# Management of Personality Disorder Associated with Addiction in the Context of Milieu Therapy

*Mahfouz R.; Hatem R.G. and Ellabbad E.*

## Abstract

Personality disorder is one of the most difficult problems in psychiatric practice, being refractory to conventional psychopharmacolgical and psychotherapeutic approaches. Addiction, when associated with personality disorder, represent the top challenge of this problem. In this paper, an attempt is made to approach the problems of management in milieu context. Personality disorder is conceptualized in structural terms emphasizing the enduring nature of defensive personality malorganization, that falls short from allowing normal unfolding. Addiction could not be considered in isolation from character pathology; but it is either associated with or underlying this pathology. Management aims at breaking through this defensive behavior; the diverse activities performed in the context of milieu therapy during the therapeutic process, help to uncover and undermine such consolidated handicapping patterns. This approach emphasizes the great importance of the "time factor" or the "time dimension". However, this should be a dynamic rather than a static variable

**Introduction:** Personality disorders represent a challenge to psychiatric practice, being refractory to conventional psychotherapeutic or psychopharmacological approaches. They are "often regarded by clinicians as untreatable, except possibly by individual or group psychotherapy in selected cases" (Tantam,1988) . Addiction, when associated with personality disorder, represent the top challenge of the problem. The frequency of this association, in daily clinical practice, seem to have increased. However, the incidence of antisocial personality disorder, for example, is variable in different studies. Using DSM-III criteria, Allen and Frances (1986) found it to be 73%. In the United States 25% to 40% of those seeking treatment for drug dependence exhibit the traits that would meet current criteria for antisocial personality (Jaffe, 1989).

Okasha et al. (1990) studied 78 male Egyptian heroin users admitted during 1987 to two private mental hospitals in great Cairo. According to DSM-III they found Axis II diagnosis in 51 patients (65.39%) - antisocial was 22 (28.20%). Among those seeking treatment for addiction in Dar El-Mokattam Hospital for Mental Health in Cairo, the diagnosis for personality disorder, especially the group with predominantly psychopathic (antisocial) manifestations, is consistently over-represented. It has been estimated that about 495 of the total number of addicts admitted to the hospital from January 1976 to March 1990 were diagnosed as Personality Disorder (Mahfouz et al. 1990a).

In this paper we shall attempt to approach the problem, of management of these disorders in a milieu context (Dar El Mokattam Hospital). Only the highlights of our approach are represented, since further details are presented elsewhere; theoretical orientation can be found in Rakhawy (1979, 1989, 1990a &b), Milieu therapy in Mahfouz et al. (1983a, 1989), some of the therapeutic milieu activities in Mahfouz et al. (1982, 1983b, 1990b) and Amin et al. (1990). The paper draws extensively from those previously published accounts.

The first part of this discussion will present our concept of personality disorder and the significance of the association of character pathology with addiction. The second part will present the general principle of management within the 'milieu' approach.

## Character Pathology and Addiction

Attempts to relate personality constructs to the risk of addiction disorder is still a point of controversy (Allen and Frances, 1986). there are many hypotheses which try to explain the frequent association between personality disorder and addiction. Jaffe (1989) summarizes these hypotheses: "One which has been in the literature for almost a century, is that such individuals experience a distinctive subjective change (positive euphoria) when they use such drugs, and it is the contrast between their normal status and the drug experience which motivates the repetitive use, despite the potential adverse consequences. Other possibilities are that such individuals are less prone to side effects, or more prone to developing physical dependence or especially intolerant to withdrawal distress or simply less inhibited by social expectations about drug use".

We think that this high frequency is, to various extents, reinforced by certain societal factors. Also, we agree with Mery's (1986) conclusion that the antisocial personality may be either one of psychological correlates of risk for substance abuse, or a consequence of substance use disorder.

Although 'Personality Disorder' and 'Addiction' are presented by the different diagnostic nosological classification as two separate categories, it is important to stress that the problem of addiction could not be considered in isolation from underlying or associated character pathology.

