappear, and those patients will be more easily received in the different treatment centers.

No referrals are accepted from the judiciary, and the unit does not serve instead of prison.

Operational program

The first step in the process is an adequate diagnosis. Most patients were never correctly diagnosed before their admission in the unit, due to the rejection of the psychiatric personnel to treat addicts.

After the diagnostic procedure, which is performed ambulatorily, patients are admitted in the unit, preferably while they are under influence. This is because most patients are dependent on opiates or alcohol. The withdrawal syndrome from opiates or alcohol begins some 8 to 12 hours after the last use. Since the patients have to come from different parts of Israel, and admission hours are in the morning, if the patients were not under influence when they arrive, they would start developing the withdrawal syndrome upon arrival, and management should be much more difficult.

It is our clinical observation that many schizophrenic patients who abuse drugs do not present symptoms of schizophrenia while they are under influence or at least the symptoms are much less pronounced. But the symptoms reappear when they stop using substances, especially when they stop using opiates. This is another reason to prefer that patients arrive in the unit while under influence.

A period of not more than 8 hours must be profited since the moment the patient is admitted until we start the treatment for the withdrawal syndrome and for the psychotic situation.

Withdrawal is assisted with Clonidine unless otherwise indicated, and antipsychotic medication is used according to the needs of the case. The great majority of patients require antidepressant medication.

After medication has stabilized them, and since the first day in the unit, patients are required to participate in the chores of the unit: cleaning and making order not only in their rooms but also in the public areas of the unit. Cleaning personnel is only used to take care of the offices of the staff.

Activities are planned to start at 7.30 in the morning and continue until 10.00 p.m., with lunch and dinner breaks, and a 2-hour rest period after lunch.

Besides medication, patients receive group therapy and counseling, and participate in educational and rehabilitational groups. Elements of rehabilitation school have been incorporated into the program (13). Sport activities are carried out within the premises.

A case description

In order to give a better idea of the kind of patients being treated in the facility, we will see a case history: The history of K"

K' was a strange character when he arrived. He was an addict of course, but there was something else.

K' was born into an apparently "normal" family, was the third of four brothers, had a normal infancy and started school at the normal age. A doctor, a nurse and a psychologist checked him, and they did not find anything wrong.

Because the family's economic situation was poor, they lived in a problematic neighborhood and there never was too much food at home, although they never went hungry.

When K' reached puberty his behavior changed. He began to run away from school and wander around, generally alone. He would sometimes go to a nearby farm in which he could find horses, and he would spend hours on end with them. He did not ride them, he only wanted to feel them near him.

Some time later he started hearing voices, or maybe it was at the same time, he was not sure. The voices were pleasant. They told him that he was not stupid, and that he could do great things in life. He rather liked his voices, and he would listen to them rather than to real people.

Sometimes he thought that it was the horses that were speaking to him, but he could not be sure.

His family was worried about his vagrancy, and they took him to a doctor, but K' did not tell the doctor about his voices. Somehow he felt that the voices were "his", and that telling about them would in some mysterious way harm him. He was also afraid that if he told about them, the voices would go away, and then he would feel lonely.

Since the doctor did not find anything wrong, he prescribed some vitamins, and attributed his behavior to a reaction to adolescence, frequently found in children of his age and background.

But K' refused to go back to school, and the parents decided to leave him alone. The doctor had said that the reaction would eventually pass and he would return to himself.

For the next two years K' was left alone by his family. He would go home to eat and sometimes also to sleep, but would keep his family at a distance, without more verbal contact than the utterance of some words from time to time.

He did not have friends either. He had never been very sociable, and the few friends he had lost interest in him when he left the school. K' was happy with his voices and the company of the horses.

But one day things started changing. Suddenly the voices stopped being nice to him. Sometimes they would curse him; sometimes they would threaten him. One day the voices ordered him to burn the field where the horses were, and he did. No great harm came of this, but the owners of the farm were very upset. They had become used to seeing him play around with the horses, and had never interfered, but the burning of the field was something else.

They had seen him in the field a short while before the fire, and they naturally questioned him. They were under the impression that he had dropped a cigarette, and that the cigarette had caused the fire, but K' told them that he had done it because the voices had ordered him. He found it natural to obey them.

The farmers contacted his parents, and K' was taken to a psychiatric hospital for assessment.

The doctors had no doubt about his condition: Paranoid Schizophrenia. K' was admitted to a closed ward, because he was dangerous to himself and to others. Under the influence of his voices he had burnt the field, but he could as well have killed somebody.

K' was very unhappy at the hospital. Some people were very aggressive in the ward, and beat him. The nurses injected medicines. There were no horses. A patient tried to rape him. He decided to leave, and he escaped from hospital.

He was afraid of returning home, because he thought his family would send him back to the hospital, so he simply wandered around. He ate what he found, and a couple of times he stole some fruit or a roll, nothing serious, only sufficient to calm his hunger. He was 17 at the time.

One day he was walking and feeling very hungry, when he saw a group of people at the side of the road. He approached them and asked for food, and was received very well. They gave him food and beer, and after some hours he felt "at home" with them.

Suddenly one of the men produced some H', and everybody smoked. He was also invited to smoke it. K' was not sure what it was, but the people had been nice and friendly to him, so he tried.

This first experience with H' opened up a new world for him. Suddenly, there were no voices, and he felt calm and relaxed. The sensation of relief also produced an unbelievable well being and exhilaration. K' felt at ease with himself and with the world, for the first time in many years. He asked for more, but was told that the material was very expensive, and that if he wanted more, he should produce some money for it.

K' had never worried about money, and did not have a clear idea of how to make money, so he asked, and was told that rich people usually have a lot of money, and that he could steal it from them.

Very soon K' was very busy with his new "profession". He was not stupid, and despite his schizophrenia, could break into apartments at night and get money with which to buy H'.

The police arrested him for the first time when he was19. He was not so naive now. His friends had also told him that if he spoke with the judge about his voices, he would probably be sent to a psychiatric hospital, and not to jail. He tried, and the judge did send him to a hospital for evaluation.

The hospital confirmed the diagnosis of schizophrenia and drug addiction, and the judge decreed that he should be hospitalized for treatment.

There followed a whole series of hospitalizations for short periods, discharges from the hospital as soon as the acute phase of his schizophrenia remitted, and new arrests and admissions.

All told, he had been in 5 hospitals when he got to me, and was not any better.

K' was in very bad shape when first examined. He looked pale and emaciated, with a frightened look in his eyes. He was unshaven, not very clean, his clothes in disorder.

He had been referred to the dual diagnosis facility because the psychiatrists who examined him first had considered that, though schizophrenic, his drug problem was first priority, and should be treated first.

When asked what his problem was, he said: "The voices don't let me rest. I haven't slept for at least two weeks. I don't want to eat, I want help". His expression was very pathetic, he really looked as though he needed help.

Very careful questioning disclosed that Heroine was what he most appreciated, because when he was intoxicated his voices would give him respite. But he needed very high doses to calm the voices down. When asked about the effect of antipsychotic medication on him, he said that he did not like antipsychotics, because when he had had enough of them to silence the voices he also felt very heavy, drowsy, and could not think clearly. He had received very high doses of antipsychotic medication in the past, as could be seen from his medical record.

There was some reluctance to give him the high doses of Methadone he requested, so he was admitted and started on different combinations of medication. It took almost a month to find the adequate combination.

K' started feeling better, his voices were not bothering him, he was not feeling heavy, and he could think and work. He started putting on some weight.

After one month with the new medication, K' was working everyday, looked happy, was helpful in many ways in the ward, but was shy and made few friends. We started working on that. His therapist had read a lot about psychotherapy with psychotic patients, and he knew that it is generally a very long and complicated process, not always fruitful. It was agreed that we were not looking for a psychotherapeutic cure for his schizophrenia, we only wanted to make him a little more sociable.

With that goal in mind, they set to work. K' was very cooperative, he was really anxious to make friends, but was afraid, since he did not know how.

K' never became one of the leaders of the ward, or one of the most prominent figures, but he did his part, was active, and worked. He did not get involved in problems, never used illicit drugs, at least as far as his urinalysis showed, and was not generally different from the rest of the population of the unit.

He was transferred from the dual diagnosis unit to the rehabilitation department, where he continued his treatment.

The rest of the story shows the importance of opiates for schizophrenic patients.

When he had been some months in the rehabilitation department, he asked to have his medication reduced. He was advised not to do it, but he was very insistent.

At a determinate point, he left the ward without coordinating his departure with the medical personnel. He simply got up one day and left.

A few days later he was readmitted in the short-term unit, showing signs and symptoms of an acute psychotic state.

The staff at the short-term unit called us in, to consider readmission in the rehabilitation unit, so there was a chance to check him. When asked for the reasons of his sudden decision to leave the hospital, he confessed that reducing the medication had been a mistake. Voices started bothering him again, but he was ashamed of asking to raise his medication, after he had been so adamant in requiring it to be reduced. So, the only way out he found was to star using opiates again. Opiates immediately calmed his voices down, by the did not want to stay in the rehabilitation department while using opiates, he thought it was unfair with the staff, who had treated him decently, so he decided to leave.

On readmission, he quit opiates at once, and continued doing well with adequate doses of antipsychotic medication.

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PSYCHODRAMA AND HELPLESSNESS IN THE HELPER OF ADDICTS

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"Ask not for whom the bells toll; they toll for thee"
(John Donne)

I - On Being a Helper of Addicts.

The psychotherapeutic process in general implies situations and interactions in which the transference and countertransference dynamics, have a very deep impact in the "helper", the therapist and in the "helped", the patient. The therapeutic relationship with addicts often brings forth much more powerful feelings of helplessness in countertransference.

Addicts usually are multi-traumatized individuals with unresolved losses in their clinical history, who grew up from dysfunctional families (Triffleman et al, 1995), and they pour into the therapeutic encounters a much more demanding relationship than other types of patients with mental disorders usually do. The addict has frequently suffered from a traumatic event such as processes of immigration and other such existential losses; the death of a parent; the divorce or repeated divorce of a parent or of him/herself; physical, emotional and/or sexual abuse (Jarvis and Copeland, 1997). This distorted development has decreased their adaptive abilities to the stresses of life (Elder, 1990). The losses have been dealt with, unsuccessfully, by using alcohol and other drugs to numb the pain (Nash, 1990).

Another source of worries for the therapists is the fact that the life span of addicts is thought to be shorter than the life span of non-addicts (Risser and Schneider, 1994). The possibility of a fatality occurring while under treatment has been found to be statistically high. The mortality rate of addicts found by Frischer et al, (1997) in a longitudinal study from 1982 to 1994 was 1.8% per year.

Therapists who deal with addicts in the process of weaning and becoming ex-addicts, and with co-dependents family relatives, may be confronted with situations of loss, much more frequently than therapists dealing with neurotics or psychotic patients.

Repeatedly during my professional experience I have been confronted with situations of loss, either of loss of my patients, or the children of my patients, or patients of other therapists. Sometimes my addicted patients would die from overdose, suicide, accident or assassination; sometimes the children of co-dependent parents who were attending my "tough-love" meetings or participating in other kinds of programs aimed at treating family dysfunction, would die, and the question should be raised whether the children did not die as a consequence of the parents applying incorrectly, in a "double message" way, what they learned with me in the therapeutic process of detachment. Sometimes, colleagues who had suffered the loss of a patient, revived once again in me feelings of guilt, shame, rage, helplessness, depression and loss of self esteem.

Grief, mourning and bereavement are the psychological reactions of those who survive a significant loss. *Grief* is the subjective feeling elicited by the death of a loved one, the term is used interchangeably with *mourning*, although *strictu sensu* mourning is the process by which grief is resolved. *Bereavement* means the state of being deprived of someone by death, and refers to being in the state of mourning (Kaplan and Saddock, 1997).

Many other therapists, like me, have learned to "cope" with death and bereavement in front of the family in mourning, the therapeutic group in grief and the rest of the staff, with scared silence.

- II - The Therapeutic Relationship: Dynamics of Transference and Countertransference in Death and Bereavement.

Transference is the patient’s displacement onto the analyst of early wishes and feelings toward other people. Just as patients project transferential attitudes to therapist-patient relationships, therapists themselves also have countertransferential reactions to their patients. Countertransference may take the form of negative feelings that are disruptive to the therapist-patient relationship, but may also encompass disproportionately positive, idealizing or even eroticized reactions (Kaplan and Saddock, 1997). The term countertransference has been given various meanings that may be summarized by the statement that for some authors countertransference includes everything that arises in the analyst as psychological response to the analysand, whereas for others not all this should be called countertransference (Racker, 1996).

As Viney (1994) states, when clients come to psychotherapy they are distressed, this distress usually being expressed in the form of anxiety, hostility, depression and helplessness. In addition to this, addicts come to treatment with a sensation of an "objectal loss" from a psychoanalytic perspective, and tend to believe that it is the function of the therapist to fill the place left by the lost object (Vera Ocampo, 1988).

The substance abuser has a self-destructive behavior (Galanter and Castanceda, 1985). Suicidal (self-destructive) patients place a special burden on the therapist and attack him/her, using the therapist as a "selfobject", an object that regulates the patient’s narcissistic equilibrium (Milch, 1990). This tendency to projective identification is part of the transferential process in the addict.

The role addicts thus project onto the therapeutic relationship contributes to the feeling of **helplessness** often seen in helpers, and specially in therapists who work with addicts.

- III - The Concept of Helplessness: Theoretical Considerations

Helpers, like most people, encounter aversive and stressful events that can have a major impact in the course and direction of their lives. They and those they love may be confronted with a disabling accident, serious illness, death or violent crime. Several authors have recognized the detrimental effects that exposure to stressful life events may have on the individual’s mental health, functioning, and adjustment as well as the importance of personality factors that determine the reactions to these events.(Abramson, Garber, & Seligman, 1980; Lazarus & Folkman, 1984; Peterson & Seligman,1984; Bandura, 1986).

After those bad events people tend to ask themselves:" Why did it happen?". "Who is responsible?" "What caused the event?" "Will it always be like this?" Abramson, Seligman and Teasdale (1978) contend that people have fairly habitual ways of explaining the causes of stressful events, which make up their own "attributional/explanatory style" consisting of three dimensions: 1) locus of **causality**, 2) **stability** and 3) **globality**. 1) Locus of **causality** refers to whether the person assigns an internal or external cause to the event. 2) **Stability** refers to whether the reason for the event is a transitory or a more or less permanent factor. 3) **Globality** refers to whether the reason given applies only to the specific event in question or extends to other events as well.

According to this theory, the attributional/explanatory style plays an important role in determining our reactions to negative, aversive uncontrollable life events. Each of the three attributional dimensions has its own impact on the individual's reaction to stress situations and explain how and why do people respond and cope with bad events. **Internal attribution** for failure ("It's me") is associated with loss of self-esteem and depressive symptoms (Klein, Fencil-Morse and Seligman, 1976; Beck, 1976; Rizley, 1978; Bowlby, 1982; Weiner, 1986; Higgins, 1987;). The more internal the attribution, the greater the reduction in self-esteem and the stronger the depressive symptoms after failure. **Stable attribution** ("It's going to last forever") affects the chronicity (duration) of the depressive symptoms and problems in functioning that may follow failure (Mikulincer,1988). The more stable the explanation, the more persistent the symptoms . **Globality** ("It's going to last forever") affects the generalization of the problems in functioning that follow (Mikulincer & Nizan,1988). The more the stressful event is explained by global causes, the broader the impact of the event on the individual's functioning and adjustment.

An attributional style in which bad events are explained by internal, stable and global causes is not only associated with depressive symptoms but also with *learned helplessness.* This phenomenon has been described as the end result of a process in which an organism learns to believe that outcomes are uncontrollable and independent of its responses (Seligman, 1975). Experiencing uncontrollable bad events has been found, in people with learned helplessness, to cause cognitive, motivational and emotional deficits, which are generalized to new situations even when uncontrollability no longer exists (Abramson, Seligman,& Teasdale,1978; Seligman, Klein, & Miller,1976). The *learned helplessness* phenomenon has strong parallels with depression in humans. Causal attributions about life events are a risk factor for depression, and the central prediction is that individuals who have an "attributional/explanatory style" that invokes internal, stable and global causes for bad events, tend to become more depressed, have more problems in functioning and more signs of maladjustment when bad events occur than someone who tends to explain the same event by external, unstable and specific causes (Metalsky et al, 1982; Peterson & Seligman,1984).

