Psychosis and newly emerging dependency groups: The search for an adapted model of care at the *Psychiatric Centres Sleidinge* in Belgium

Dirk Bryssinck, Eric Broekaert and Stijn Vandevelde

ABSTRACT: For some years, the residential treatment department for people experiencing psychosis at the Psychiatric Centres Sleidinge psychiatric hospital in Belgium was populated by an explosive cocktail of potential psychotic youngsters with severe addiction problems. These clients were DSM-labeled as co-morbid or dually diagnosed residents. Confronted with this new population, and until then only experienced in working with "classic psychoses", the department engaged in a radical innovation. They chose to reorganize their work from a psychoanalytic Lacanian perspective. According to Lacan, the psychotic process contains an attempt at recovery, in the sense of a subjective effort to accept what was originally seen as intrusive. Within this, the addiction has its own independent status. The treatment of people experiencing psychosis consists of carefully building a long-lasting relationship, based on mutual trust. Congruent with their Lacanian position, the staff turned to institutional psychotherapy and milieu therapy. "Staff-resident" meetings were introduced as powerful instruments to stimulate free communication in the group. A special workgroup called the "drug cartel" was installed. Many spontaneous meetings took place, addressing not only drug use but also rules and activities which were discussed and adapted. The "classic people experiencing psychosis" left. A new open interaction with the staff emerged, and a charter of basic rights that governs the community was established. The separate "key position" of the analyst was replaced by a complex of "referents" or personal assistants from which the residents could freely choose. By doing so, the changes within the resident group and staff became interconnected in a mutual effort to demystify positions and functions. A new well-functioning model of treatment was born.

Dirk Bryssinck is a psychologist at the Psychiatric Centres Sleidinge (Belgium) and is responsible for the Department of Dual Diagnosis. Eric Broekaert is a professor in Orthopedagogics (Special Education) at Ghent University, Ghent, Belgium. Stijn Vandevelde is a lecturer at Hogeschool Gent, Department of Social and Community Work (SOAG), Ghent, Belgium. Please address all correspondence to Prof. Dr. Eric Broekaert, Ghent University, Department of Orthopedagogics, H. Dunantlaan 1, 9000 Ghent, Belgium. Email: Eric.Broekaert@UGent.be

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Introduction

In an evolving society, the psychiatric landscape is continually in motion. Since Nietzsche's "God is dead" credo began to represent religious delusions, "classic" psychosis has become increasingly rare. Since the 1980s, youngsters experiencing psychosis have followed illustrious trendsetters such as Burroughs, Huxley, and Leary and found their comfort in illegal substances (Leary *et al*, 1983). This new conjuncture of classic psychosis and newly emerging dependency groups was experienced at the *Psychiatric Centres Sleidinge* psychiatric hospital in Belgium. For some years, its residential treatment department for people experiencing psychosis was populated by an explosive cocktail of potentially psychotic youngsters with severe addiction problems. They were DSM-labeled as co-morbid or dually diagnosed residents (Minkoff and Drake, 1991; Van Hoorde, 1996). They were shuttled from one facility to another and often refused because they might disturb the "equilibrium" of the treatment setting. They were not even welcome in departments for people experiencing psychosis because of the threatening character of their addiction. When they did not find a treatment place, they risked becoming the passive or active victim of violent or delinquent acts. They frequently ended up in prison or committed suicide. It is not an exaggeration to state that they are the real outlaws or pariahs of our society. They suffer from a double exclusion: they are not only isolated from the general public but also from the users' groups where they initially could maintain themselves.

Confronted with this new population, and with their only prior experience working with "classic psychoses", the department, supported by the management, engaged in a radical innovation and search for an adapted treatment model.

History of the Department

The unit of dual diagnosis is part of the psychiatric hospital. Besides this unit, the psychiatric hospital also houses a unit for people suffering from psychosis (without addiction problems), a unit for persons suffering from personality disorders, a unit for re-socialization, and a geriatric ward. These are all "open" units; moreover, there is also a closed unit for crisis intervention and a unit for detoxification.