Personality disorder is defined, in structural terms, as an established personality (psychic) malorganization. This established malorganization reflects a defective unfolding of the rhythmic, phasic, biological growth process. The patient's behavioral repertoire is an expression of an ideo-affective strategy, developmentally determined and environmentally reinforced. In personality disorder this ideo-affective strategy with its associated behavioral expression could have the same psychopathological significance as stable delusion system. It is fixed, unamenable to modification, repeatedly failing to cope with reality, repeatedly failing to form "real object" relations, and handicapping as far as growth and self-realization are concerned.

Handicapping defenses play an important role in consolidating such established malogranization as much as addiction. As a matter of fact, beside the symbolic meaning and the function of the addictive substance in reaction to the development fixations, addiction has the important function of abolishing psychic pain. In that context we stress our view that the process of psychic growth and maturation with its concomitant confrontation and increasing awareness is basically and existentialling a painful process, especially if occurring in unfavorable circumstances.

Addiction, through its pain abolishing and growth aborting functions, would thus be on the one hand secondarily related to character pathology that utilizes addiction: a)as an escape and dampening mechanism away from inevitable threatening confrontations and a painful awareness; b) as a cohesive factor that prevents the disintegration of the fragile, vulnerable self; and c) as a suitable subject for real object relations. On the other hand it could be primarily related to character pathology that become established after the personality is deprived from its

healthy unfolding and drive, through addiction, into protection and handicapping defensive regression.

Thus, our view suggests that personality disorder and addiction could be structural, dynamically and technologically related.

Gordon (1985) states that "an early entry into drug abuse distorts personality growth and disrupts social, educational and occupational experience at such an important life stage that the struggle towards effective social recovery is easily frustrated by the imbalance between attainable alternatives and the ready temptations of relapse".

Lastly, it has be mentioned that personality disorder conceivably be relevant to prognosis and the associated addiction because it increases the likelihood of recurrence, or because it is associated with particular social outcome (Tantam, 1988).

## Management Issue

*1) The Milieu*

The ideal aim of treatment in character disordered addicts is to provide an appropriate therapeutic environment that would a) enhance the organization of various treatment modalities; b) allow breaking the defensive patterns; and consequently c) unblock the biological, rhythmic growth process and allow it to proceed in the direction of a favorable outcome. Accordingly, milieu therapy, in simple terms, can be viewed as a total living experience which acts to form a medium appropriate for the organization of various therapeutic modalities and the establishment of the therapeutic objectives specific for each patient.

The milieu, in a mental hospital adopting the therapeutic community discipline like ours, could be conceived, rather analogous to the state of consciousness, as a matrix and an integrated whole that could not be separated from its interacting parts and contents (see fig.1). Like consciousness, milieu has its quantitative and qualitative aspects, form and content as well as states of health and disease. It has to be emphasized that therapeutic milieu is part of the general milieu prevailing in the society at large. In our practice both Egyptian and other Arab patients have certain specifications that modified the classical imported information about the subject.

*2)Phases of the treatment plan*

It has to be mentioned that the chances for observing these phases are related to the extensive integrated therapeutic plan which includes the following: The first phase of detoxification usually does not represent a treatment problem for us, as it is well known that detoxification programs for substance with established addiction potential are reliably established. (Gordon, 1985). We almost always follow the policy of abrupt withdrawal expect in cases of barbiturates and minor tranquilizers where we adopt the policy of gradual withdrawal. Symptomatic treatment is given to ameliorate discomfort. Nonpharmaceutical milieu supports can also play an important and useful role during the detoxification period. Most helpful is a warm, kind and reassuring attitude of treatment staff. Staff members do need to take a firm stand about visitors, however, since it is not uncommon to have them attempt to smuggle in drugs.

In this phase of treatment exploration of various personality aspects of the patient, its structural configuration, developmental determinants and environmental conditions is focused upon. For this purpose the different hospital activities, the

patient and therapist availability over 24 hour, would allow a preliminary probing of the extent and depth of the problem. It is also in this phase that the milieu is challenged by the patient's maneuvers, manipulation, psychopathic acting out aiming at sabotaging the therapeutic process and which the milieu has to tolerate, understands and confronts. It is also in this phase thst alliance or contracting, at different levels, is made between the patient and the milieu, which bypass the initial patient's uncooperativeness to engage in this potentially therapeutic journey.