A research literature review shows that there are at least three means through which explanatory style may be acquired: first, vicariously: one may learn it by imitating parents, particularly the mother, the primary care-giver in our society (Seligman et al, 1984); second, one may learn from the type of criticisms leveled by teachers following failure (Dweck and Licht, 1980); third, the reality of one's first traumatic loss plays an important role in setting explanatory style: for a young girl the mother's death may represent a stable and global loss which causes an underscored helplessness, which in turn will cause her, as an adult, to impose internal, stable and global explanations on other bad events, rendering her vulnerable to depression (Brown and Harris, 1978).

- IV - Helplessness in the Helper: Needs and Conflicts.

The attribution of personal helplessness in any helper and in the addict's therapist in particular, implies the development of a subjective perception and expectation that nothing he/she can do will help solve the problems of his/her patient/patients. Those who treat the survivors of crisis, trauma and PTSD: social workers, nurses and doctors, not only often develop the helplessness syndrome described above, but also become extremely psychologically vulnerable themselves, and fall victims to secondary traumatic stress disorder (Figley.1995). Although it is a well documented fact that not everybody who undergoes a traumatic event develops a PTSD (March, 1990); direct evidence for the importance of subjective perception is provided by studies demonstrating that cognitive perception of low controllability (Frye and Stockton, 1982; Mikulincer and Solomon, 1988) exacerbate the risk of PTSD or its course.

The planning of a treatment program must take into consideration different needs which provoke conflicts in the helper, in the family, in the therapeutic group and in the staff, keeping in mind that death and loss may suddenly enter the scene.

- Needs and conflicts of the helper.

Close and prolonged work with trauma can have serious psychological consequences for the professionals beside the perception and feeling of helplessness, and can include anxiety, intrusive thoughts, alienation, dissociative episodes, paranoia, hypervigilance, and disrupted personal relationships (Blair and Ramones,1996). Despite this, the therapist has to coordinate the overall intervention in the treatment program and be involved in a controlled fashion with the social service requirements confronting death and trauma. The helper must also take a pragmatic and responsible approach to the case. The fainthearted will find himself in dire straits in this field.

From my professional experience I have learned that the roles of the therapist coping with death and bereavement in general and in the treatment of addictions in particular, are multiple. He/she has to confront the family, the group, the staff, the law, the bureaucratic organization (police, social security, insurance etc.), and, worst of all, has to confront powerful negative countertransference reactions. The therapist must know how to balance the issues of control and affiliation. The helper must feel comfortable with the appropriate use of authority when needed, without losing sight that a therapeutic relationship is essential.

The death of a patient is perceived as a failure by any therapists, from whom there are inner and outer expectations of omnipotence (Menninger, 1958; Greenson, 1972). This kind of failure is difficult to accept by any of us.

- Needs and conflicts of the mourning family.

The direct or indirect impact of trauma on other family members besides the index sufferer is another issue that requires ongoing assessment. Trauma does not occur in a vacuum, and often a number of family members may be similarly traumatized. Even when family members are not directly victimized, the indirect effects on them may be severe (Turnbull and McFarlane, 1996). The treatment of grief and loss needs to be extended to all family members.

As professionals we should be continually interested in the long-term outcome of the family. Sometimes we prefer not to know, because we want to have as little to do with some of these families as possible. However, this type of countertransference negates our therapeutic effectiveness, and maintaining an active and long-term interest may demonstrate our personal interest and responsibility to these families. We cannot let the mourning families drift away no matter how passive or active their aggressiontoward us may be, because we failed to fulfill the expectationsof omnipotence they had from the helper.

-Needs and conflicts of the therapeutic group of addicts.

Addicted patients are characterized by a clinical history of traumatic unresolved losses in their lives. The losses have been dealt with unsuccessfully by using alcohol and other drugs to numb the pain. As they engage in the treatment process, these patients perceive another very important loss: that of their preferred addictive substance. When the group also suffers the loss of some member, and most particularly when the loss is caused by sudden death, the grieving process may become unbearable, and the new situation must be immediately dealt with using a crisis intervention approach (Niekirk, 1987; Elder, 1990).

Discussions on the role of self-disclosure of the group conductor during times of personal crisis have been mostly confined to the theoretical. Little clinical material has been published. This lack contributes further to the sense of loneliness of the therapist facing the therapeutic group, and the helper's uncertainty in terms of how to provide adequate intervention to the group of patients while protecting him/herself at a time of great vulnerability (Kahn, 1987, Vamos, 1993).

- Needs and conflicts of the staff.

Being a helper entails its own particular hazards, and the staff reactions to death and bereavement are exacerbated by administrative incompetence to deal with it, and the staff's own countertransference issues (Cooper, 1995). Crothers (1995), examining the projections of vicarious traumatization on the helpers, found that during the first 6 months of working with survivors of trauma, staff may experience post-traumatic stress disorder, imagery associated with the patient's story, lack of attention, poor work performance, medication errors, sick calls, treatment errors, irreverence, hypervigilance, and somatic complaints. Our fellow therapists often place a heavy burden on us due to their doubts about us having intervened the best we could, or because we intervene differently from what they usually do, or because we are not capable of realizing that there may be some other options in this complex treatment field of addictions. It can result in personal and professional isolation that we should try to avoid.

- V - Helping the Helpless Helper to Cope with Death and Bereavement in the Treatment of Addictions.

The goal of the therapeutic process in general and in the treatment of addictions is to promote change. Change, whether it is good, or bad, is a bit like dying. There is pain in letting go of the familiar. There are feelings of disorientation and confusion experienced by each of us whenever we strike off into the unknown and the unexpected. Experiencing migration, the death of a family member, divorce, losing a job, or any irreversible process elicits mourning reactions.

Therapists interventions in the field of addictions are aimed at radically changing the patient’s life-style, as in cessation of drug and alcohol use, which trigger the grief and loss response. When the process of change from the slavery of drug addiction toward a future of freedom is halted by the sudden death of a family member, a patient of the therapeutic group or any significant other, the stages of grief and loss follow a predictable pattern: denial, anger, bargaining, depression and acceptance (Kubler-Ross,1969; 1975).

It is difficult to "stay alive" in the area of treatment, when death and bereavement sometimes make us fail and where we are seldom fed by positive outcomes, by the success of our clients, but where we rather have to feed all the time. Preparing a therapist for the possibility of a sudden encounter with death, should be part of the conventional training, but it rarely is.

No matter what therapeutic technique is applied in facing the needs of the helpless helper, we have to give him/her the legitimization that grief is a normal and highly personal reaction to loss. Bereavement care (individual and/or groupal) can assist the family, the group, the staff, and the helper him/herself, in coping with the feelings of grief, thereby reducing the possibility of complicated grief reaction.

The expression of grief encompasses a wide range of emotions, depending on cultural norms and expectations. Some cultures encourage and even demand an intense display of emotions, through acting out (for example Mediterranean cultures), whereas other cultures (for example the most Northern) expect the opposite (acting in, "being cool"). Working with grief is a complex psychological process of withdrawing attachment and working through the pain of death and loss.

Grief may be normal, or it may be pathological (Stoudemire, 1990). Normal (uncomplicated) grief is initially manifested as a state of shock that may be expressed as a feeling of numbness and a sense of bewilderment, feelings of weakness, decreased appetite, difficulty in concentrating and sleep disturbances. Self reproach is common. *Survivors guilt* occurs in those who are relieved that someone else than themselves has died. Abnormal (pathological) grief can range from inexistent or delayed grief to excessively intense, prolonged grief, or grief associated with suicidal ideation or with psychotic symptoms. For Freud (1917), normal grief results from the withdrawal of the libido from its attachment to the loss object, while in abnormal grief the lost object is not given up but incorporated in the survivor’s psyche as an object infused with negative feelings

Identification with the deceased is normal, but overidentification is a pathological process.

Table 1 - Models of grief, mourning and bereavement stages.

By John Bowlby	By C.M. Parkes	By E. Kubler-Ross
(Grief and Bereavement)	(Grief and Bereavement)	Reactions of dying patients)

1 - **Numbness or protest** Characterized by distress, fear And anger. Shock may last for moments, days or months.	**1 - Alarm** A stressful state characterized by physiological changes, e.g. Rise in blood pressure and heart rate, similar to Bowlby's first stage.	**1 - Shock and denial** Patient's initial reaction is shock, followed by denial that anything is wrong. Some patients never pass beyond this state and may go doctor shopping until they find one who supports their position.
2 - Yearning and searching for the lost figure World seems empty and meaningless, but self-esteem remains intact. Preoccupation with the lost person physical restlessness, weeping and anger. May last several months or years.	**2 – Numbness** Person appears superficially affected by loss, but is actually protecting him/herself from acute distress.	**2 - Anger** Patients become frustrated, irritable and angry that they are ill; they ask: "Why me?" Patients in this stage are difficult to manage because their anger is displaced onto doctors, Hospital staff and family. Sometimes anger is directed at themselves in the belief that illness has occurred as the result of wrong doing.
3 - Disorganization and Despair Restlessness and aimlessness. Increase in somatic preoccupation, withdrawal, introversion and rritability. Repeated reliving of memories.	**3 - Pining (Searching)** Person looks or is reminded of the lost person. Similar to Bowlby's second stage.	**3 - Bargaining** Patient may attempt to negotiate with physicians, friends, or even God, that in return for a cure, he/she will fulfill promises, go to church, give to charities, etc.
4 - Reorganization With establishment of new patterns, affects and goals, grief recedes and is replaced by cherished memories. Healthy identification with deceased occurs.	**4 – Depression** Person feels hopeless about future, cannot go on living, and withdraws from family and friends.	**4 - Depression** Patient shows clinical signs of depression: withdrawal, psychomotor retardation, hopelessness and possibly suicidal ideation. The depression may be a reaction to the effects of illness on his/her life, e.g. loss of job, economic hardship, or it may be in the anticipation of the actual loss of life that will occur shortly.
	5 - Recovery & Reorganization Person realized that his/her life will continue with new adjustments and different goals.	**5 - Acceptance** Person realizes that death is inevitable and accepts its universality.

Other theoretical models also exist (Imara, 1983, Speck, 1978) to deal with the bereavement process, the above mentioned are only some of the most useful.

Different kinds of death cause different reactions in the mourners. The context in which death occurs greatly influences the way the family, the group, the staff and helpers experience the process(Devan,1993).

For instance, people may experience death as *timely* or *untimely*: *timely (anticipatory)*, when a person's expected survival and actual life span are approximately equal; and *untimely*, when a person's death is unexpected or premature.

The Kubler-Ross model is more suitable in coping with timely death, while the reactions caused by untimely sudden death are better understood and handled by the models described by Bowlby and by Parkes (see above).

Death can also be thought of as intentional (suicide), unintentional (trauma or disease), and subintentional (substance abuse, alcohol dependence). Death may have multiple psychological meanings for the dying person in a timely terminal illness, or for the related others, or for society in general.

Specific sets of circumstances cause specific grief reactions. For example, a) parents' reactions after the death of a child. The death of a child is often a more emotionally intense situation than the death of a parent. Feelings of guilt and helplessness in parents may be overwhelming. They may believe that somehow they did not protect their children adequately. The inversion of the natural order of parents dying before their offsprings may manifest in lifetime grief. b) Bereavement in children is similar to adults once the child can understand the irrevocability of death. According to Bowlby (1969), the mourning process, like separation, involves the three phases of: 1) protest; 2) despair; and 3) detachment. In the protest phase the child has a strong desire for the caretaker who died and cries for his/her return; in the despair phase, the child feels hopeless about the return of the caretaker, and becomes withdrawn and apathetic; in the detachment phase, the child relinquishes some of the emotional attachment to the dead caretaker, and shows renewed interest in the surroundings.

Grief sometimes occurs in situations not related to death, and it may be triggered by: 1) the loss of a loved one through separation, divorce or incarceration; 2) the loss of an emotionally charged object or circumstance, e.g., loss of a prized possession or a valued job or position; 3) the loss of a fantasized love object, e.g., death of intrauterine fetus, birth of a malformed infant; and 4) the loss resulting from narcissistic injury, e.g., amputation, mastectomy.

Grief is different from depression in that: 1) as the loss becomes remote, the grief-stricken person usually shows shifts of mood from sadness to a normal state and finds increasing enjoyment in life's experiences, while the mood disturbance in depression is pervasive and unremitting; 2) shame and guilt are common in depression. When they occur in grief, it is usually due to not having done enough for the deceased before his/her death, rather than because of a person's fundamental belief that he/she is wicked or worthless, as usually found in depression; 3) the grief-stricken person usually elicits sympathy, support and consolation from others, while the depressed person usually may irritate and annoy listeners; 4) suicide rate of depressed people is higher than that of people in grief (Brown and Stoudemire, 1983).

People who have experienced depression in the past are likely to develop depression instead of grief at the time of a major loss.

Training the helpers: What works in grief therapy in the treatment of addictions.

There is much literature about how to assist mental health professionals to cope with grief and bereavement they find in the course of their professional lives, either when they suffer it by themselves, or when they have to assist others to undergo it. Grief therapy is an increasingly important skill in the treatment of addictions (Nash,1990).

The main "dos" and "don’ts" are common to other populations as well, and are different for coping with timely and untimely death (based on Feifel, 1977; Parkes, 1970; Siegel, 1982):

Do encourage ventilation of feelings;

Don’t deter the bereaved from crying or getting angry;

Do allow the grieving person to hear other people talking about the deceased;

Don’t cope with anxiety by medical prescriptions on a regular basis, but with verbal exchange;

Do visit the bereaved person frequently for short periods instead of few long visits;

Do pay attention to delayed bereavement reactions, which may be particularly frequent as anniversary reactions, and which may trigger a relapse into substance abuse;

Do note that anticipatory grief reaction happens in advance of loss, and can mitigate acute grief reaction at the actual time of loss;

Do be aware that the person grieving about the family member who died by self-destructive behavior (suicide, overdose, non compliance with medication) may not want to talk about his or her fear of being stigmatized.

Helpers should be trained to cope with death and bereavement through individual or groupal approaches. In either situation there is a strong tendency to develop attachment to the therapist, because the grieving person is in need of a temporary support until the level of anxiety descends. The use of psychotherapy for the treatment of grief is based on the fact that psychotherapy can relieve self-destructive anger and guilt, advance the recovery phase, and stimulate psychological strength and personality growth (Borins, 1995).

Retention in treatment is the most important single factor in the success of the treatment of addictions, therefore, a therapy which may produce the abandonment of treatment by the addict will have a low success rate(Rounsaville et. al.,1987, Hansen et al., 1990). Long-term psychoanalytic psychotherapy is generally difficult to implement with addicts, because they often lack the necessary constancy to continue in treatment for a long time. Therefore shorter forms of psychotherapy, both individual and groupal, have been advocated for the treatment of addictions, and those forms are also useful to deal with the grief which may accompany those patients.

Specifically the individual grief therapist of the chemically dependent or co- dependent family, must encourage the patient to confront life in an autonomous fashion, without developing a situation of symbiosis. The therapist must dare to treat intense reactions of sorrow, anger, guilt and self-abasement (Richman, 1978).

Among the many forms of individual shorter-term psychotherapies which could be used for the treatment of grief, we are going to mention (Ursano and Silberman, 1988):

1. Brief focal psychotherapy (Malan and the Tavistock group), was developed by the Michael Balint group at Tavistock. Malan’s selection criteria for treatment included eliminating absolute contraindications, which, in his opinion, were: serious suicidal attempts, substance dependence, chronic alcohol abuse, incapacitating chronic obsessional or phobic symptoms, and gross destructive or self-destructive behavior. Therefore, this technique could be used to assist the helper, but not the addict.