The open unit for dual diagnosis has fifteen individual rooms for residents and also serves six patients who come on a daily basis. The unit is situated on the second floor of the hospital, with its own kitchen and living rooms. There are also therapy rooms and offices for the eight nurses, two psychologists, one psychiatrist, and one social worker on this floor who are integrated in the daily life of the unit. The rooms for sport, creative therapy, and music therapy – each with their own therapists – are collective areas. The unit is open during the whole day until 9:00 pm. Patients can freely walk in and out.

The specificity of the new model and the innovative way of working can only be described against the past of the organization, the institution, the department, and treatment team. According to the staff members' opinions, the organizational

culture or "spirit" of an institution can be considered as a combined action of conscious and especially unconscious fantasies, grounded in tradition and the past (cf. Jones, 1982). This imaginary reality leads the dynamics of groups and group members. At the level of the department and the team, as well, there is a culture that generates certain scenarios which will inevitably have their influence on treatment and residents. In psychoanalytic terms, where people live together and work together, "transference" exits. This transference starts from a history and determines, in its turn, the actual functioning. Therefore, before describing in which specific way the work with this special population of double-diagnosed residents functions, the story of the clinic and the department has to be told.

About fifteen years ago, the clinic changed from a hierarchically structured medical psychiatric institute into a dynamic, democratic model. The new management blew some wind into the "chronic sails" and dramatically reformed the organization structure. During the first phase, the old structures were replaced by a divisional model, forming multidisciplinary teams around a specific treatment philosophy. The introduction of psychoanalytic theory in the work with psychotic people deeply penetrated the organization. It was noticed that the old imposed therapy model for psychoses frequently led to paradoxical consequences and alienated the residents from their own longing. After all, how could socially excluded people question their symptoms if they ended up in a psychiatric hospital, which was structured like the world that locked them out? How could they enjoy sports, creative and occupational therapy, and other activities in which they constantly failed outside? How could they flourish in a setting where they were in fact forced "not to be psychotic"? The new project should, in the first place, contrast with the authoritarian, stereotypic, and compulsory line of the old clinic. The former therapeutic interventions not only had to change in name, they had to become attractive encounters.

The subjects were to question themselves about the reason for staying in the department, leaving false certitudes behind. This is in accordance with Lacan's ethical principles and his key understandings of the role of the "signifiers" (Lacan, 1986). The clinic of the "acting other" with his omniscient answer was gradually reorganized to a clinic of the "listening and speaking subject."

During the second phase, the resident population changed little by little. In order to make this possible, the clinic had to adapt its policy and evaluate its shelter function. An acute admission policy for people who did not find accommodation somewhere else was implemented. Related psychiatric clinics from the region almost systematically referred their difficult cases, and judicial authorities cooperated with this procedure. The clinic and department of psychoses, in particular, became their appreciated dumping ground. Treatment staff were supposed to work with what was offered. The label "psychosis" was used for everyone who did not fit in a therapeutic project of another department. The department for people experiencing psychosis changed bit by bit into an unfathomable mix: "the group of those who did not belong to any group". Their

behaviour led to unbearable situations. Unconsciously, the staff established a more repressive culture, with continuous urine controls and wild discharges. The interactions between the resident group and team led to a spiral of conflicts and acting-outs: the space which should normally be present for the resident was filled up with mutual grumbling. Different group regressions, as described by Bion (1961), came to the surface. Although the necessity to change was widely accepted, the staff remained in a sort of narcissism and ended up in what Hobson calls the "therapeutic community disease" (Hobson, 1979).

Dually diagnosed residents

The residents are commonly labeled as dually diagnosed residents. In the narrow sense, dual diagnosis means "the going together of a medical diagnosis with a non-medical one". It is a specification of the more general term co-morbidity, which literally refers to the co-existence of two or more diseases. The use of a term such as double diagnosis could be questioned. Could it be an artifact of the one-sided classification system of the DSM, which counts rather than integrates the totality of diagnostic features (Iannitelli *et al*, 2002; Van Hoorde, 1996)?