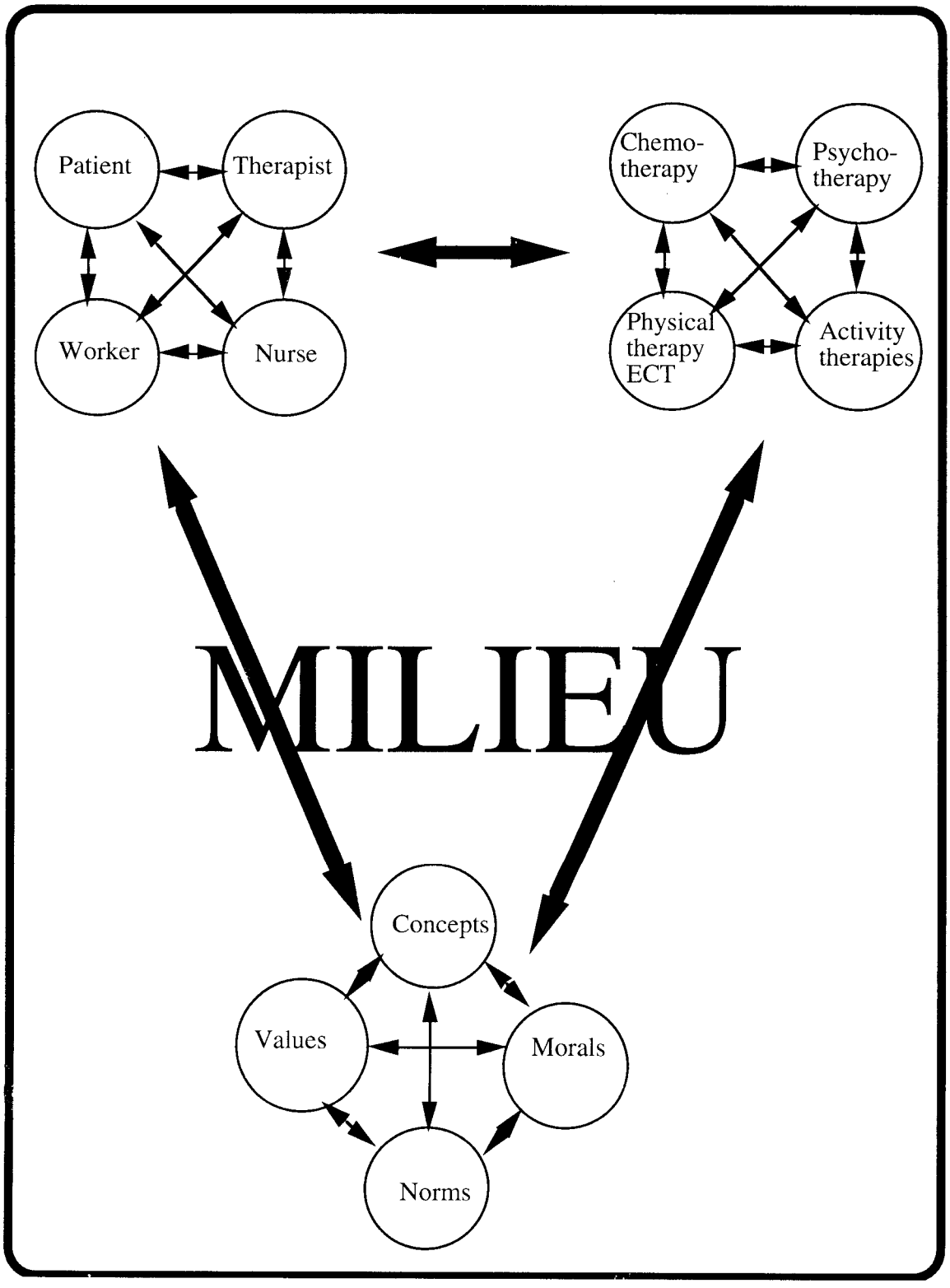
The next phase of treatment comprises the utilization of the transference relation with the patient in its diverse manifestations in order to undermine or breakthrough the patient's defensive barriers and behavioral script. Here too the different therapeutic modalities like group therapy, play, dance, work, running therapies, recreational and intellectual activities, timing and appropriate use of psychotropic medications and individual psychotherapy are integrated in the treatment plan to reach the specific goals. It is worth mentioning that in some resistant cases, and after due preparation, exhaustive techniques like sleep deprivation, long running, and intensive work may be restored to in order to get access to deeper levels of consciousness otherwise inaccessible. The successful undermining or breaking through the patient's defensive barriers would expose a week, vulnerable traumatized self and here the milieu has to assume a most important function as protective, healing environment that could also offer a genuine alternative reparative life model.