2. - Time-limited- psychotherapy (Mann), a psychotherapeutic model based on exactly 12 interviews, focusing on a specified central issue, which could be grief. Mann

considered determining a patient's central conflict reasonably correct. He did not determine excluding criteria for his form of therapy, but his exceptions for acceptability include major depressive disorder (grief is not a **major** depressive disorder), acute psychotic states, and patients who need, but cannot tolerate, object relations.

3. - Short-term Dynamic psychotherapy (Davanloo, McGill University), which, as conducted by Davanloo, encompasses nearly all varieties of brief psychotherapy and crisis intervention. Davanloos' selection criteria emphasize the evaluation of those ego functions of primary importance to psychotherapeutic work: the establishment of a psychotherapeutic focus (for example: psychological reactions to death and loss); the psychotherapeutic formulation of the patient's problems; the ability to have emotional interaction with evaluators; the history of give-and-take relationships with a significant person in patient's life; the ability to experience and tolerate anxiety, guilt, and depression; patient's motivation for change; the patient's ability to respond to interpretation and to link evaluators with people in the present and pass. Those characteristics make this particular form of therapy adequate for the treatment of loss and grief.

4. - Short-Term Anxiety-Provoking psychotherapy (Sifneos, Harvard University). Sifneo established the following criteria for selection: a circumscribed chief complaint (implying a patient's ability to select one of a variety of problems to be given top priority, and the patient's desire to resolve the problem in treatment); one meaningful or give-and-take relationship during early childhood, the ability to interact flexibly with an evaluator and to express feelings appropriately; above-average psychological sophistication (implying not only above-average intelligence, but also an ability to respond to interpretation); a specific psychodynamic formulation; a contract between therapist and patient to work on the specified focus (grief, mourning and bereavement), and the formulation of minimal expectations of outcome, and good-to-excellent motivation for change and not just for symptom relief.

5. - Interpersonal psychotherapy (Myrna Weissman & Gerald Klerman) is specifically used to treat depressive disorders (e.g. pathological grief). Patients are taught to realistically evaluate their interactions with others and to become aware of their deliberate self-isolation, which contributes to or aggravates the depression they complain about. Studies have shown that in selected cases, interpersonal therapy compares favorably with drug therapy that uses antidepressant medication.

Groupal grief therapy has proved to be one of the most effective and important tools we can put at the therapist's disposal, in coping with the needs and conflicts of themselves, the mourning family, the therapeutic group and the staff. Different modalities of group psychotherapy are applied in the treatment of grief, mourning and bereavement. Short-term group psychotherapy; psychoeducational-support groups; and self-help groups, can assist family members in coping with death and losses, thereby reducing the possibility of complicated grief reactions.

Specifically in the treatment of grief, Lieberman and Yalom (1992) tested the hypotheses that 1) brief group psychotherapy during the early stages of loss would facilitate adjustment assessed by measures of mental health, positive psychological states, social role and mourning, and 2) that positive effects would be maximized for subjects who were more distressed psychologically.

Although group participants, compared with untreated controls, did over 1 year show modest improvement on role functioning and positive psychological states, overall the study failed to find substantial support for both theories.

When we refer to group psychotherapies, we have to take into consideration that the goals of group psychotherapy are: Alleviation of symptoms, change of interpersonal relationships, and alteration of specific family-couple dynamics. Group psychotherapies can also be used for the treatment of grief and loss.

According to Vinogradov and Yalom (1988), inclusion criteria for group psychotherapy are:

- Ability to perform the group task;

- Problem areas compatible with goals of group;

- Motivation to change;

while exclusion criteria for group psychotherapy are:

- Marked incompatibility with group norms for acceptable behavior;

- Inability to tolerate group setting;

- Severe incompatibility with one or more of the other members;

- Tendency to assume deviant role

Among the groupal forms of psychotherapy which can also be adapted for the treatment of death and loss, we can mention (Kaplan and Saddock, 1997):

1. - Supportive Group psychotherapy, mostly indicated for the treatment of psychotic and anxiety disorders, some forms can be specifically used for the treatment of bereavement (Goldstein, Alter and Axelrod, 1996, , and Balint staff-support groups, see below);

2. - Analytically Oriented Group psychotherapy, mostly used for the treatment of anxiety disorders, borderline states and personality disorders, with communication contents aimed at present and past life situations, intra- and extra-group relationships, and with the goal of a moderate reconstruction of personality dynamics after experiencing death and loss ;

3. - Psychoanalysis of Groups, designed for the treatment of anxiety and personality disorders and aiming at the extensive reconstruction of personality dynamics. This form of therapy is usually too long for the treatment of grief;

4. - Transactional Group therapy, aimed at treating anxiety and psychotic disorders, this form of therapy fosters positive relationships and analyzes negative feelings. The end goal of the treatment is alteration of behavior through mechanisms of conscious control which can be achieved, on the one hand, by giving legitimization to the "inner child" in the bereaved, and on the other hand by the acceptance of reality and by empowerment; through the transactions with the "adult" and the "parent" projected in the "here and now", in the intragroup dynamics.

5. - Behavioral Group therapy, although mostly used for the treatment of phobias, passivity, and sexual problems, can also be used to modify the external behavior related to grief. In this form of therapy, the action of the therapist is to create new defenses, active and directive;

6. and other forms of specific interventions for determinate populations, like the Balint groups (Rabinowitz, Kushnir and Ribak, 1994 and 1996), aimed at improving the situation of medical and para-medical staff. Balint groups are aimed at preventing burnout and increase self-efficacy among health professionals. This intervention has shown significant increases in awareness and ability cognitions after the Balint group and reduced emotional exhaustion and cognitive weariness. Balint groups that have helped health professionals to cope with psychosocial stressors in a supporting and accepting group atmosphere should be included in educational programs for social workers in general and substance addiction therapists in particular.

Grief management techniques advocated by other authors include:

1. - Psychoeducational groups (Goldstein, Alter & Axelrod, 1996), providing eight- session therapy providing psychosocial support and information aimed at assisting in the bereavement process. It is used to treat family members and friends of recently deceased patients. People who underwent the experience found it beneficial, especially regarding the opportunity of talking with others who had experienced similar (or the same) losses;

2. - Short-term focused interventions, which were found ineffective and misleading, because a sizable proportion of patients with pathologic grief will be unresponsive to treatment (Rynearson, 1987);

3. - Grief counseling for complicated (pathological) grief (Devan, 1993), a combination of intervention techniques which includes grief counseling, brief dynamic psychotherapy, group psychotherapy and family work. The therapist is encouraged to provide empathic approach, active listening, encouragement of verbal expressions of affect, permission to grieve, but to maintain therapeutic neutrality.

4. - Psychodrama, a method of group psychotherapy originated by the Viennese-born psychiatrist Jacob Moreno in which personality makeup, interpersonal relationships, conflicts and emotional problems are explored by means of specific dramatic methods (Moreno, 1947; Kipper, 1992). The dramatical dimensions of psychotherapy have been explored by several authors that propose that role playing is in fact the metaphor on which psychotherapy bases itself. "Believing in make believe", perhaps offers a more appropriate fit than individual and groupal approaches(MacCormack,1997). Although much has been written about psychodrama as a therapeutic and educational method with patients, there is little evidence of it’s inclusion in training programs for professional clinicians. Costa and Walsh (1992) describe how the basic elements, phases and techniques of psychodrama have been used with groups of health workers to improve their clinical performance and personal life. Psychodrama as therapeutic approach, has important applications in helping staff come to terms with the emotional stresses that characterize the work of a helper. Didactic psychodrama is a powerful action learning method that can be successfully employed in the mental health field (Goble,1990). Among the many approaches in which therapists and helpers could be trained for dealing with grief in therapy, we are going to concentrate on the psychodramatic one.

VI - Psychodrama in Coping with the Helplessness of the Helper of Addicts

The rationale for the implementation of psychodramatic techniques in the treatment of addictions is based on "The Psychodrama of Grief in Chemical Dependency Treatment" by Tom Nash (1990). Other authors have also used psychodramatic techniques to treat addictions (Nelson and Howell, 1982-83; Cooper, 1989; Loughlin, 1992; Rustin & Olsson, 1993).

When an addict abandons his/her addiction, a feeling of loss is elicited. If this feeling is accompanied by the death of a significant other, a helper, or a member of the therapeutic group, grief is much more intense. When this process occurs while in treatment, the psychological reactions of grief, mourning and bereavement, are extended to the family, the therapeutic group, the staff and the helper.

The use of psychodramatic techniques for dealing with grief may provide effective and fast relief for everybody involved (the helper, the group, the mourning family, the staff). Psychodrama can also be used to improve the teaching of other skills to helpers: to facilitate information gathering, diagnostic decision-making, and treatment planning and implementation, like in staff training groups designed to teach about the inner world of adolescence. (Pisa and Lukens,1975; DeCann and Hegarty, 1987Holmes, 1988;),

- A PSYCHODRAMATIC TRAINING MODEL FOR THERAPISTS COPING WITH ADDICTION AND DEATH.

Addiction treatment professionals are a unique blend of recovering and non-recovering, college and "school of hard knocks" graduates. In spite of this diversity, or perhaps because of it, a camaraderie usually develops within the staff in most therapeutic milieus, which creates a basic ground favorable to the implementation of psychodrama. The rationale behind a training seminar is that it can lead addictions programs and helpers to be more effective if a "common language of treatment" is shared; if the staff members come to know each other as individuals and network their own particular expertise; conflicts and needs in general and feelings of helplessness in coping with loss and grief, in particular, in a psychodramatic intervention.

The following proposed model is based on two personal experiences: a training seminar for substance abuse therapists which took place in Pittsburgh, and my participation in the workshop on psychodrama of the course "Death and Bereavement", for which I am writing this paper. This psychodramatic model is aimed to cope with the holistic needs and conflicts linked to the feelings of helplessness in the helper, after death and loss.

At the **opening** phase of such a seminar, as a "starter," each participant would write two obituaries: the first one as she or he would like it to appear if she or he were to suddenly die that day; the second one announcing the sudden death of a member of the therapeutic group. The following step is sharing the obituaries with the participants, while walking with the director(the trainer, the therapist) around the room (the stage). From my past experience in one such seminar I attended in Pittsburgh, I would expect sharing obituaries with the group to be easier for some than for others. In that occasion one therapist, "P", shared he had suppressed an impulse to write a "bit of fluff" about being remembered for his smile. He instead shared his uncertainty about his life’s accomplishments and his desire to be remembered through his poetry. His simple yet elegant words touched each of us that day. On the other hand, when he shared the obituary of one of his patients who, in the past, while in treatment, went back to drugs and died from overdose; strong countertransference feelings of guilt, anger, helplessness, and fear of self disclosure aroused, in him. The "starter", writing the obituaries, assisted in the "warm-up" process, and triggered the "act hunger" in the "audience", the group of addiction treatment helpers; while the "barriers" of fear of punishment ,depressed the need for action in "P", "the protagonist". The director suggested him, a psychodramatic exploration of feelings. Reluctantly, he agreed, and the biochemical-psychological process of "warm-up" continued. "P" and the director walked around the stage area, and engaged in a "soliloquy" about his buried feelings of shame, guilt and fear of being thought weak and a failed professional. When the director sensed that the anxiety level and the "barriers" that halted the internal sources in "P," went down, he moved to the second phase of the psychodramatic training model.

The **second** phase- the "action" stage: The possibility of individuals to act, enables us to express our abilities and feelings, and experience self-control. The psychodramatic enactment permits "spontaneity" and "creativity", basic concepts in Moreno’s conception. Psychodrama, by its very action oriented nature, allows a complete therapeutic exploration of issues that characterize the addiction’s field: unresolved losses, death, guilt and grief. The treatment process is perceived as a grieving process where the addict loses the drug, the most trusted friend and ally; a social role in the peer group, and a life style (Niekrik,1987). The therapist of addicts is in fact performing grief therapy which is inherent to the change process in which the chemically dependent patient is involved and which triggers the response pattern predicted by Kubler-Ross: D.A.B.D.A.: denial, anger, bargaining, depression, and acceptance. The bereavement process stages sound as follows:

Denial: "This can’t be happening" or "It’s just not true". At this initial phase of recovery the addict refuses to give up his\her belief system and a distorted perception of reality. When the family, the group and the staff have to cope with death, they feel this same gut reaction: denial.

Anger: "Why me God?" "Why did this awful thing happen to destroy my life?" The anger is expressed in the recovering addict, by demanding that the staff grants privileges and by acting-out devaluating the program, the staff and the peers. After the death of a patient, the group, the family and the staff may displace their anger onto the helper, whom they blame for the loss; while the helper is also experiencing anger and displacing it on himself.

Bargaining: May express itself as a sudden religious fervor. Bargaining grievers talk to God and promise to "clean up their acts": "I’ll quit heroin forever if you take my craving away", will cry the addict. After the sudden death of an addict, some people eliminates this stage and the grief process lasts longer. Others go through a stage of bargaining by justifying the self-destructive behavior of the deceased who was a victim and undoubtedly will be accepted in Heavens. Others have to be given enough time to get out of the state of denial and anger. The therapist must help the group, the staff and himself /herself to "finish unfinished businesses" before admitting, "This is really happening".

Depression: Once the bargaining stage "dies", the patient experiences sadness, withdrawal, delayed reaction time, hopelessness and suicidal thoughts. The addict’s response in this stage of the recovery process, is characterized by emotional, cognitive and behavioral deficits, typical to a reactive depression. The mourning family, after the "unexpected" , will remain in the stage of denial and anger, long before reaching this stage. The group, the staff and the helper, will first mourn past losses; they will experience their own death anxiety; and guilt feelings, that will prepare the ground for depression (Yalom and Lieberman, 1991).

Acceptance: "This is really happening." "It really has happened". Addicts who achieve acceptance of sobriety hold no regrets about the prospect of never using again. The mourning family has to be given indefinite time to accept the sudden death of the loved one; years of working through the grief may be needed. In most therapeutic milieus for addictions, the group, the staff and the helper will fortunately try to reach the acceptance stage, through "The Serenity Prayer:

> "God: grant me the serenity
> To accept the things I cannot change;
>
> Courage to change the things I can;
>
> And the wisdom to know the difference."

There is no set amount of time one must spend in any given stage. Each of us controls the length of time the stages last. Revelations of the personal pain, denial, fear and feelings of aggression brought about by major life change, can be unsettling for therapists. When confronted with the sudden death or a terminal illness of a patient or a colleague, on the one hand, we react with the grief and loss response and pull back our support just when it is needed most; and on the other hand, we experience fear of disclosing our human vulnerability; fear of losing the omnipotent position hidden in the expectations of being a helper. Being aware of our own feelings and intellectual denials helps us recognize the response within. Recognizing our own grief and loss responses is a real challenge. Major change of any kind is death to the " old way". This is true for each of us when a loved one dies. Life is never the same after a change. Some life changes are welcomed, and some are avoided, yet major changes always happen. No one is exempt from the grief and loss response. In the treatment of addictions, we will experience it many times to a lesser or a greater degree. Acceptance of change is achieved by confronting the fear attached to change.

The role of psychodrama in the training of the helpers to deal with grief in the addicts and in their close vicinity must take into consideration that the process of grief generated by the loss of the preferred addictive substance and the one generated by the loss of a significant other, have a very similar basis and development. Knowing how to deal with one will certainly help to deal with the other. Therefore, it is our contention that teaching psychodramatic technique to therapists is important and should be encouraged.

Psychodrama is a group psychotherapy approach originated by Jacob Moreno, in which personality makeup, interpersonal relationships, conflicts, and emotional problems are explored by means of special dramatic methods. The goal of the technique is to cause a catharsis with the possibility to get rid of our internal conflicts, at the same time transforming them into positive elements through reframing.

The following are the essentials of psychodrama which any therapist treating addicts and grief in addicts should learn in a training seminar:

A) - The basic therapeutic elements required for the dramatization of emotional problems are:

1. the protagonist or patient: the person who acts out problems with the help of:
2. auxiliary egos: persons who enact different aspects of the patient, and
3. the director, psychodramatist, or therapist: the person who guides those in the drama toward the acquisition of insight (Kaplan and Saddock, 1997). Also important elements are:
4. the public (or audience): members of the group who provide more auxiliary egos as needed, and
5. the stage: the place where the psychodrama takes place.