Without a doubt, in a short time span the new term caused a true proliferation of subdivisions: there appeared a whole range of severe psychiatric anxiety, mood, impulse control, personality disorders, and post-traumatic stress symptoms, all combined with the misuse of substances and further specified as light, moderate, or severe (Minkoff and Drake, 1991). In the specific situation of the *Psychiatric Centres Sleidinge*, the staff members chose to exclusively focus on clients suffering from psychosis with substance abuse problems in the new department of dual diagnosis. This was first of all because the department already had extensive experience with a population experiencing psychosis. Moreover, it was exactly this subgroup of substance-abusing clients suffering from psychosis for whom no regular treatment opportunities had existed until then.

Soon after the decision not to mix people with psychosis and dually diagnosed clients, another section in the clinic was set up for clients with "classic" psychoses. Staff members who decided to no longer work with dually diagnosed people switched to another section in the clinic. No staff members or patients were fired; they all had the option of relocating to another department.

The DSM classified the residents as schizophrenic with different subtypes. More recent terms are SPMI (Substance Use Disorder combined with severe and Persistent Mental Illness), CAMI (Chemically Abusing Mentally Ill), and MICA (Mentally Ill Chemical Abusers). In the department, staff members spoke of people with classic psychotic structures – schizophrenia, paranoia, manic-depressive psychoses, and melancholia – who also (mis)use substances. They experienced severe traumata, such as physical and psychological abuse or neglect. In DSM terms they could be diagnosed as persons suffering from post-traumatic stress disorders, although the psychosis comes in the first place (Michael *et al*, 2002). When clients

show anti-social features, they should be labeled as suffering from personality disorders, although in origin they have a psychotic structure. Many of the residents also have judicial pasts or presents, and as a result are diagnosed as triple-diagnosis residents. They can be admitted or collocated ("interned") by the *Commission for Safety of the Society*, which also decides where and under what circumstances the treatment should happen. (The Commissions for Safety of the Society depend on the Ministry of Justice. They impose measures on "mentally ill criminal offenders" who are not considered responsible for their acts, in the framework of the protection of society. In Belgium, serious mental illness and intellectual disability, among others, could lead to "collocation".) The clients can be temporarily released in expectation of further investigations or a process. They are followed by the probation commission, charging them with probation conditions. In this respect, it is important to note that many treatment settings and therapists are discouraged from working with these clients, exactly because of the aforementioned coercive and judicial nature of treatment. Moreover, it is important to underscore the importance of coordinated and continuous treatment for this specific subpopulation of substance abusers. Research has already demonstrated the chronic and relapsing nature of substance-abuse disorders (McLellan *et al*, 2000). This certainly seems true for dually diagnosed clients, for whom – as a consequence – integrated treatment systems and adapted methods, such as case management, could particularly offer promising prospects (Vanderplasschen *et al*, 2004).

Next to the diagnosis and judicial condition, it is also important to consider the products they use. Compared to "regular" drug users, the people experiencing psychosis are less selective and tend to use whatever is available on the market. In recent years, an increase in designer drugs could be observed. These synthetic drugs based on fentanyl are mostly combined with amphetamines and hallucinogens and are difficult to retrieve. The most well-known are XTC, speed, crack, and MPTP (Henderson, 1988). We have also noticed a recent increase in heroin. There is, of course, also the massive availability of cannabis.

Most of the residents experience their fellow humans as extremely threatening: one word, look, or object can be wrongly interpreted and enough to initiate conflict. Their answers to this massive fear are "fight or flight": aggression or escape. As a result, they are often excluded from the social security and care system. This refers to earlier exclusion, sometimes starting at birth and moving from generation to generation. The residents suffer from a low socio-economic status and limited training. Like real *sans papiers*, they are always on the run and their loyalty is limited. Their severe abuse of substances in combination with their impulsivity contains a high risk for suicide and active or passive destruction.