This phase is followed by a phase of assimilation. Here the milieu and its members, through the positive alliance with the patient, has the function of consolidating the patient's achievement.

It is important to stress that this therapeutic process, with its different phase, achieves its results in a piecemeal manner, i.e. it is a gradual process, that would consider positive any limited quantitative or qualitative achievement provided that it is in the proper direction. After a period of consolidation and reassessment of data, another active interference may be attempted that could be in the same hospitalization period, during the after discharge follow-up period or in subsequent rehospitilization.

Thus we do not aim to cure, in the conventional medical sense, i.e. no relapse, we rather expect a change, quantitative or qualitative, in the pattern of relapse. For example, the patient may come on his own instead of being brought by his family, he would ask for help after a shorter period and less severe involvement with the addictive substance, the patient now knows what it is there, has already established a relation with the milieu, thus initial resistance are bypassed and the treatment plan would start taking into consideration the patient's previous accomplishment. In this connection, we have to say that our view of relapse is quite near to the concept offered by Marlatt and George (1984). They state: "Rather than looking pessimistically upon a relapse as a dead end, the RP (relapse preventation) approach views it as a fork in the road, with one path returning to the former problem behavior, and the other continuing in the direction of positive change."

The continued relation, through follow-up and participation in day activities, tolerance, support and boosting of the patient's positive aspect-sometimes even when the patient is actually involved in drug abuse-would prepare the patient for properly timed quantitative change, This mean that the behavior of drug abuse is not employed as the sole outcome meas-


Patient
Therapist
Worker
Nurse
Chemo-therapy
Psycho-therapy
Physical therapy ECT
Activity therapies
MILIEU
Concepts
Values
Morals
Norms

ure, "measure of the domains such as social adjustment and mental and physical health should in addition be recorded" Duckitt et al. 1985).

In other words, we try to shift the periodicity from a remittent downstairs scarring process to some periodical upstairs therapeutic process. Both could be considered, symptomaticaly, as a relapse. Nevertheless the outcome is in a reverse direction, In this long therapeutic journey :time dimension" (Edwards, 1990) or "factor time" is highly emphasized in the treatment of personality disorder associated with addiction.

We do not claim that this is an easy or practical job, but we do no stop including it, whenever possible, in our treatment planning.

## References

***Allen M.H. and Frances R.J. (1986):*** Varieties of psychopathology found in patients with addiction disorders: a view. In Meyer R.E. (ed.), Psychopathology and Addiction Disorders. The guideline Press.

***Amin Y.; Mahfouz R. ; Hamdi E.; El Defrawi M.H. and Arafa M. (1990):*** Running as a group activity therapy: A preliminary report. Egypt. J. Psychiat., 13: 113-120.

***Duckitt A.; Brown D.; Edwards G.; Oppenheimer E.; Sheehan M. and Taylor C. (1985):*** Alcoholism and the nature of outcome. Brit. J. Addiction, 80:153-162.

***Edwards G.(1990):*** Alcohol dependence: Taking a long term view. Paper presented at the second U.A.E. Psychiatric Conference, Abu Dhabi, April 30th May 2nd 1990.

***Jaffe J.H. (1989):*** Addiction: What does biology have to tell? International Review of Psychiatry, 1:51-61.

***Gordon A.M. (1985):*** Psychosocial aspects of drug abuse. In Granville-Grossman, K. (ed.), Recent Advances in Clinical Psychiatry. Number five. London: Churchill Livingstone.

***Mahfouz R. ; Hamdi E.; Amin Y. and Rakhawy Y.T.(1982):*** Sleep deprivation therapy: A part of an integrated plan in a special milieu. Egypt. J. Psychiat., 5:282-193.