B) - The basic therapeutic concepts to be taken into consideration in psychodrama are (Artzi, 1991):

1) -Spontaneity: which was the principal idea in Moreno's conception.

2) -Creativity: which is always linked to spontaneity.

3) -Barriers: which halt our internal sources. Those barriers are called in the professional world "defense mechanisms".

4) - Act hunger: because generally, our barriers do not depress our need for action.

5) - Warm up: a biochemical and psychological process which prepares us to enter in action. This process was attributed great importance by Moreno in the development of spontaneous and creative processes.

6) - Starters: are physical and mental processes, generally related to one another, which assist in the warm-up process. Starters may be physical (walking, breathing, talking, etc..) or mental (psychological, like hopes, initiatives, anxiety, etc.; or social, like social values, social requirements, group criteria, etc.).

7) - Cultural conserve: which is the result of all the creative production of the individual and of the society.

8) - Roles: According to Moreno, each individual interprets, since birth, dozens of different roles. Those roles appear even before the process of individuation, and accompany the individual all through his (her) life. There are three categories of roles: **Somatic** (related to physical action); **Psychodramatic** (related to fantasy, imagination and the unconscious); and **Social** (general roles, not personal, related to social and cultural agreements, like "mother", "son", "the teacher").

9) - Encounter: a dialogue between two persons in which both of them try to accept the other. Those encounters, to be effective, require spontaneity and creativity. According to Moreno, in order to promote encounters, it is important that people can assume the role of the other (role reversal).

10) - Group (or Audience): A group in which participants share at least one common criterion. Topics or problems are open by participants in turn, and the director, and other members of the group, help him/her convert the subject into an experience, assisting him in the development, and creating an atmosphere of warmth and security.

11) - Action: Although action itself is not one of the objectives of the psychodramatic process, "action" had a central role in the interpretation by Moreno of "self" and "society".

12) - Empathy, Tele and Transference - These three linked concepts are an integral part of Moreno's theoretical infrastructure (Rabson, 1979). According to Moreno, there is a difference between empathy and transference and the phenomenon he calls "Tele". He defined "Tele" as a process of feeling in which one, two or more persons may participate. It is the experience of some real factor in the other person and not a subjective fiction. Tele is the basis for intuition and insight. It grows out of person-to-person and person-to-object contacts from the birth level on and gradually develops the sense for interpersonal relationships.

13) - Social atom: This has been defined as "the smallest living social unit". The concept is developed from the telic process, and, according to Moreno, it is the basis for society. According to his conception, society is composed of a network of social atoms, which are activated by positive or negative telic relationships. The social atom inside us is like the "object relations" we internalized from our past experiences with significant others. After death and loss the intra - balance of the social atom is disrupted, and can be regained after the process of grief, mourning and bereavement.

14) - Here and now : The protagonist is asked to experience the past or the future as though it were happening now.

15) - Corrective emotional experience : The term, created by Franz Alexander, refers to the situation in which the analytic situation assist patients to modify the results of traumatic events in their past life. Patients are able to master past traumas and grow from their experiences due to the positive emotional involvement with a supportive and trustworthy therapist, (or a group or audience) (Kaplan and Saddock, 1998).

16) - Catharsis: Moreno's concept of catharsis is integrative rather than abreactive. In this kind of catharsis the protagonist's own self has an opportunity to find and reorganize itself, putting together the elements which may have been left apart by insidious forces, to integrate them and to attain a sense of power and relief (Rabson, 1979). Catharsis is the first stage toward transformation.

1. - Acting out : Psychodrama does not encourage the simple acting out of impulses and feelings, it rather aims at a form of controlled acting out.

2. - Search pattern : Is the human tendency to fill the emptiness created inside us after a loss. Each individual has his own "search pattern". The "addict's search pattern" is drug addiction.

C) - Basic psychodramatic means are (Artzi, 1991):

1) - Stage: It is a space which enables the protagonist to feel liberated, to experience real freedom during the time of work. Kipper (1993) speaks of a division between the psychodramatic stage, where things happen "in vitro", and the natural habitat, where things happen "in vivo".

2) - Protagonist: Is chosen by the group, and, as such, becomes their representative. His (her) story often includes elements of the deep pain affecting most or all members of the group.

3) - The director: According to Moreno, the director is a therapist, a social investigator (sociometrist) and a producer at the same time.

4) - Auxiliary ego: It is everybody who participates in psychodrama, except the director, assisting the protagonist to process his case. The auxiliary ego relates simultaneously to the three pillars of psychodrama: the protagonist, the group and the director.

5) - The group (or Audience): In psychodramatic work there are two ways of relating to the group: in one, the group and its problems are at the center; in the other, the group is secondary to the protagonist and his (her) psychodramatic activity.

D) - Some common psychodramatic techniques are (Artzi, 1994):

1) - The double: Played by an "auxiliary ego", he/she is the one asked by the protagonist to play the role of himself, not as a duplicated "self", but in the role of a larger and more complicated "self", which assists to reach the depth of the individual's unconscious.

2) - The mirror : An auxiliary ego who presents the behavior of the protagonist, while he/she steps out of the scene to observe. In this way the protagonist is able to see how he/she appears to others, reflected in the mirror of the perceptions of the group members.

3) - Role reversal (De-role): By this basic technique the participant represents something or somebody not himself. The protagonist represents the characters or objects related to his subject, and the auxiliary egos represent the same characters, or the protagonist.

4) - Soliloquy : This technique is performed by the protagonist, and it is usually used when the protagonist becomes very anxious and falls into a compulsive defensive action.

5) - Empty chair: This is one of the most famous and popular of the psychodramatic techniques. It is related with our natural need for role reversal.

6) -Role playing: This technique relates to non-apparent aspects of behavior or social mechanisms, and has been adopted by many other therapeutic schools.

7) - Non-verbal techniques : May be used in psychodrama for group warm-up, or as part of the activity of the protagonist. They may also be used as a part of the work-up of physical problems.

Since it is estimated that the number of psychodramatic techniques range between 200 and 300, including closure techniques which allow protagonists and group members to enter the sharing phase of the psychodramatic process, we should recommend to refer to Treadwell, Stein and Kumar (1990) for more details on some of the techniques.

We must always remember that the population of our patients, as stated before, suffers from severe loss caused by the disengagement with their favorite substance, and to that loss we must sometimes add the one caused by the untimely decease of some significant one.

The process of grief caused by the disengagement from the drug may cause the patient to rationalize that the second grief he experiences, the one caused by the loss of a significant one, is an excellent reason to return to the drugs. As the patient struggles with feelings of deprivation and grief caused by the loss of the substance, he/she is also feeling other losses: the loss of the addictive drug style, the loss of the peer group, of the pseudo-omnipotent self-image.

The enactment of the conflict, through psychodramatic techniques, allows to achieve a level of spontaneity in which the familiar "story" of the addictive period of his/her life falls apart, and the emotional reality of the loss becomes apparent. Often enough, there is an emotional catharsis, shared by the group, in which the protagonist finally permits him/herself to fully experience the loss, without mood-altering substances.

The process of self-forgiveness, necessary to achieve normal levels of functioning and feeling, after a severe loss with the consequent guilt and shame feelings, may be achieved, or at least started, by the technique of role-reversal. Only an addict who has forgiven him/herself can remain abstinent for a lengthy period.

The final act of the process of grief is usually dramatized by the protagonist "letting go" of the loss object. The physical enactment of the separation, e.g. by the protagonist accompanying the lost object to the tomb, or similar symbolism, opens the way for a more stable recovery from addiction.

Immediately after this dramatization, "the sharing" of the feelings with the group, and the physical warmth with which the group receives the protagonist, is essential to ensure a rapid emotional recovery after the psychodramatic experience. This "sharing" also has the secondary purpose of allowing each group member to relate to the central theme of the dramatization, a theme which, as mentioned before, usually emanates from the group as a whole, and not only from the protagonist.

In my personal experience, having undergone this process with the group in class, I can attest for the importance of offering every therapist, and not only the protagonist, the opportunity to work with his/her own grief and loss.

I came to the group in a difficult moment of my life, both professionally and personally. Just before the beginning of the group activities, I had suffered the loss of a very dear colleague, an ex-addict, who had been my patient. I had also had to accompany the families of two addicts who had died very untimely. Those families had been in my treatment, learning the principles of "Tough Love", and nobody could tell whether the (incorrect) application of Tough Love techniques on the part of the families had been responsible for the deaths of the addicts.

My own son had undergone a serious cardiac problem and had been hospitalized in an emergency cardiac unit, a fact which had elicited in me very intense fear and anticipation of loss.

The moment I started participating in the dramatic studies group, I was suffering from anger in front of the losses, of guilt and of shame, unable to find out what my role had really been in the causation of all those losses. I had already left behind the stage of denial

I was asking myself, as mentioned before about other people with loss, Why me?. I had been trying to bargain with God, promising to do this and that if only things would stop happening to me. I had not (and I am not sure whether I have now) reached the stage of acceptance.

Even after the dramatization of my plights in class, it has taken me more than a year to reach the stage in which I can function more or less normally in relation with those deaths. I have been paralyzed by the grief during all this period.

At the same time, I had to fulfill many roles for the others. I had to be the "good enough mother" for my other patients, their families, and my staff. I had to provide comfort and support for everybody else, but I myself could not even talk about my feelings, due to my fears: fear of having failed to cause in the co-dependent families the change that will permit them the correct application of the "Tough Love" approach ; fear of not having been sufficiently present in the difficult moments; fear of not having done enough for everybody; fear of being accused by others of not having been professionally good enough, or personally good enough; irrational fears, but natural fears.

I also felt helpless, |I could do nothing good enough for the others. I "knew" that everything was my fault, it should always be so, and nothing I did could change the new reality. Having had no resources where to vent my anguish, my grief, my anger, my fears, I was blessed by the opportunity to do that during the course. Other therapists are not so fortunate. The creation of some instrument where helpers could receive the kind of assistance I received is imperative, and

I strongly recommend the creation of training seminars to learn how to cope with the needs and conflicts elicited in the helper after a sudden death , through a psychodramatic intervention.

VII-Conclusions

Writing this paper has been a process of personal exploration. I wanted, among others, to explore my internal processing as I work with death, grief and bereavement. Many therapists start their training early in their family of origin. We soon learn how to cope with losses. We learn how to comfort, soothe, listen, hold, accept and direct others in grief. A therapist's effectiveness is not always correlated with previous personal experience with a similar issue. Our personal maturity and resiliency in coping with aversive events has major impact in our personal reaction and therapeutic intervention. Despite all this, all of us helpers share in the negative hallucination of not wanting to believe what is before our eyes. None of us wants to believe that tragedies we see before our eyes, have actually occurred. We find refuge in denial, blame, anger, and depression.

The actions taken to restore the disrupted psychic equilibrium may be viewed within an operational framework, or an intra-psychic one. The operational framework is more readily inferred from observable features, but the intra-psychic one describes what goes on in the mind of the patient and the therapist. If death and loss will cause in the helper the "subjective perception" that leads to the cognition and expectation of low controllability; which characterizes an "attributional/explanatory style", that explains aversive, bad events by: internal, stable and global causes; the "helplessness syndrome", depression and reduction of self esteem, will be elicited in the helper.

Some therapists, as some patients, can restore their equilibrium faster than others (Abrams, 1989) because reality imposes on us a "forced response", but we need the framework to do so, where the therapist must acknowledge and accept the inevitable feeling of hoplessness losses and mourning patients cause, and be able to cope with them (Libbey, 1989).

Groups for the training of professionals support and assistance with their own personal conflicts, already exit (Aveline,1986). Some of the subjects mentioned earlier have been put to test and found useful, like countertransference, used by Szajnberg (1985) to create: 1)a moment of illusion for the patient; 2) an observational frame of reference for the staff, and to 3)clarify certain intra - staff differences about the patient's therapy. The therapist must also be ready to confront the "addiction to negativity" described by Lane, Hull and Foehrenbach (1991), and to solve his/her countertransference reactions, especially induced by feelings of frustration, rage and helplessness.

All this considerations move us to the conclusion, already enunciated, that especial tools must be created to assist therapists with their feelings of helplessness. Psychodrama, a method of human relations training and psychotherapy ,based on concepts of social interaction as encounter, spontaneity, catharsis and role playing, may be one of the best ways to achieve this goal.

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Development and Implementation of a Functional Skills Measure for Rehabilitation Therapy in a Forensic Psychiatric Inpatient Facility

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Abstract

Following the adoption of a biopsychosocial rehabilitation orientation to treatment, the rehabilitation therapy service at Atascadero State Hospital began to search for assessment and treatment planning measures to facilitate and support this approach. Failing to find existing measures which adequately served these functions for the hospital's forensic psychiatric population, the Functional Skills Assessment – Rehabilitation (FSA-R) was developed to measure functional skills related to the delivery of rehabilitation therapy treatment activities in a secure inpatient facility. The FSA-R is now a standard part of the rehabilitation therapy assessment and treatment planning process, whereby all patients are evaluated upon admission and quarterly throughout their course of hospitalization. The FSA-R is a reliable and valid measure of patient performance. Standardized measures such as the FSA-R support several aspects of performance improvement, including effective treatment planning, service delivery, and program development.

Introduction

Forensic psychiatric inpatients are difficult to treat. They are involuntarily committed for treatment, and few would seek inpatient treatment of their own volition, despite or perhaps because of gross psychiatric and functional impairment. Treatment of this population is also expensive, with an average annual cost of $105,000 per patient in California's maximum-security forensic state hospital. The effective delivery of rehabilitation therapy services in this setting demands a focused process of assessment and treatment activity explicitly linked to expected outcomes. These outcomes must be defined in terms of patient functioning necessary for successful adaptation to the anticipated discharge environment. (Brown et al, 1979; Lang and Mattson, 1985).

The treatment setting and target population

Atascadero State Hospital (ASH) is one of four California State hospitals. It is the maximum-security forensic facility which houses approximately one thousand judicially committed male patients from the state's criminal justice system. Average age is 41.5, with a range of 19 to 85 years. 48% are White, 29% African-American and 18%

Hispanic. Patient records indicate that 68% have never married, 21% are divorced or separated and 9% married. Average reported education is eleventh grade. The distribution of primary diagnoses consists of 61% psychotic disorders (mostly schizophrenia and schizoaffective) and 26% non-psychotic sexual disorders (mostly paraphilias). The remaining 13% are mainly a mixture of mood and substance abuse disorders, often with psychotic features. Most patients also demonstrate features of personality disorder, and most have a history of violent behavior.

There are three primary commitment types. 41% of patients are mentally disordered offenders who have served their sentence in prison and subsequently been paroled to Atascadero State Hospital for mental health treatment prior to release to the community. Another 17% are inmates from the department of corrections who require psychiatric treatment unavailable in the state's prisons. Following treatment, these patients are typically returned to the Department of Corrections to serve the remainder of their sentences. Finally, a statute enacted in 1996 has resulted in the civil commitment of a sex offender population mandated to receive treatment following their prison sentence and prior to release to the community. This group currently represents 30% of patients in residence. The remaining 12% consists of other commitment types, including individuals found incompetent to stand trial and those found not guilty by reason of insanity. Patients are treated on one of twenty-eight residential treatment units of between 30 and 50 patients. Units are organized into six different treatment programs, which are primarily specific to one commitment type.

This diversity of commitment types introduces differences in treatment goals. Patients being prepared for return to the Department of Corrections present different discharge criteria from those being prepared for release to the community under the supervision of the state's conditional release programs or parole. These disparate discharge environments impose different demands in terms of functional skill level and psychiatric stability. The Functional Skills Assessment - Rehabilitation (FSA-R) was developed to accommodate this range of commitment types, diagnoses, and associated treatment goals, allowing it to be used in a standardized fashion across the facility's patient population.