To be admitted to the unit for dual diagnosis, the patients have to be diagnosed as suffering from psychosis and addiction. Cases of high suicide risk and aggressive behaviour are referred to the closed unit, and cases of heavy withdrawal symptoms are referred to the detoxification unit. As soon as the crisis or detoxification phase is over, they can be admitted to the unit for dual diagnosis.

Psychoanalysis and social identities

As mentioned before, the department chose to reorganize the work from a psychoanalytic perspective, in particular a Lacanian vision. For a more extensive and accessible explanation of Lacan's theory, we refer to Verhaeghe (2002) and Maleval (1996). This does not mean that the authors are disrespectful of other psychodynamic authors who are well known in the field of treatment for people experiencing psychosis, including Klein, Bion, Steiner, and Berke. However, in Flanders, a strong Lacanian tradition exists, supported by influential university departments (cf. http://allserv.ugent.be/~evdbussc/en_index.html) and partially also because of the wide accessibility of the French language.

According to Lacan, the psychotic process contains an attempt at recovery, in the sense of a subjective effort to accept what was originally seen as intrusive. The therapeutic handling of the psychotic transference is hampered by its intense, massive, functional, and ambivalent character. The interpretation can be impossible and even dangerous due to the difficult accessibility of the delusion: speaking is only indirectly possible if one acts as an ally, witness, or aid of the psychotic subject. For this, the central aim in the treatment of people experiencing psychosis is embedded in a careful building of a long-lasting relationship, based on mutual trust. Within this, the addiction has its own, independent status that co-determines the course of treatment. The psychosis is primary and the addiction is secondary (De Hert, 2003). Above this, drugs that overwhelm the subject – substances such as LSD and the new designer drugs – can provoke a psychosis.

On the other hand, some products such as marijuana, morphine-like substances, and some opiates with an anti-psychotic effect can have an opposite result. The manifest psychotic symptoms are covered up, and appear only at the detoxification. Certain substances can form a dam or barrier against what is threatening the psychotic. In this way, drug use gives a functional answer to the structural trauma and halts the unbearable fear for a while (Le Poulichet, 1987; Zafiropoulos, 1996).

But also the speaking and writing obsessions, the bulimia, and the Walkman with loud music to conceal auditory hallucinations have something "addictive" and are an attempt of the subject to tackle the reality of the body, the voices and delusions and the compelling physical laws.

The fact that neuroleptic medicines also have the potential to cover the reality does not necessarily mean that a psychotic subject will easily exchange his self-medication. A primary reason is that these medicines have similar but not identical effects. Clients suffering from psychosis report that psychotropic substances give them the possibility not to think, while neuroleptics only "prevent" them from thinking (De Ridder and Rozenberg, 2000). Some drugs can be experienced as favourable because of the side-effects of neuroleptics. But there is more: especially the younger population prefers being called a "substance abuser" to being labeled "psychotic." The identity of a "user" offers the opportunity to be part of an existing subculture. Moreover, people experiencing psychosis who use drugs most often

have more and better social contacts than non-using people experiencing psychosis.

Drugs not only have a stabilizing "real" effect on the body; there is also a symbolic and an imaginary effect, or the identification with an image. These effects are especially prevalent when clients suffering from psychosis, who are not abusing substances, call themselves addicts. The clients' identification with the signifier "addict" can help them to maintain themselves in a specific *discours*. It can refer to an ultimate attempt to establish themselves in the world, to find or keep some way of connection that makes their position viable. By means of "abuser slang," residents are represented by a constellation of signifiers. This specific jargon, with its own history, can offer an alternative for the common *discours* that is not accessible for the client suffering from psychosis. In contrast to regular substance abuse treatment services, the department tolerates this identification which can serve as an anchor from which people can establish themselves again in the outside world. In this sense, it is interesting to point out that the word "joint" literally means "connection" and that "social bonding" is the cornerstone of the new way of working in the department.

Milieu therapy as new approach

Social exclusion and bizarre behaviour

The starting point of the new way of working is the recognition of the clients' radical social exclusion: being welcome in the shelter offers them an anchor in their fight against segregation. Acceptance of their "being different" signifies in psychoanalytic terms a first form of treatment. Their "bizarre", "anti-social" behaviour constitutes an answer to their exclusion and reduction to an object.