***Mahfouz R. ; Hamdi E. and Amin Y. (1983a):*** Milieu therapy: An Egyptian experience. Egypt. J. Psychiat., 6:141-147.

***Mahfouz R. ; Hamdi E.; Amin Y. and Hatem R.G. (1983b):*** Work treatment: Meaning and rationale. Egypt. J. Psychiat., 6:310-317.

***Mahfouz R. (1989):*** Milieu therapy in Psychiatric practice: A reorientation based on an Egyptian experience. Paper read at the Forth Arab Congress on Psychiatric, 5-7 December 1989, Sana'a Yemen.

***Mahfouz R. ; Arafa M.; loutfi Z. Abdel-Wahab E.; Amin Y. and El Defrawi M.H. (1990b):*** Management of chronic psychiatric patients: The effective role of a activity therapy program within a therpeutic milieu. (submitted for publication).

***Marlatt G.A. and George W.H. (1984):*** Relapse preventation: Introduction and overview of the model. Brit. J. Addiction, 79:261-275.

***Mery's R.E. (1986b):*** Psychopathology and Addiction Disorders. The Guidline Press.

***Okasha A. ; Khalil A.H.; Fahmy M. and Ghanem M.H. (1990):*** Psychological understanding of Egyptian heroin users. Egypt. J. Psychiat.,13:37-48.

***Rakhawy Y.T. (1979):*** A Study in Pschopathology. Cairo: Dar El Ghad. (in Arabic).

***Rakhawy Y.T. (1990a):*** Addiction-Another field of psychiatric research illusions: Failure to access levels of pleasure and loneliness through a structured research design. Paper presented at the second U.A.E. Psychiatric Conference, Abu Dhabi, April 30th May 2nd 1990.

***Rakhawy Y.T. (1990b)***: Qualitative results of intensive therapy for drug dependent patients. Paper pesented at the second U.A.E. Psychiatric Conference, Abu Dhabi, April 30th May 2nd 1990.

***Tantam D. (1988):*** Personality disorder. In Granvvlle -Grossmaan, K. (ed.), Recent Advances in Clinical Psychiatry. Number ix. London: Churchil Livingstone.

## Authors

***Mahfouz R.***
Psychiatriy Dept., Menia, Medical School

***Hatem R.G.***
Psychiatriy Dept., Menia, Medical School

***Ellabbed E.***
Psychiatriy Dept., Menia, Medical School

## Address of correspondence

***Mahfouz R.***
Al Mokatttam Hospital for mental Health
Cairo.

## علاج اضطراب الشخصية المقترن بالإدمان فى سياق علاج الوسط

يمثل اضطراب الشخصية أحد الصعوبات الكبرى فى الممارسة الطبنفسية، حيث أنه لا يستجيب بسهولة للعلاجات النفسية و الكيميائية المعتادة، و يمثل الإدمان المقترن باضطراب الشخصية قمة التحدى في هذه المشكلة. و سنتعرض فى هذا البحث للصعوبات العلاجية الخاصة بهذه الفئة فى إطار علاج الوسط و من واقع خبرتنا العملية.

و يمكننا فهم اضطراب الشخصية- من منظور بنيوى - على أنه تنظيم لمكونات الشخصية بشكل مستتب و دفاعى بحيث لا يسمح بحدوث عملية البسط التلقائية. وكذلك لا يمكن فصل الإدمان عن اضطراب صفات الشخصية إذ أن الإدمان غالبا ما يكون مقترنا باضطراب الصفات أو يمثل واجهة لهذا الاضطراب . و العلاج فى هذه الحالة يستهدف اختراق السلوك الدفاعى من خلال النشاطات المختلفة فى علاج الوسط، و التى تساعدنا على كشف و إيضاح هذا النمط المعوق المتجمد. كذلك يؤكد البحث أهمية "البعد الزمنى" فى العلاج، على أن يتصف بالديناميكية و الحركة، حيث يتدخل المعالج و العلاج كمتغيرات حية تساهم فى التحريك و تساعد فى تحديد نتائجه.

# THE OKASHA AWARD
## for the best
## Research in Psychiarty

**Offered by Prof. Okasha to the best research/paper published in "Current Psychiatry".**

**3000 L.E. presented to the authors and a certificate**

**Names to be announced during the "Okasha " lecture ervery July**