The FSA-R was designed to contribute to the facility's performance improvement efforts in several ways. It organizes the initial functional assessment of the patient in areas relevant to rehabilitation therapy. It facilitates treatment planning, whereby levels of functioning are used to determine the assignment of treatment activities. It provides a basis for program evaluation, so that service delivery can be better matched to assessed patient needs. And it supports outcome evaluation, both in terms of response to the treatment provided during hospitalization and the association of functional level with post-discharge outcomes.

The treatment planing process. ASH has adopted a biopsychosocial rehabilitation (BPSR) approach to treatment, which emphasizes reduction of psychiatric symptoms, primarily through medication, and the development of functional skills associated with relapse prevention and adaptation to less restrictive environments. Treatment planning is based on a locally developed assessment of functional skills, the Atascadero Skills Profile (Vess, 2000). This instrument covers ten areas of functional skill determined to be critical to the functioning of a forensic psychiatric inpatient population in the anticipated discharge environments. Discipline specific assessments, including assessment conducted by rehabilitation therapists, are designed to relate directly to the domains of functional skill delineated by the Atascadero Skills Profile.

Optimally, treatment is explicitly aligned with specific assessment findings and intended patient outcomes. The treatment process is dynamic, influenced significantly by patient response to treatment. Evaluating this response to treatment involves staff observations of patient behavior using patients' return demonstration of skills, patient interview, chart review and standardized assessment instruments. Since treatment recommendations are based upon assessment, it is important that assessment data be reliable, valid, and relevant. Figure 1 illustrates the sequence of assessment and treatment planning for rehabilitation therapy.

Figure 1. Treatment Planning Process

Prescribe
Treatment

All treatment activities at ASH, including those of rehabilitation therapy, are defined by written protocols describing a group of strategies or actions initiated in response to identified deficits or specific symptoms (Grote, Hasl, Krider, & Martin-Mortensen, 1995). These protocols are not intended to be descriptions that define a single rehabilitation therapy discipline or modality, but rather specific interventions that lead to expected treatment outcomes (Knight and Johnson, 1991). The rehabilitation therapy protocols define treatment activities designed to help the patient recognize the importance of a healthy lifestyle and realize the value of his involvement in constructive leisure activities. Most groups are designed to facilitate the patient's experience of the value in productive choices and natural consequences of his behavior. Assessments in this setting need to capture the content and scope of leisure behavior (Dunn, 1984; Stumbo & Rickards 1986; Witt, Connolly, & Compton, 1980) while evaluating characteristics common in a forensic setting, including minimizing problems, projecting blame, not accepting responsibility, and substance abuse issues.

Rehabilitation Therapy at ASH

Within the biopsychosocial rehabilitation framework, rehabilitation therapists seek to increase patient skills in specific areas of functioning. ASH employs 49 rehabilitation therapists, including the disciplines of art therapy, dance/movement therapy, music therapy, occupational therapy and recreation therapy. The rehabilitation therapist provides goal-oriented treatment services in the following areas:

- Stress and Anger Management
- Recreation and Leisure
- Independent Living
- Interpersonal Skills
- Substance Abuse Education and Prevention

All patients admitted to ASH are evaluated on the admissions unit. These are locked units because of the patients' acute condition, lack of stability on medication, and their potential for violence. Patients in this phase of their hospitalization often have difficulty orienting or adjusting to the facility. The rehabilitation therapists on the admission units provide groups to help the patient orient to treatment at ASH and establish a baseline to document patient needs and subsequent progress.

The rehabilitation therapist conducts an individualized assessment, collecting data including strengths, interests, abilities and deficits to determine appropriate interventions for treatment planning. The FSA-R provides the rehabilitation therapist with a baseline of skills relevant to all the disciplines. When patients are transferred from admissions to their next residential treatment unit, treatment planning is handed over to the interdisciplinary treatment team on the receiving unit. The FSA-R provides a standardized measure from one treatment team to the next, maintaining a continuity of care for the patient that was previously lacking.

Rehabilitation Therapy Assessment

Thorough and comprehensive patient assessment is an essential prerequisite to the appropriate provision of rehabilitation therapy services (Witt et al., 1980; Wehman & Schlein, 1980). The treatment process at ASH begins with an assessment of functional skill level and the identification of patient interests. The evaluation process is completed during the first seven days after admission and every 90 days thereafter. This process includes utilization of standardized assessment procedures for each clinical discipline (e.g. psychiatry, psychology, social work, nursing, and rehabilitation therapy) and collaboration among members of the interdisciplinary treatment team.

In a continuing effort to more accurately capture the unique needs of the forensic population and measure patient progress, an explicit search for a comprehensive and focused rehabilitation therapy assessment instrument began in 1995. It has been observed that there is a general lack of standardized assessment tools in rehabilitation therapy (Stumbo, 1991). Further, most available measures have limited content and scope, and lack psychometric adequacy. In considering the vital role assessment plays in planning appropriate intervention, it became increasingly apparent that the needs of forensic psychiatric patients are unique. Whereas rehabilitation therapists in other psychiatric settings must address patients' social skills and cognitive deficits, patients at ASH also present legal and characterological issues, often involving their potential for violence and history of institutionalization.

Development of the FSA-R

An instrument that addresses the needs of this population within the parameters of the treatment setting must serve several purposes:

- Assist with treatment planning and program development within a biopsychosocial rehabilitation framework.
- Assist with JCAHO accreditation by demonstrating a means of tracking patient progress and provide clinical justification for specific treatment.
- Align with the facility's overall treatment evaluation tool, the Atascadero Skills Profile.
- Assist with state-required documentation responsibilities.

- Transfer information efficiently from data collected on the admissions unit to be utilized by the receiving treatment unit.

- Provide sufficient standardization to allow data aggregation and analysis.

- Be sufficiently broad in scope to remain relevant for all rehabilitation therapy disciplines.

In order to meet the identified assessment and treatment planning needs, a measurement committee was formed to review available published instruments that might serve these purposes. The search discovered a variety of well-established tools focused on leisure attitudes, barriers to participation, leisure activity skills and interests. Among the instruments reviewed was the Leisure Diagnostic Battery, which assesses a client's perceived freedom in leisure and potential barriers to leisure activities (Ellis and Witt, 1982). The Functional Assessment of Characteristics for Therapeutic Recreation, or FACTR, examines functional skills and behaviors considered to be prerequisite to leisure involvement (Burlingame and Blaschko, 1990). The Leisure Activities Blank measures past leisure participation and intentions regarding future involvement (McKechnie, 1975). Finally, the Comprehensive Evaluation in Recreation Therapy-Psychiatric/Behavioral, or CERT-Psych, measures 25 behaviors required in a variety of leisure activities, including general, individual and group behaviors (Parker, Ellison, Kirby and Short, 1975). The CERT was initially implemented at this facility before being replaced by the FSA-R as a more effective measure of patient functioning.

While some instruments were appropriate for the psychiatric setting, none were considered to adequately meet the needs of a forensic inpatient population. A decision was reached to develop a local measure based on the relevant constructs. An effort was made to follow procedures to develop an instrument with credibility, standardization, generalization and adequate psychometric qualities, such as validity and reliability (Burlingame & Blaschko, 1990; Kinney, 1980; Stumbo & Rickards, 1986; Touchstone, 1975).

A work group was formed to identify behaviors that could easily be assessed within a maximum-security inpatient setting. In addition to the concerns previously mentioned, the work group was challenged to define the construct of motivation in terms of observable behavior within a secure setting. In the relationship between intrinsic motivation and mental health, rehabilitation therapy can be seen as having value in planning and promoting experiences which satisfy intrinsic needs (Levy, 1971). Similarly, mental illness may be seen as associated with the failure to find satisfying recreational activities that meet intrinsic needs (Levy 1978). Part of the goal of rehabilitation therapy services at ASH is to move patients from a reliance on extrinsic factors to more intrinsic forms of motivation.

For ASH patients to make positive and purposeful choices about their free time and experience the value inherent in good decision making, the structured environment must provide the patient with the opportunity to recognize the benefits of such choices. The social environment needs to allow the patient to safely experience the consequences of unhealthy choices that are harmful, disruptive or destructive, and the differences between these and healthier choices. Consistent with the BPSR model, interventions align with the functioning level of the patient. In rehabilitation therapy, the stages of BPSR are viewed as steps through which the patient acquires skills leading toward increasingly positive decision-making in his daily life (Neville, Taylor and Craig, 2000).

In the treatment readiness phase the rehabilitation therapist identifies patients whose thinking and behaviors are detrimental to self or others, such as fighting, suicidality, criminal thinking, or poor eating, sleeping and exercise habits. These patients will be placed in treatment readiness groups to remediate these deficits. Here the job is to motivate the patients toward making healthier choices in thoughts and actions.

Skill building is the second stage of the BPSR treatment model. If the rehabilitation therapist observes a patient who participates in groups but does not truly involve himself, then skill building is the goal. While the patient may attend treatment activities to pass the time or possibly to look good for his court hearing, the rehabilitation therapist teaches in this phase the benefits and values of a healthy, active lifestyle and the importance of emotional connection to one's environment.

The third stage is discharge readiness. A patient in the discharge readiness stage consistently applies what he has learned. The rehabilitation therapist will facilitate opportunities for the patient to independently chose and schedule activities in which his behaviors must reflect his learning. Discharge readiness will also include leadership and time management skills and will gradually increase the patient's freedom of choice.

The measurement committee attempted to identify interventions that maximize healthy internal control in a maximum-security, externally controlled environment. As indicated, the interventions vary according to functional ability, along with the specific focus or goal. A concentrated effort was made to identify the behavioral aspects of a patient's leisure choices and lifestyle and measure the patient's perception of value and benefits of his participation or constructive use of free time. An initial list of behaviors consistently observed from all five rehabilitation therapy disciplines was identified, focusing on social skills, cognitive skills, wellness/well being and the patient's perception of value in constructive use of free time. The list of behaviors was presented to all rehabilitation therapists in the form of a data collection sheet. Each rehabilitation therapist was asked to observe and record these behaviors in randomly selected treatment groups.

These groups ranged from cognitive based treatment activities to scheduled leisure opportunities. The random sample of groups included a cross section of various interventions. All groups provided the patient with opportunities to examine thoughts and feelings that affect choices and behavior (e.g., anger, trust, denial, etc.), to demonstrate skills in a variety of settings, to work with others in cooperative efforts, deal with frustration, and to experience success in group process.

The staff completed their observations during a twelve-week period. Following data collection, staff were asked to evaluate the measurement process. Responses to a survey conducted with all rehabilitation therapists indicated that most agreed that data collection provided information about the patient's condition which helped in making appropriate referrals to treatment groups. The information gathered was viewed as an effective measure of patients' performance abilities and identified important strengths and weaknesses. Survey results also confirmed that the information gathered aligned with other assessment measures in use by the interdisciplinary treatment team. The group concluded that use of the measure should continue.

A useful by-product of this process and the resulting measurement tool was the unifying effect within the rehabilitation therapy staff. Because the target behaviors were chosen so as to span the activities of all rehabilitation therapy disciplines, staff now had a common language and conceptual framework for patient assessment and treatment planning.

The pilot study and evaluation process confirmed that behaviors in the areas of social skills, participation, interests, values, perceptions, and benefits of leisure were identified that were observable within the hospital environment and shared across the rehabilitation therapy disciplines. These behaviors were then divided into four sub-components and defined as follows:

> Social Interaction – The patient's ability to communicate thoughts and feelings effectively, recognizing that the absence of adequate social interaction skills can be as much a barrier to appropriate involvement/participation as the lack physical skills or knowledge.
>
> Scope of Involvement – The patient's ability to recognize and internalize the value of constructive involvement and to demonstrate healthy, positive choices.
>
> Performance Abilities – The patient's ability to concentrate, attend to task and/or exhibit a sustained interest in activity.
>
> Competence/Control – The patient's ability to select an activity to participate in and control the nature and intensity of their involvement related to enjoyment and self-expression.

The initial version of the FSA-R consisted of five behavioral items in each of the four sub-components just described. Principal components factor analysis with varimax rotation was conducted on 383 administrations of this form of the instrument. This resulted in the identification of two primary factors. Examination of the factor loadings for each item suggested that these factors reflected the constructs of level of involvement and performance abilities. Level of involvement was defined as a measure of the patient's willingness to make positive choices regarding his lifestyle, ability to modulate the nature and intensity of his involvement, and recognition of the value of constructive activities to prevent relapse. Performance abilities were seen as a measure of the patient's ability to access opportunities in his environment, through appropriate verbal expression and task related skills, such as concentration and attention to the task. The organization of the instrument was then revised to reflect these two domains, and several items were modified to identify them more clearly with the construct to which they belonged. The total number of items was reduced from 20 to 18.

Psychometric and descriptive statistics

Reliability. Internal consistency was evaluated using Cronbach's alpha. Observed alpha coefficients were .95 for Involvement, .93 for Performance, and .96 for the total scale, indicating excellent internal consistency. Interrater reliability was evaluated using three pairs of Rehabilitation Therapists, with each pair rating 10 patients familiar to both raters. Reliability coefficients for each pair of raters ranged from .87 to .98 for the entire instrument, indicating good interrater reliability.

Validity. Two types of content validity can be evaluated for the FSA-R. One is face validity, which refers to the extent to which an instrument looks as if it measures what it is intended to measure. Any instrument that is intended to have content validity must meet this standard, although face validity alone is not sufficient. The FSA-R has been found by users to address issues relevant to the patient population, and therefore to have face validity.

A second type of content validity is logical or sampling validity. While face validity is evaluated after the instrument is constructed, logical or sampling reliability refers to the method by which an instrument is constructed. It involves the use of expertise to define an area of interest, drawing a representative sample of ideas or issues from this area, and preparing instrument items that match these ideas or issues (Roscoe, 1975). In the construction of the FSA-R, the existing professional literature on assessment instruments and the expertise of rehabilitation therapy staff were used to define the content areas relevant to the patient population. A group of experienced clinicians then developed items that assess patient functioning in these areas, based on their experience with the ASH patient population.

The third type of validity evaluated for the FSA-R is a form of construct validity referred to as factorial validity. Based on factor analysis, clusters of highly correlated items are considered to represent the distinct constructs measured by an instrument (Nunnally, 1970). To evaluate the factor structure of the revised FSA-R, a principal components analysis was conducted using varimax rotation on the FSA-R ratings of a sample of 309 patients. The results of this analysis are presented in Table 1.

Table 1. Results of Factor Analysis of FSR-A scores.

FSA-R Item	Factor 1	Factor 2
LEVEL OF INVOLVEMENT		
A. Contributes ideas, thoughts, and feelings	.817	.205
B. Participates in rehab therapy treatment	.766	.219
C. Demonstrates effective listening skills	.605	.562
D. Accepts various group roles	.802	.322
E. Encourages and supports the involvement of others	.821	.225
F. Varies form of participation	.821	.262
G. Participates in leisure time activities	.802	.171
H. Uses available leisure/recreational resources	.833	.234
I. Identifies benefits of leisure in relapse prevention planning	.828	.322
PERFORMANCE ABILITES		
A. Provides feedback to peers	.790	.288
B. Cooperatively assists others	.743	.366
C. Accepts structure and rules	.487	.732
D. Directs and maintains attention	.652	.447
E. Independently carries out tasks to completion	.719	.368
F. Return-demonstrates learning of specific skills	.732	.394
G. Refrains from derogatory/negative comments	.076	.877
H. Accepts constructive criticism from peer and staff	.349	.839
I. Handles conflicts effectively	.292	.858

Factor analysis of FSA-R scores yielded a two factor solution. The Eigenvalue of the first factor was 11.3, accounting for 62.8% of the total variance. This factor consists of items focusing on level of involvement or participation in rehabilitation therapy activities. The Eigenvalue for the second factor was 1.7 and accounted for 9.5% of the variance. This factor appears related to the patient’s adjustment to the structure and process of the activities. Several items correlate substantially with both factors, indicating a somewhat mixed factorial composition. Examination of the content of items which load on both factors suggests that listening skills, maintaining attention and accepting structure are behaviors common to both constructs of patient involvement and performance in rehabilitation therapy activities. Thus while the division of the instrument into Level of Involvement and Performance Abilities domains is useful conceptually for those utilizing the measure, it is recognized that several items are significantly related to both dimensions of rehabilitation therapy assessment.