These symptoms are answers of the subject, and neglecting them would mean yet another turning down of their demands and a restoring of the dismissive spiral. The shelter function – historically the primary objective of the psychiatric clinic – offers them the possibility to "live" their symptoms without the assumption that residents should be motivated, have insight into their disease, or have a "question" to adapt to a therapeutic ideal. It may not be forgotten that our psychotic people willingly or unwillingly are forced to live together as "the group of those who don't belong to a group", and that this was exactly what the old psychiatric approach was doing to them (Foucault, 1976). The question "Who are they?" was replaced by "What do we want?" This had a very depressing effect, not only for the residents, but also for the team (of staff members).

The department then turned its focus to the pioneers of the institutional psychotherapy (Oury *et al*, 1985), milieu therapy (Bion, 1961; Bridger, 1983), the democratic therapeutic community movement (Jones, 1956; Rapoport, 1960), and anti-psychiatry (Laing, 1961; Szasz, 1972), as their thoughts seemed most in convergence with the department's Freudian-Lacanian reference frame. This

branch of therapeutic environments should be distinguished to a certain extent from the concept-based drug-free therapeutic communities for (dually diagnosed) addicts, which were, from origin, more behaviourally oriented (Broekaert *et al*, 2000; De Leon, 2000; Westreich *et al*, 1996). In a sense, the department followed the progressive examples of pioneers such as Mosher at Soteria in California (Mosher *et al*, 1986), Ciompi in Bern, Switzerland (Ciompi *et al*, 1992), and Berke at Arbours in London (Berke, 1990).

The creation of a milieu forms the quintessence of treatment in milieu therapy and institutional psychotherapy. The institution itself, its structure (or way of dealing with the necessary rules), and group dynamics must determine the therapeutic position. This can only be achieved by placing not only the team but also the residents in a co-responsible relationship. This is the main agent for the department's atmosphere.

Structure and group dynamics

An important change consisted in the installation of the "staff-resident" meeting, a powerful instrument to stimulate free communication in the group. Every topic could be disclosed in the group, including drug use. In the early beginnings, the older, non-using people experiencing psychosis were supported by more traditional staff members, whereas the younger people experiencing psychosis were backed up by the more progressive team. In accordance with the department's basic assumption, the staff members recognized their subculture and made an appeal to their expertise. This led to the foundation of a special workgroup – a sort of ethical examination committee – with the ironic name the "drug cartel." At that point, the traditional people experiencing psychosis and staff left. Under the umbrella of the drug cartel, many spontaneous meetings with the drug users took place, during which not only drug use, but also rules and activities were discussed and adapted. The "drug cartel" was characterized by the absence of an identifying leader. It was "fatherless", and the vertical bonds with the leader were replaced by mutual horizontal "peer" equality. This development was in clinical correspondence with the literally absent, unknown father of the residents and with their drug subculture in which peers determined their own rules to regulate life and enjoyment. As a consequence, the "clan" itself developed its own set of laws to manage drug use. It demanded trust and group autonomy and counted on the delegation of decision making competences.

This introduced an important shift regarding control, safety, and order in the hospital. It led to tolerance (permissiveness) (Rapoport, 1960) for personal problems, anger and aggression. The department evolved from a supportive model with isolated therapies to a small milieu therapeutic community. If rules and structures are more clearly defined, a special bond develops which has to be constantly analyzed, strengthened, and adjusted. Within this milieu, the residents could start from their psychotic experiences, and they evaluated social relations a

less threatening. They were in constant resonance and interaction with their environment. From then on, the department continuously stressed the development of a horizontally underpinned clear structure and an open group dynamic context. According to Moos (1974) and Gunderson (1978), this corresponds with a more effective approach in treatment departments for young people experiencing psychosis.