Descriptive statistics. Means, standard deviations, and sample sizes for various patient commitment types are reported in Table 2.

Table 2. FSA-R Means and Standard Deviations for Various Patient Commitment Types

Patient Commitment Type	N	Involvement Mean / (S.D.)	Performance Mean / (S.D.)	Overall Mean / (S.D.)
Patients from Corrections	50	17.7 (7.0)	19.1 (5.7)	37.2 (12.3)
Mentally Disordered Offenders	308	18.7 (7.1)	20.9 (6.8)	39.5 (13.5)
Sexually Violent Predators	226	18.7 (8.3)	19.9 (8.0)	38.4 (15.4)
Other	35	18.3 (8.1)	19.8 (7.5)	38.1 (15.1)
Total	619	18.6 (7.6)	20.3 (7.2)	38.8 (14.2)

As can be seen in Table 2, the means for different patient commitment types do not vary significantly. The lowest scores are observed for patients referred from the Department of Corrections, who are generally considered the most acutely disturbed patients among the commitment types examined.

Application of the FSA-R at ASH

Staff training. The implications for staff training are significant. Of primary importance is the standardization of assessments, treatment plans and outcome measures. A scoring manual has been developed to ensure consistency in patient ratings across rehabilitation therapy disciplines and patient commitment types. Scoring descriptions are based on the frequency and adequacy of observable patient behavior. All rehabilitation therapists receive a two hour orientation training by the senior author and other rehabilitation therapists who were involved in the instrument's development. Newly hired rehabilitation therapists also receive orientation and guidance in the scoring of the FSA-R as part of their clinical supervision during the first year of their employment.

Data collection and treatment planning. Assessment is an essential component for designing treatment and measuring patient progress. Patients often present with similar diagnoses but significantly different functional abilities. The three elements of assessment data, treatment objectives, and therapeutic resources must be aligned to ensure that the patient is given the opportunity to learn and demonstrate those skills which will allow him to successfully adapt to the post-discharge environment. The FSA-R defines the observable behaviors associated with this treatment process.

FSA-R data are collected at the time of the 10 day treatment planning conference following admission to the hospital, and at each subsequent quarterly treatment planning conference. Through assessment, the rehabilitation therapist aligns the identified patient needs and deficits with appropriated treatment opportunities as defined by protocols. Using the FSA-R, a patient's current level of functioning is identified and recommendations are based on his profile of strengths and weaknesses. In relation to outcomes, the FSA-R has provided data indicating patient improvement in level of functioning and objectives met, thereby allowing evaluation of treatment efficacy.

Program Evaluation. The FSA-R has proven to be a useful tool for program development. By aggregating patient scores, data generated from the FSA-R is evaluated to determine the current functioning of the patient population for each treatment unit or program. The distribution of patient scores on each of the areas assessed by the FSA-R provides information regarding the amount and content of treatment activities that are currently needed to facilitate patient progress towards discharge readiness.

These data have been used to evaluate the content, process and outcomes of rehabilitation therapy services provided. For example, FSA-R data aggregated by patient commitment types has helped determine staff allocation and organizational structure related to program needs. The information has proven helpful in determining which commitment populations require a more intense level of intervention than others and has allowed the scheduling of staff time and room availability to meet these treatment concerns. Regarding the content and process of treatment activities, the FSA-R data has determined the level of intervention and types of groups needed for each residential treatment unit.

Summary

The FSA-R was developed at Atascadero State Hospital when existing rehabilitation therapy assessment instruments were found inadequate for treatment planning and outcome evaluation with a forensic inpatient population. It has demonstrated adequate psychometric properties and a high degree of clinical utility. It supports the facility’s adoption of a biopsychosocial rehabilitation approach to treatment. Besides assisting with individual treatment planning, the FSA-R provides data that facilitate program evaluation and resource allocation. It has contributed to the standardization of rehabilitation therapy procedures, and assisted in quantifying the contribution made by rehabilitation therapists in the treatment of a challenging patient population.

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Support Groups for Relatives of People Living with a Serious Mental Illness: An overview

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Abstract

Relatives of people living with schizophrenia play a vital role in the mental health system, yet their needs are often underestimated or overlooked entirely. Taking care of a relative who has a serious mental illness can place considerable strain not only on the primary carer but also on friends and other members of the family. Support groups offer many carers an avenue through which to 'unburden' themselves among people who have faced similar situations and at the same time provide carers with some sense of control over an otherwise chaotic life experience. This report provides an overview of such support groups while placing an emphasis on factors associated with their success.

History and development of the self-help movement

The concept of self-help is not a new one. Self-help forms of organisation are "especially salient during periods of social fragmentation and unrest and are characterised by loss of relatedness and alienation" (Chapman 1997, p150). This phenomenon can be seen from as early as the 18th and 19th centuries, when unions and friendly societies developed in reaction to the Industrial Revolution. This reaction is indicative of later self-help movements that have historically tended to ebb and flow in response to major social changes. The anti-Vietnam and Women's movements in the mid 20th century for example, not only marked reactions against authority but also served as catalysts for the more contemporary forms of self-help. These and other disenfranchised groups based on race, ethnicity and disability were formed in reaction to authority and bureaucracy, and typically arose from exclusionary policies and discrimination in larger society (Borkman 1997, Chapman 1997, Constantino & Nelson 1995). Thus, the self-help movement as we know it today has emerged from the needs of individuals and families facing major life crises.

A number of factors that have been emphasised in the literature as being facilitative of the growth of self-help include:

- The erosion of the traditional family format;

- The failure of mental health services to adequately address or meet the needs of those who attempt to access them, particularly those people who belong to a minority group, have lower incomes or are coping with a major disrupting disease;

- A greater acceptance of experientially gained knowledge and social support as useful assets in health maintenance;

- Advances in medical science which have increased the proportion of people who have an improved life-span and concomitant chronic medical problems;

- Various civil and consumer rights movements which have stimulated an increased sense of personal entitlement and empowerment, which in turn has increased people’s desire for personal control over their own health care (Chapman 1997, Jacobs & Goodman 1989).

Size and scope of the self-help movement

The development of contemporary self-help groups has been linked with the 1935 founding of Alcoholics Anonymous (Borkman 1997), however the seeds of self-help as we know it today were sewn in the societal changes of the 1970s. Since then, the self-help movement has mushroomed. There are groups for almost every presenting problem that clinicians confront, with millions of members worldwide (Toro et al. 1988). As Davison et al. describe it: "through self-help groups, millions of Americans attempt to overcome addictions, discuss innovations in insulin treatments, grieve for the loss of a breast, or share fears about the possible progression of HIV" (p205). In fact, by 1990 in the United States alone, it was estimated that six and a quarter million Americans (or 3.7% of the population) participated annually in some form of self-help group (Jacobs & Goodman 1989).

Beginning of the mental health self-help movement

The origins of self-help are closely related to major societal changes and the same can be said for the beginnings of the mental health self-help movement. Following reforms in the nineteenth century, incarceration became the fate (or punishment) of those who were classified as lunatics or inebriates. However, with the advent of deinstitutionalisation in the 1950s, such settings no longer constituted the centre of the mental health system. These days, people experiencing mental illness are increasingly expected to live and receive treatment in the community. Unfortunately, due to lack of public funding, assertive community treatment has failed to live up to expectations, as services are either nonexistent or where available, often lacking in quality. As Grosser and Vine (1991) point out, many families are "frustrated by a system of mental health care delivery that fail(s) to consider their needs a priority, disappointed by the inadequacy of programs for their discharged relatives, and angered by their negative experiences in working with professionals, clinicians and public servants" (in Constantino & Nelson 1995, p56). This lack of services and the resulting frustration of the families who care for their mentally ill relatives, has led to the growth of the mental health self-help movement. In fact, over the past 20 years, the number support groups for family members of people with severe mental illness has grown exponentially. One indicator of this phenomenon comes from data available from the National Alliance of the Mentally Ill (NAMI). In 1979, representatives of 100 family support/advocacy groups came together to form NAMI. By 1996, NAMI had 1,100 chapters and 140,000 members, which represents a ten-fold increase (Mannion et al. 1996, Citron et al. 1999). Carers then, are very much involved in the self-help process.

Definitions and characteristics of self-help groups

The literature is replete with definitions, characteristics and ideologies that have been varyingly attributed to self-help groups. In addition, varying terminology for self-help groups abounds and is often used interchangeably, which can add to the confusion. Generally, however, the terms ‘self-help group’, ‘support group’, ‘mutual help group’ and ‘educational support group’ can be said to represent similar concepts. For the purposes of this review, it should be assumed that ‘self-help’ and ‘support’ refer to the same entity.

In the US, some consensus as to how to define these groups was reached following the major public policy event in self-help outlined in the *Surgeon General’s Workshop on Self-Help and Public Health* (1988). Here, self-help groups are defined as "collectives of voluntary associating persons who share a common problem; they are self-governing, rely on the experiential knowledge of their members as the group’s source of authority, provide mutual assistance which is at least emotional support and do not charge fees" (in Borkman 1997). In a later report published in 1999 by the Surgeon General, self-help was further defined as being: "geared for mutual support, information and growth (and) is based on the premise that people with a shared condition who come together can help themselves and each other to cope, with the two-way interaction of giving and receiving help" (chp.2).

Although there is a broad variety in format, style and ideology among support groups, the process itself remains essentially shaped by the following ideologies and characteristics:

- Groups function within an ethos that highlights and values notions associated with empowerment, experiential wisdom, mutual support, social learning, empathy and shared experience (Borkman 1997, de Balcazar et al. 1989, Chapman 1997, Constantino & Nelson 1995, Davison et al. 2000, Dunne & Fitzpatrick 1999, Jacobs & Goodman 1989, Kane et al. 1990, Kurtz 1990, O'Riordan 1989, Rootes & Aanes 1992).

- The emphasis is placed on social support and mutual aid with members both providing and receiving help, while also serving as role models (Constantino & Nelson 1995, Kane et al. 1990, Meagher 1998).

- Groups reject professionalisation and bureaucratisation (the primary characteristics of service organisations) in favour of autonomy and solidarity (the primary features of mutual-benefit associations). This rejection places the emphasis on the value of democratic and egalitarian principles (Chapman 1997).

- The democratic nature of groups involves self-governance, equal rights within group processes, leadership at the pleasure of the group, free expression of thought and feeling, independence from external rule, internal system of checks and balances and de-emphasis of rank and privilege (Chapman 1997, Jacobs & Goodman 1989, Rootes & Aanes 1992, Wintersteen & Young 1988).

Demographics

Much research has been conducted into the characteristics of people who attend support groups. Davison et al. (2000) conducted a study in which it was found that support seeking was highest for diseases viewed as stigmatising and that people who felt their illness was embarrassing, socially inappropriate or disfiguring were more likely to seek the support of others with similar conditions. They offer this explanation:

> *"The experience of illness is a profoundly social one. Suffering elicits intense emotions and hence the desire to talk to others. Through interpersonal exchanges, patients develop an understanding of their illness: They may talk to friends, relatives and professionals about what their diagnosis and treatment may entail. Over the course of their particular illness, relationships are strained or broken, and new ones become valuable, such as those with doctors, nurses or physical therapists. For some, the condition itself constitutes a dangerous secret that erects a barrier between themselves and their support network. Thus, patients' experiences of illness both influence, and are influenced by, the social fabric that surrounds them" (p205).*

Festinger's (1954) social comparison theory states that individuals seek to have and maintain a sense of normalcy and accuracy about their world. In times of uncertainty, affiliative behaviours increase as people seek the opinions of others about how they should be thinking or feeling. Social comparison is intrinsic to the health care setting, where anxiety levels are often high and information, when available, may not be delivered in a format that patients readily understand. Diagnosis, treatment, side effects of medication and other kinds of disruption prompt people to talk to others und0ergoing a similar challenge (Davison et al., 2000). Furthermore, the reluctance of people to discuss such intensely personal problems in 'normal' social situations and the deeply held feelings that others who have not experienced a comparable crisis cannot truly understand, increases the need to actively seek out support groups (Wintersteen & Young 1988).

Overall, the literature concurs on the characteristics of people who attend support groups. These figures are representative on the whole of white, middle class females who have higher than average education levels. Similar findings are reported for family members who attend support groups due to a mentally ill relative (Borkman 1997, Mannion et al. 1996, Norton et al 1993). In these 'carers' groups, more parents participate than their siblings, spouses or adult children, and members report smaller social networks than non-members (Mannion et al. 1996).

Who are the carers?

> *Few people become carers by making a rational decision about what they are going to do with their lives, rather, "the caring role creeps up on them, as it becomes clear that their relative is going to need help for much longer than anyone imagined" (Berry 1997, p17).*

In the field of mental health, self-help groups have been developed by two different stakeholder groups: people who have experienced mental health problems, (who refer to themselves as 'consumers', 'survivors' or 'service users', depending on their country of origin an/or their particular stance) and parents and family members of people with mental health problems. Relatives (including friends, family and spouses) in turn are commonly referred to as 'carers', 'relatives', 'family' or 'secondary consumers', terminology which is still being modified as the mental health forum develops. Still one further step removed are the groups for human service workers who face the daily stress of working with those who are seriously ill or dying (Jacobs & Goodman 1989). Sometimes, groups involve and include all three stakeholders.

In 1997, the National Schizophrenia Fellowship in the United Kingdom (NSF) conducted a study into the demographic characteristics of carers. They revealed that around one and a half million people in Britain spent 20 hours per week or more looking after someone who has a mental illness (most of these people were identified as having schizophrenia). Some 60% were women and their average age was 60. Only 3% were in full time employment (Berry, 1997).

The vital role that carers play cannot be overestimated. Since deinstitutionalisation and the resulting emphasis placed on community care, there has been an increased assumption that families will take on much of the responsibility for the care of the person diagnosed with schizophrenia (Brady 1996). Deinstitutionalisation has also been premised on the use of unpaid labour of volunteers, who are mainly women, in the home or in private organisations (Chapman 1997).

Much of the literature available today emphasises the role that carers play in the wider mental health spectrum. Carers are referred to as the "glue that holds the system together" (Chapman 1997, p149), the "paraprofessionals who play a significant role in the service delivery system" (Abramowitz & Coursey 1989, p236), the "coordinators of services and advocacy for their handicapped relative" (Winefield & Harvey 1995, p140) and the "primary source of care for persons with a severe mental illness…they provide housing, financial aid, companionship and emotional support" (Pickett-Schenk et al. 2000, p413).

Abramowitz and Coursey (1989) estimated that by 1982, 250,000 chronically mentally ill patients in the United States were discharged to their families. Other studies have estimated that between 40-60% of people with schizophrenia return to live with their relatives (Brady 1996, Norton 1993). The NSF estimated that the money carers of people with schizophrenia save the British government every year is in the region of three billion pounds (Berry 1997). It is obvious therefore, that the present policy of treating the mentally ill in the community simply could not exist without the family members who almost always bear the main burden of care.

Burden of care

Such reliance on the families of people with a mental illness inevitably results in some form of ‘burden’ experienced by carers. This burden is unique to carers of people with a mental illness. As Karp (2000) explains:

> *"Although their sickness might dramatically disrupt the logistical routines of everyday family life, physically ill people are ordinarily deeply involved in getting well and returning to their presickness social roles. In contrast, mentally ill people often cannot abide by the usual rules of social settings, may engage in behaviours considered socially repugnant, sometimes deny that they are ill, and frequently treat their caregivers with hostility instead of gratitude" (p7).*

Being a ‘front line’ carer for someone with schizophrenia can create considerable costs for families and often involves the family unit in a long-term stress that threatens the physical, social and mental wellbeing of all family members (Dunne & Fitzpatrick 1999, Kane et al. 1990, Pickett-Schenk et al. 2000, Toseland 1990). Carers are often thrown in the deep end, with little or no formal training in mental illness. They also face a lack of information about the disorder and its medication, a lack of resources and treatment facilities and, at times, a lack of responsive professionals (Abramowitz & Coursey 1989). These very real obstacles place both objective and subjective burdens on family members (Chapman 1997). Objective burdens are actual physical problems such as those associated with financial hardship or disruptions to household and social functioning, while subjective burdens are the associated feelings of anguish, guilt and loss. As can be seen from Figure 1: 'Burden of Care’ below, burden of care directly stems from the role carers play in the wider mental health spectrum. A fundamental lack of services in the community leads to an over-reliance on family members, which in turn generates physical and emotional problems for carers. This provides the basis then, from which the needs of carers can be identified.

Figure 1: Burden of Care

Few people become carers by making a rational decision about what they are going to do with their lives, rather, "the caring role creeps up on them, as it becomes clear that their relative is going to need help for much longer than anyone imagined" (Berry 1997, p17).

Objective burdens

There is general consensus in the literature as to the nature of both the objective and subjective burdens placed on carers of people with schizophrenia. The objective burdens can include:

- *Economic losses*: such as financial and employment difficulties, as well as loss of opportunity and potential for the carer (Abramowitz & Coursey 1989, Brady 1996, British Columbia Ministry of Health 1993, Berry 1997, Chapman 1997).

- *Impaired physical health*: in a study conducted by the NSF in 1997, over 70% of carers surveyed felt that their health had suffered because of their caring role.

- *Disruption of relationships*: family relationships can suffer because the relative's behaviour can be extremely difficult to cope with and symptoms can be very disruptive (Abramowitz & Coursey 1989, Brady 1996, British Columbia Ministry of Health 1993, Chapman 1997).

- *Reduced social networks*: this is due in part to the disruption of normal social and leisure activities as well as to the stigmatisation that often occurs hand-in-hand with a diagnosis of mental illness (Abramowitz & Coursey 1989, Brady 1996, British Columbia Ministry of Health 1993, Chapman 1997).

Subjective burdens

Subjective burdens experienced by caring family and friends has been directly linked to the experience of objective problems (Cuijpers & Stam 2000). Subjective burdens are more emotional in nature and include feelings of anxiety, stress, guilt, shame, self-blame, depression, fear, anger and confusion (Abramowitz & Coursey 1989, Berry 1997, Brady 1996, Chapman 1997, Wintersteen & Young 1988). Caring for someone with schizophrenia can be both time and energy consuming; family and friends are often relegated to second place and the carer's own plans and ambitions are more often than not put on hold, which can lead to feelings of anger and resentment (Berry 1997). Grief is also very common. Grief as it relates to carers of people with schizophrenia, often manifests as the adjustment of coming to terms with the disintegration of personality in the family member:

> *"There is always the sense of loss, almost like a death. Schizophrenia cuts down young people just as they are realising their potential and the person left often seems a pale shadow of the person they were before. There is a grieving that needs to be done for this lost person, a grieving that will help the carer adjust to the new person the sufferer has become" (Berry 1997, p26).*

Other experiences include lowered self-esteem and increased isolation and withdrawal due to stigma and reduced social networks (Brady 1996, Wintersteen & Young 1988).

Carers' needs

As the burden of care is directly related to the emotional and physical costs of caring for someone with schizophrenia, so too then are the carers' needs, which stem from the role they are forced to play within the mental health system and its contemporaneous burdens. It follows then, that the needs of carers fall into two distinct categories: the need for assistance with problems stemming from objective burdens (for instance, information and coping strategies etc.) and the need for assistance in coping with the associated subjective emotions (learning to come to terms with feelings of guilt, anger, fear, depression, shame and grief). Carers not only need information and advice about how to cope with their ill relative, they also need emotional support.

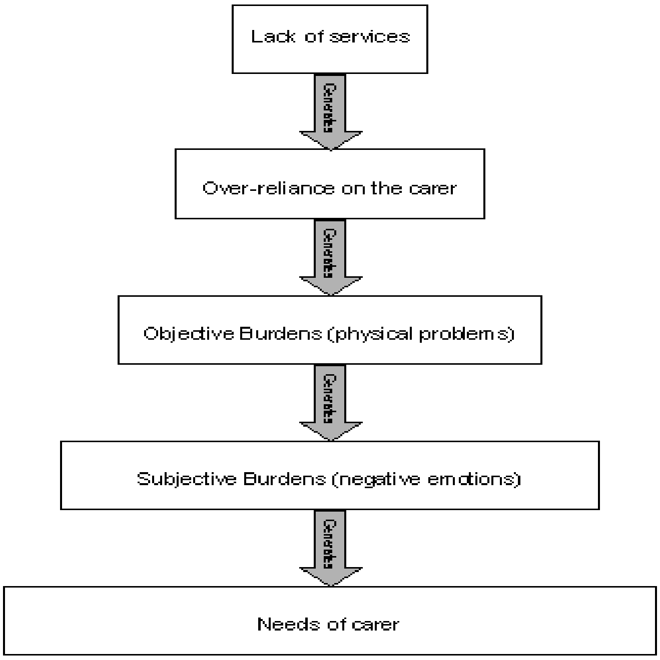
It is also crucial to recognise that the needs of individual carers change over time:

> *"Sometimes in the rush that happens before someone is finally diagnosed as suffering from schizophrenia, the feelings connected with caring are pushed aside, as if they matter little. After the diagnosis, there are so many practical things to deal with, as both carer and sufferer adjust to the new life of learning to live with the illness. It is only after the immediate problems are sorted out that carers find the*

> *time to reflect and ponder about the emotions involved. Recognising these emotions is as important to caring as working out the practical side" (Berry 1997, p25).*

When a relative is first diagnosed with schizophrenia, there is a sense of urgency that often accompanies the carer's need for information on schizophrenia and its treatment, as well as the need for information as to what services exist and are available for their relative's use (for example sourcing accommodation and rehabilitation facilities). In addition to this, there is a crucial need for effective coping strategies as relatives grapple and come to terms with the inherent behavioural problems associated with schizophrenia. As time moves on and the sense of urgency passes, carers begin to recognise their own emotions and the need to share their isolating experience with others who have found themselves in similar situations. Still further down the line, carers may begin to feel the urge to help others who are faced with schizophrenia in their own families. This may evolve into a desire to actively advocate for the mentally ill (by lobbying the government for improved services and/or increasing awareness of mental illness in the community to reduce stigma) or it may manifest itself through the carer becoming a long-term member of a support group or as a speaker within a psychoeducational setting. Figure 2, 'The Changing Needs of Carers' below, highlights these changing needs over time and suggests possible outlets/interventions in meeting these needs. It introduces the distinction which should be drawn between 'beginner' carers, who are new to the concept of schizophrenia in their own family, and 'advanced' carers, who have many years experience and have developed their own kind of expertise in the area of mental health. The diagram presents these carers as being on either side of a time-line continuum, while emphasising that most carers are likely to be somewhere in between.

Figure 2: The Changing Needs of Carers



This concept is evidenced in Winefield et al.'s (1998) qualitative study, which involved interviewing carers at various stages on the caring continuum. They found clear differences between a 'two-year carer', who was still very much in information-gathering mode and a 'twenty-year carer' who was ready to put their energies into political action. Carers with middling amounts of experience were dealing with yet other issues. One carer of ten years clearly expressed the grief and sense of loss that many feel upon finally accepting the chronic nature of their relative’s disability. They concluded that carers with less than five year’s experience wanted more information about the illness and medication compared with longer term carers, and were less interested in lobbying to improve services. After ten years, acceptance grows and, after that, a readiness for political activism replaces hopes of a cure.

The concept of the different stages and therefore differing needs of carers is also evidenced in Wintersteen and Young’s (1988) study, which also concludes that: "families move through predictable stages of coping, and gradually turn from an inward to an outward orientation. As they come to accept the illness and move ahead, they need less support and more opportunities for positive action" (p24).

Furthermore, in a recent qualitative study, Karp and Tanarugsachock (2000) mapped the changing emotional needs of carers, based on fifty in-depth interviews. They found that carers’ emotions changed drastically over time, from confusion (pre-diagnosis), to relief (upon diagnosis), hope (for the relative getting better), grief (at the realisation that the illness was permanent), anger and finally acceptance.

It is therefore critically important to acknowledge these changing needs of carers when attempting to develop interventions aimed towards relatives of people with schizophrenia and other serious mental illnesses. Directing a ‘beginner’ to a support group where they could well be confronted with worst-case scenarios or where they have to sit and listen to how people are feeling when what that person really needs is information and coping skills delivered in a structured and timely environment, could prove disastrous. Conversely, placing an ‘advanced’ relative in a psychoeducational program geared towards explaining the basics of schizophrenia when all they really need to do is to talk to others in similar situations and develop social networks is also unlikely to prove helpful. Moreover, some relatives may need neither of these approaches. They may have ‘done the groups and bought the tee-shirt’ and are now interested in channelling their energies into the wider community in the form of advocacy.

What are the potential benefits of support groups?

The benefits of support groups have been widely documented in the literature. The fundamental therapeutic qualities to be potentially gained include: opportunities for disclosure, empathic connection, shared goals and psychological adjustments to life challenges. Support groups underscore the medical value of meaningful, group-based programs whose focus elicits psychological and physical health benefits (Davison et al. 2000). In the words of Jacobs & Goodman (1989):

> *"The new member, who frequently has felt stigmatised and criticised (or at the very least isolated and not understood), frequently finds immediate acceptance as a member of the group. That sometimes stunning experience seems to be a vital step toward making the cognitive, emotional, and behavioural changes necessary for more effective functioning and improved quality of life" (p538).*

Benefits that can be derived from participating in support groups are directly related to the perceived needs of carers. If attendance is timely (i.e. at an appropriate stage in the carer’s life, as described above in ‘The changing needs of carers’), then benefits can be gained on both the objective and subjective levels, that is, information and coping skills can be developed, as well as emotional support given and received.

Direct outcomes which assist with the objective burdens of caring for someone with schizophrenia fundamentally include the provision of education and information. Through this, carers’ knowledge of schizophrenia is increased and the illness is demystified. As well, an increase in the knowledge of services available is experienced along with the enhancement of the problem solving capacity of carers. Practical advice and suggestions for coping with difficult behaviour are provided, new ways to think, to feel and to deal with life experiences are discovered, and a shift in the illness attributions perceived by members from blaming themselves to the view that their relative's problems are due to a biological disorder is engendered (Brady 1996, de Balcazar et al. 1989, Carney 1988, Citron 1999, Dunne & Fitzpatrick 1999, Kassis et al. 1992, Kurtz 1990, Kurtz 1992, Mannion et al. 1996, Norton et al. 1993, Rootes & Aanes 1992, Sheridan & Moore 1997, Wintersteen & Young 1988).

Outcomes associated with the subjective burdens directly stem from the sharing of experiences and the sense of peer support fostered in a group environment. These include being able to compare predicaments, decrease negative emotions, form friendships and re-establish social networks. It involves arriving at the realisation that one is not alone, sensing a common understanding, being provided with renewed hope and being exposed to positive role models (Brady 1996, de Balcazar et al. 1989, Citron 1999, Dunne & Fitzpatrick 1999, Mannion et al. 1996, Norton et al. 1998, Sheridan & Moore 1997, Winefield et al. 1998, Wintersteen & Young 1988). Members who have had similar experiences identify and ally themselves with one another, which makes people aware that they are not alone in their struggles. Moreover, people who have had similar experiences are in a powerful position to understand and accept new and existing members (Rootes & Aanes 1992). This kind of peer support is often the only resource available to family members experiencing the loss and emotional distress involved in coping with a mental illness in their family (British Columbia Ministry of Health 1993) and is therefore of paramount importance to carers.

Are there any weaknesses in support groups?

Like any intervention, support groups are not without their weaknesses. One of the major problems cited in the literature is the sense of pessimism that can arise through carers telling their worst-case scenarios. Part of a study conducted by Karp and Tanarugsachock (2000) included the documentation of long-term observations of a relatives support group. They note:

> *"Newcomers also learn something from veterans that visibly upsets them. They actually wince, shake their heads in disbelief, and sometimes audibly gasp when they learn many of the regulars have been dealing with the ill person in their life for years, sometimes decades. Although the talk of the regulars is peppered with optimistic references to new drugs, new treatments, and the progress made by a loved one, their expressions of hope seem fundamentally contradicted by their own biographies" (p16).*

Obviously, relatives cannot be shielded from the truth forever but there must be some timeliness in its delivery; as emphasised earlier, attending a support group at the wrong time in a carer's life can be decidedly unhelpful and discouraging. Other problems cited in the literature, which need to be watched for, include:

- Over-dominance of leaders and/or members;
- Level of training (or lack thereof) of coordinators;
- Possibility of the creation of dependency on the group;
- The expression of intense feelings which can overwhelm members; and
- That some leaders can confuse support with therapy (Dunne & Fitzpatrick 1999, Meagher 1998).

Support groups: which components, when, and for whom?

Family support groups for relatives of people with schizophrenia and other serious mental illness vary in their leadership (e.g. professional, paraprofessional, nonprofessional or collaboration), membership (e.g. inclusion of ill relatives seeking support for themselves), objectives (e.g. emotional support, education, social networking, advocacy), types of support activities carried out during the group and in their affiliation with larger, national organisations (Mannion et al. 1996). Therefore, the ability of a particular group to help a specific individual may depend on that group's climate (Meagher 1998).

Most nonprofit organisations in the mental health arena typically offer 'support groups' as part of their service delivery program. However, just what these support groups offer is incredibly varied and often reflects the aims and objectives of their founding members (even among groups under the umbrella of the same organisation). Support groups for relatives typically function on several levels and often include components of information and advocacy in addition to support. This is often a reflection of the changing needs of its carers. For just as carers have changing needs, so are those needs naturally reflected in the ever-evolving objectives of the support groups which they attend. As groups mature, they tend to shift their focus according to the needs of its carers – usually from the need for information and support to the desire to advocate on behalf of their relatives. Invariably, most groups will be some form of blend of all three functions:

> *"Groups may go through a natural metamorphosis, in which, as the group matures, the focus moves from individual and family concerns to more action-oriented programs. There is both strength and risk in this. Families move through predictable stages of coping, and gradually turn from an inward to an outward orientation. As they come to accept the illness and move ahead, they need less support and more opportunities for positive action. The risk of course is that they may lose sensitivity to new members who still require support, information and an opportunity to divest themselves of their strong feelings with an accepting context. For this reason, some groups have chosen to offer several different types of meetings, and to encourage active outreach to new members" (Wintersteen & Young 1988, p24).*

Wintersteen and Young point out the potential trap of attempting to meet the needs of all (for in doing so, often the needs of few are satisfied). However, they also point to a solution: instead of trying to achieve everything in the one support group meeting, it seems common sense to offer several different types of meetings. In order to perform at optimum levels, groups need to continually reassess their common goals and objectives and in doing so, find an appropriate way to meet them. Sense of purpose is paramount: so long as groups remain focused about what it is they hope to achieve and they retain some sense of structure in their service delivery, it is entirely possible to meet the needs of different carers. This sense of direction, as Winefield and Harvey (1995) point out, is paramount to the group's success: "groups need an agenda other than…'tea parties', to increase the sense of purpose and facilitate the satisfactions to be derived from a feeling of progress" (p145).

With these points in mind, several possible functions of support groups are discussed below.

Emotional support

The fundamental characteristic of any support group is, quite simply, emotional support. As mentioned earlier, the terms 'support group' and 'self-help group' are often used interchangeably. It follows then, that the fundamental features of the support process (including general characteristics of and benefits to be gained from) are the same as those of the self-help process outlined previously in this review (see 'Definitions and characteristics of self-help groups' * and 'What are the potential benefits of support groups?' *). The supportive aspect of any group necessarily deals with the more subjective burdens by providing an environment where carers can:

- Compare predicaments;
- Decrease negative emotions;
- Form friendships;
- Re-establish social networks;
- Decrease isolation;
- Establish hope; and
- Focus on positive role models within the group.

Information provision

This component should not be confused with psychoeducation or family education programs, as there is a fundamental difference in the way these services are delivered. Educational programs are generally delivered by mental health professionals within a specified time frame, whereas information provision within a support group setting is more ad-hoc in nature and can be provided through a variety of avenues, including:

- Guest speakers, for example clinicians, legal workers and other service providers who talk to the group about their particular field of interest;
- Books and leaflets which are brought along to the meeting by the organising committee; and
- Videos which are shown to the group.