Pharmacology and drugs

Clinical experience teaches us that neuroleptics can make the psychosis bearable and that these medicines can delay acute disturbances. On the other hand, they warn us that human subjectivity is not merely reducible to a neuronal network or a neurotransmission-process. With the "clinic of the medicines", the whole treatment is often all about medication. Within a "clinic of transference", the whole treatment concerns every moment of life and all related facts. Both clinics are grounded in a different basic principle and different ethics: "human as biological object" versus "human as subject". From the department's point of view, pharmacological therapy is only efficient when it is embedded in a context of transference from the living community. It was observed that insisting on taking or reducing medication proved to be much more efficient when it started from within the group. The social therapeutic model, focusing on equality, offers more possibilities than the vertically enforced authority. It excludes subtle games between the doctor who prescribed the medication and the nurses who administered it. The treatment of substance abuse in itself followed the same evolution. Although it is the department's aim to stop drug use, we have often referred clients to methadone as a substitute (harm reduction).

In the beginning, this resulted in doubts and irritations. Some team members were afraid that residents would demand higher doses than necessary, and that those who did not really need it would start asking for it. But through open discussions in the group, good results on this specific topic were achieved as well. Some residents even managed to stop using methadone. The department noticed a comparable evolution with regard to cannabis use in the grounds of the hospital. As in many secure settings such as correctional establishments, it seemed quite impossible to keep cannabis use out of the institution (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2003). Moreover, moderate use of cannabis can reduce anxiety, depression, dysforia, and other negative symptoms, as mentioned above (Dixon *et al*, 1990). Again, the culture of information, debate, and openness led to more responsible choices. The department experienced how important it is to provide residents with valid information on the biological and psychological effects of drugs and their interactions with neuroleptics (cf. Jones, 1952). This more responsible procedure was unthinkable in the old clinic. The uncomfortable relationship between the law of the outside world and the department's internal rules blocked spontaneous psycho-education. The department did not focus on using

sanctions "in the name of the law", and so avoided the vicious circle of exclusion. The reality of "deviant" behaviour confrontation takes place in the context of the community and during the numerous group meetings (cf. reality testing in Rapoport, 1960). The residents can freely speak about their drug use, and will not be sanctioned or removed from the department. In this atmosphere of safety and trust, restrictions are challenged by social learning experiences. Only seldom, in cases of acute psychosis or a too-sharp paranoia, is the reality confrontation avoided. The department also chose not to use urine controls which often provoke paranoia, as associated with outside repressive behaviour.

The department patiently tolerated a period of time for experimentation, which was necessary for enabling change. If these possibilities were not allowed, indispensable autonomy was likely to get lost, which could provoke a process of hidden crises and covered processes. The new way of working consisted exactly of making these crises and processes visible, so that staff members and residents could learn from them (cf. living-learning experiences, see e.g. Jones, 1982). This innovative method demanded tolerance and flexibility from staff members, especially with regard to handling destruction and managing their own fears.

Community rules and "basic charter"

Over the years, some minimum lines were drawn in which prohibitions were replaced by rights and responsibilities, in accordance with the department's adage of "minimal structure with a maximum of responsibility". This "basic charter" of the department, in which each resident can reflect him/herself during the intake, leads to an intake agreement. It forms an alternative for the well-known written contracts which are not optimal for using with paranoid people.

Every participant in the therapeutic programme has the right to:

1. Treatment without distinction based on gender, race, nationality, belief, sexual inclination, and juridical past.
2. Respect and mutual security.
3. A supportive drug-free environment.
4. Knowledge of the philosophy and methods used by the treatment team.
5. Accurate information on all rules and appointments.
6. Insight into fees, costs, and payment modalities during the intake and when leaving the institution.
7. A supply of healthy food, safe and adequate lodgings, and all possibilities for personal hygiene.
8. Physical and medical care and psychological counselling by qualified staff.
9. Social contacts.
10. Advice and assistance when leaving the institution concerning other services and institutions, financial support, and places to stay.

Treatment team and group inter-vision

The department learned that the residents' attribution of "knowing" to the therapist or the traditional neurotic transference on the analyst are not always functional in the clinic for psychosis and newly emerging dependency groups. The analytical interpretation can be a reason for these subjects to paranoid transference. Therefore, the separate "key position" of the analyst was replaced by a complex of "referents" or "personal assistants" from which the resident could freely choose one or several. This enabled a sort of "transference *à la carte*": the possibility of slowly building relationships with a "partner" and the lateral development of a network of relations. The free choice of the referent based on transference was more important than the qualification of the team member. The position of the referents and the potential difficulties they experienced are discussed in the team as a form of "group inter-vision". This team discussion is essential, because everyone needs to be aware of the other colleagues' do's and don'ts. The work is and remains collective, multi-referential, and carried out by all at each moment. This way of working is also therapeutic for the team itself.

Earlier internal disagreement or rivalry that arose from the artificial split between those who could interpret (psychotherapists) and those who had to control (sociotherapists) was removed. This connects with the characteristics of the department's model, which is the integration of authority by communication and exchange of ideas. It reduces the risk of team members using something personal against one another and undermining the basic charter of respect and mutual security.

The fact that everyone carries out the same work does not exclude differences that are in accordance with the principle of equivalence. Specialization and differentiation of tasks relate to the principle that the part refers to the totality as the totality refers to the parts. Specific tasks can be ascribed within defined time and space borders, with respect for mutual differences. The most important point is the demystification of, and openness in, relations and functions. This corresponds to the position of our residents who are involved in a rotating system of changing functions and responsibilities.

Conclusions

In Belgium, at the *Psychiatric Centres Sleidinge*, an innovative treatment model for newly emerging dependency groups was established. During this process, the department discovered that the Lacanian vision on psychosis and addiction could be combined with the principles of milieu therapy. The starting point of treatment for the newly emerging dependency groups is the acceptance of a social exclusion spiral that determined those residents' lives. They are the real pariahs of society and are superficially labeled as dual-diagnosed patients. Confronting them in unsafe circumstances and in a repressive or authoritarian way can provoke psychotic reactions. Trust and respect is the starting point for treatment. If one respects their symptom pathology, people experiencing psychosis can function in an interrelated way and can process in a group toward responsible acting. Addiction is secondary to psychosis, but the new subculture, in which psychosis is denied through the status of substance abuse, can help to establish social interaction and morality starting from the group. The separate key position of the analyst can be replaced by a complex of "referents" or personal assistants from which the resident can freely choose. This contributes to the flexibility of functions within the team, where specializations have to be linked back to the group as the common denominator. Staff group inter-vision plays an important role, as everyone has to be aware of each others' interventions and relationships.

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Individual psychotherapy versus milieu therapy in childhood and adolescence

Michael Günter

ABSTRACT: The paper describes the use of a model combining milieu therapy with an individual therapy framework, based on theoretical concepts and the practice of psychoanalytically oriented therapy in the residential treatment of adolescents suffering from psychosis. Educational work in everyday life, which is reflected upon psychoanalytically, and classical therapy sessions are seen as complementary elements of treatment. Core problems in the treatment of psychotic adolescents are discussed in terms of their relevance for the milieu-therapeutic setting and team processes. Especially for adolescents suffering from a severe psychological disturbance, acting out in everyday life behaviour has a defensive component, but also facilitates emotional growth and is thus of great maturational significance. The analysis of the very complex transference/countertransference relationship involving the whole therapeutic team is an outstanding feature of such a psychotherapeutic concept. Thus the team's capacity to adapt to the individual patient's conflictual dynamics, even in everyday life on the ward, is supported. This is the basis for the aspired-to therapeutic success: to stabilise the patient and remove developmental obstacles. Finally, problems of an integrated milieu-therapeutic approach are discussed.

Key words: milieu therapy, individual psychotherapy, adolescents, schizophrenia, residential treatment

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Dr. Michael Günter is Professor for Child and Adolescent Psychiatry and Psychotherapy the Department of Psychiatry and Psychotherapy in Childhood and Adolescence, Universi of Tübingen, Osianderstr. 14, D-72076 Tübingen, Germany. E-ma michael.guenter@med.uni-tuebingen.de

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