Again, the potential benefits to be gained from the provision of information are numerous and are outlined in full in 'What are the potential benefits of support groups?' (*). To reiterate, they are directly related to the relieving of objective burdens of care and include:

- Increased knowledge of schizophrenia;
- Increased knowledge of services available;
- Demystification of the illness;
- Enhanced problem solving capacity;
- Increased coping skills; and
- Shifting of illness attributions.

Advocacy

By participating in a shared mission, members of self-help groups sense potential for power and influence. Self-help groups have the ability to influence legislation and the direction of community services, as well as acting to influence the attitudes of people who lack intimate contact with the mentally ill. This in turn can provide relatives with an increased sense of power and competence (Borkman 1997, Carney 1988, Constantino & Nelson 1995, Dunne & Fitzpatrick 1999, Kurtz 1992, Wintersteen & Young 1988). As can be seen in Figure 2: 'The changing needs of carers', (see page * above), when a relative embarks on the path of advocacy, they have usually already been through the predictable stages of information gathering and emotional support and are now ready to outwardly channel their energies.

It is interesting to note that in a recent study conducted by Chelser and Chesney (1996), it was found that groups who had professional co-leaders or extensive involvement with professionals were unlikely to have advocacy goals. Among relative-led groups, some engaged in no advocacy whereas others mounted major campaigns to change professional services.

Psychoeducation/family education

As mentioned previously, psychoeducation is distinct from the education normally derived from support groups. The hallmark of psychoeducational programs is education, usually provided by mental health care specialists in some organised, structured format. These programs are designed to educate families about mental illness and its treatment, while also recognising the need for training in communication and problem-solving skills to reduce family tension and to manage the relative's behaviour more effectively (Kane et al. 1990). There has also been a distinction made in the literature between psychoeducational and family education models. Pickett-Schenk et al. (2000) make this distinction:

> *"Psychoeducation models typically are adjunctive to treatment and focus primarily on client outcomes, while family education models are independent of treatment and focus on improving family outcomes by increasing families' competencies to better cope with their relative's illness. Family education programs are typically short term, varying in length from one-day workshops to three months, and may be led by professionals, family members or a professional-family member team" (p414).*

Family education programs are often discussed in the literature *as they relate* to the traditional support group. Many studies and reviews have been conducted in an attempt to ascertain the superiority of one form of intervention over another. However, results inevitably tend to recommend *both* forms of intervention as each have unique advantages over the other. Again, it is useful to place this in the context of Figure 2: 'The changing needs of carers' (see page * above). When viewed in this light, it is clearly understandable why both methods of intervention are recommended. 'Beginner' carers often need speedy access to information and basic coping skills, and this is best delivered in a short, tailored program accessible through the family education model. More 'advanced' carers, however, may be looking for a supportive environment in which to discuss their situation. This can be gained through the more traditional support groups.

One such study investigating the strengths of family education programs in relation to support groups was carried out by Kane et al. in 1990. Their results, which are indicative of other, similar investigations in the field and are used in Table 1: 'Family Education versus Support' below, conclude that family education programs are more suitable as short-term interventions, whereas support groups are better suited as longer-term methods of intervention.

Table 1: Family Education versus Support

Family Education	Support
Information is provided in a timely, structured manner and is tailored to the immediate needs of the family coming to terms with schizophrenia.	Information delivered is more ad hoc in nature, sometimes with the aid of a 'guest speaker' on a particular topic of interest, other times through the collective experience of family members.
Information is usually provided by professionals, which can instil trust in the family member.	Information is provided by other family members, which may have more relevance and meaning.
People who do not cope well with uncertainty may find the organised structure more comfortable.	Those with a higher tolerance for ambiguity may favour free-flowing discussions.

Individual differences then, in addition to the notion of time frames, play a significant role in deciding which intervention is most suitable for family members.

Education *and* support: the comprehensive approach

Like everything in life, the needs of carers cannot be simply labelled and neatly categorised. Firstly, the needs of one particular carer will almost certainly change and evolve over time. Secondly, individual differences must also be taken into account: what might be a 'godsend' for one carer might not be so helpful for the next. Clearly then, carers need a range of options from which to choose. One example of this comes in the form of a group formed under the auspices of Schizophrenia Ireland in Dublin. This group was established following a short-term family education program run by staff of the Eastern Region Health Authority. Following an eight week course, family members were invited to establish a group of their own in order to address their continuing need for emotional support. The professionals responsible for the delivery of the education program were instrumental in the establishment of the group, yet after one year's duration, they relinquished the ownership, returning it to the members. In addition to this, education programs continue to be conducted on an annual basis. This serves two purposes: new referrals are regularly made to the group and longer-term members are afforded the opportunity of refreshing their knowledge. Furthermore, the provision of this information in a separate, structured manner frees members in the support group environment to shift the focus away from their relatives and back to themselves. That is, during the support group meetings they can focus more on their own emotions (subjective burdens) than on problems centred around their relative (physical burdens).

Measuring success

Are support groups successful? According to Rootes and Aanes (1992), the value of self-help groups in helping people to solve problems is widely accepted. A review of the literature decidedly agrees, although there is some variance as to the *type* of support group studied (e.g. psychoeducation versus support, short-term versus long-term).

Success of support groups has generally been measured in two ways:

- Impact on the ill relative (indicated by reduced time in hospital and relapse rates etc.) and/or

- Impact on the carer (indicated by reduced levels of anxiety, stress, depression etc. and an increased sense of personal wellbeing).

Measurement of the efficacy of self-help is problematic from the outset because it is inherently self-selected in nature. However, investigations into the effects of support group participation, even under random assignment, have yielded positive results on the whole (Davison et al. 2000). In a controlled study conducted by Mannion et al. (1996), the idea that participation in a support group positively affects certain key variables in the participant's adaptation to mental illness in a relative was mostly supported. In this analysis, members reported more extensive adaptive coping and less subjective burden than did non-members. Other studies conducted in this vein have also yielded positive results. Biegel and Yamatani (1986) surveyed members of a mutual help project for families, who reported a perceived high degree of social and emotional support which was directly attributable to their involvement in the self-help group. Medvene and Krauss (1989) reported that membership in a local NAMI chapter engendered a shift in the disease attributions perceived by members from blaming themselves to the view that their relative's problems were due to biological disorders. Norton et al. (1993) concluded that NAMI members perceived greater benefits than non-members. Similar findings have also been reported by Winefield and Harvey (1995, 1998), and Potasznik and Nelson (1984).

Structure and focus appear to be the prominent factors in predicting the success of any group intervention. For example, in a controlled study conducted by Abramowitz and Coursey (1989), a stress-coping framework was used to design a six-session educational support group offering families information about schizophrenia, training in problem-solving and greater access to social support and community resources. Results indicated a significant difference between the experimental and control carers following the intervention. Carers reported significantly reduced anxiety and personal distress and significantly more active coping behaviours. Even more recently, Pickett-Schenk et al. (2000) determined that participation in a twelve-week combined educational/support group increased participants' knowledge of the causes and treatments of mental illness, increased understanding of the mental health service system, and improved morale.

What is it about support groups that people find most helpful? Citron et al. (1999) investigated the factors that were perceived by local NAMI support group members as being helpful. Results indicate that members who felt that information provision and the gaining of support and self-understanding from the group process was helpful, and who were longer-term participants, were more likely to perceive benefits from belonging to that group.

Relationship with professionals

Generally, support groups for families of people with a mental illness can be divided into two categories: groups run by relatives and groups run by (or with the assistance of) health professionals. This variance in leadership is a reflection of the fundamentally different styles and ideologies of carers and professionals, which tend to have their basis in conflicting worldviews. For instance, the education of professionals tends to promote an ideology that emphasises distance, expertise, and clinical and textbook knowledge, whereas the ideology of self-help groups is based on experiential knowledge, intuition and subjectivity. Furthermore, professionals are highly valued members of society who are well paid and well recognised for their work, whereas family members have often been blamed for their problems, and remain isolated and stigmatised by society (Constantino & Nelson 1995).

Choice of leader (i.e. professionally led or carer-led) is reflective of the variance in attitudes of self-helpers towards the helping profession. Some challenge professional ideology and practices whereas others uncritically complement professional services. Most fall somewhere in between (Borkman 1997, Constantino & Nelson 1995, Wintersteen & Young 1988). In a study conducted by Emerick (1990), survey responses were obtained from 104 groups in the mental health sector and categorised as being ‘radical’ (anti-psychiatry), ‘moderate’, or ‘conservative’ (pro-professional). The radical extreme, which was represented by the National Alliance of Psychiatric Survivors, was separatist from professionals and had an outer-focused model (i.e. legal advocacy and public education). In the moderate and conservative positions were the groups who tended to have an inner-focused model (i.e. support groups and drop-in services) and were more amenable to partnerships with professionals. The majority of groups fell within the ‘moderate’ category.

Just as carers vary in their attitudes towards professionals and the degree to which they are happy with them, so do the attitudes of professionals towards self-help vary. In several investigations and reviews conducted into the attitudes of professionals towards the self-help phenomenon, the following points have been noted:

- Professionals have admitted to feeling threatened by self-help groups that have anti-psychiatry and anti-professional attitudes (Constantino & Nelson 1995);

- Professional practices reinforce the difference between ‘them and us’, such as diagnosis and labelling, which alienates professionals from consumers and family members (Constantino & Nelson 1995);

- As a profession, psychologists tend to shy away from self-help because the tradition is to work primarily with more dependent help-seekers or because they are viewed merely as inexpensive, naive adjuncts to therapy – "hand-holding, morale-boosting, do-no-harm meetings of fellow sufferers" (Jacobs & Goodman 1989, p536);

- There is some concern, particularly among psychiatrists, that the philosophy and approach of some self-help groups might clash with the clinical management of the patient and undermine their professional approach (Dunne & Fitzpatrick 1999);

- There is a general consensus that most mental health professionals (in Ireland) see a role for self-help groups in augmenting existing services by providing an after-hours contact point for people and feel that the aims and objectives of self-help groups should be closely aligned with those of the mainstream models of mental health (Dunne & Fitzpatrick 1999).

In 1997, Dunne and Fitzpatrick surveyed the attitudes of Irish general practitioners and found that while practitioners had a generally positive attitude to the principle of self-help, they did not have a clear view on how the self-help movement in general might or should relate to mainstream services. More recently, Dunne and Fitzpatrick (1999) studied the referring patterns of mental health professionals to self-help groups in Ireland. They concluded that "the views of professionals on self-help groups can vary from disinclination to refer patients at all, through caution, neutrality, to enthusiastic support for the self-help option" (p88). Their study incorporated 225 mental health professionals drawn from the staff lists of two regional health boards and included consultant psychiatrists, clinical psychologists, social workers and psychiatric nurses. While this study mainly focused on referral of *patients* to support groups, it seems likely that the general themes that have emerged can be extrapolated to include relatives also. Factors relating to the decision to refer included:

- Clinician’s awareness of the relevant support group;
- The person’s motivation to attend, and their level of need for information and/or support;
- Organisational aspects of the group, including training level of facilitators, whether or not the group was well-established, levels of dedication, commitment and confidentiality within the group, nature of the relationship between the group and mainstream services, regularity of meetings and accessibility (transport, cost etc.);
- Group atmosphere (groups needed to be supportive, open, encouraging and friendly); and
- Group reputation (this was ascertained through feedback from people who had previously accessed the group).

The partnership ethos

In the current climate of burgeoning self-help, it seems imperative to foster the idea of *partnership* between relatives and the helping profession. Parents, siblings and extended family members have a wealth of experience in working with mental illness on a day-to-day basis. Likewise, professionals also bring with them indispensable knowledge and expertise which can be a vital resource for relatives. As Dunne and Fitzpatrick (1999) state: "the challenge would seem to be for the self-help movement and the caring professions to create a partnership which capitalises on the special strengths of each approach while maintaining the integrity of both" (p89).

They go on to state that any developmental links between the medical services and self-help groups would have to proceed with caution and careful planning from the point of view of both parties in order for these partnerships to be successful and productive. Mowrer (1984) notes that what he calls ‘co-option’ of self-help programs by professionals could potentially eliminate those very elements through which the benefits of mutual help are achieved, i.e. equal status between the helper and the helped (all members share the same problem). Potential difficulties to look out for between self-help groups and agencies include agencies minimising the utility of groups, the tendency towards professional domination and risks of rivalry. Equally important are the reservations that family members feel, based on previous experiences with professionals. These issues should certainly not dissuade professionals and support groups from working together, but all parties must meet with an attitude of mutual understanding and respect (Wintersteen & Young 1988).

What role then, can professionals play in the running of support groups? Aside from providing referrals, they can share knowledge and expertise as well as providing tangible support. Involvement can include consultation, initiation of groups, acting as professional advisor to the group or merely attending meetings as a show of support (Kurtz 1990). The role of the mental health professional then becomes one of the "enabler, educator and catalyst rather than one of leader and quasi-therapist to the group…the appropriate professional role to groups identifies opportunities for education and social action, and fosters their collective determination to get on with the tasks at hand" (Wintersteen & Young 1988, p27).

In 1998, Wintersteen and Young developed guidelines for professional involvement in support groups, which are replicated in Table 2: 'Guidelines for professional involvement' * below. These guidelines were developed as a result of their own study and in conjunction with similar research in the field. They can be applied to both professionals as individuals and professionals as organisations. In essence, they conclude that professionals play a significant, if backstage, role in facilitating the development of the family support movement. They can assist this movement by fostering its growth and independence through the encouragement of lay leaders and local priorities. Professionals should also recognise that in essence, they share a common goal with carer support groups, that is, the desire for an increased sense of well-being and empowerment of family members who care for a mentally ill relative.

Table 2
Guidelines for professional involvement

1. The appropriate professional role is as a liaison and resource person, not as a therapist. Support group members are there for mutual support, information, and social action, but not to receive therapy from the liaison person.

2. A knowledge of group processes is necessary in order to understand what is transpiring and to assist leaders in carrying out their tasks.

3. The liaison must become familiar with the literature of self-help groups before undertaking this role, in order to keep the group focused and to self-monitor personal performance.

4. Ownership of the group belongs to the members, and is not the service of any agency. Leadership emerges from the group and is selected by the group alone. The group alone is responsible for its success or failure.

5. The liaison can help the group by supplying information, referring new members, and offering advice as appropriate. The liaison takes no action that extends the power of this role or conflicts with the basic purpose of this group.

6. The liaison and employing agency should be aware of the sensitivity of members to patronising or stigmatising attitudes and work to eliminate them from personal or organisational behaviour.

7. The liaison must be able to tolerate the wide range of emotions that will be expressed, without becoming defensive, internalising the comments, or attempting to support or rationalise the mental health system of the behaviour of staff. They may clarify practices of policies as an explanation of events, but should do so in a way that avoids communicating judgement on a group member's words or feelings.

8. The liaison should understand that professionals have much to learn from families, and should be prepared (within the limitations of confidentiality) to serve as a conduit of information to colleagues. The liaison also works with other professionals to increase their awareness of and support for the group.

9. The liaison is aware of talented individuals who may serve on boards or advisory committees, so long as this function does not take leadership from the group.

10. Since social action is one function of self-help groups, agencies should at least be aware that the group may monitor the programs of the agency. This should be seen as a legitimate function, and the agency should neither threaten nor manipulate the group. In fact, the advisor may be aware of a policy on a local or state level that is harmful, and request intervention by the family group.

Conclusion

Carers play a vital role in our mental health system, yet their needs are often overlooked. Taking care of a relative who has a serious mental illness can place a serious strain not only on the primary carer but also on friends and other members of the family. Support groups offer many carers an avenue through which to ‘unburden’ themselves among people who have faced similar situations and at the same time provide carers with some sense of control over an otherwise chaotic life experience. Health professionals and non-profit organisations are in an excellent position to facilitate the development of self-help groups, so long as they do so constructively and in the spirit of partnership.

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