Borderline personality disorder and drug addictions. Patient's treatments in Public Drug Addiction Services (PDAS) and in Therapeutic Communities (TC).

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Introduction:

The expression "dual diagnosis" (DD) means the presence of two psychiatric disorders that satisfy diagnostic criteria within a nosographic reference frame; in the psychiatric field instead , it refers to the co-presence of a substance dependence or abuse with another psychiatric disorder (American Psychiatric Association, 2002; Torres, 2008).
The use of psychotropic substances thereby, is seen as the cause, the consequence, the co-morbidity of psychiatric disorders which can go from a single symptom or sign of psychiatric suffering, to sub-threshold disorders to severe disorders of psychotic nature.
Other combinations with traits or personality disorders, generally part of the B cluster, vary and multiply the clinical pattern with diagnostic, prognostic and therapeutic specifications which can be very different.
The expression DD is an approximate translation from the English "Dual Diagnosis" (De Leon, 1989); the co-presence of two or more diagnosis in the same patient is also known as "co-morbidity".
Nevertheless both definitions have caused some criticism: the word "co-morbidity" refers to two distinct etiologies (uncommon in the psychiatric sector), while the expression "DD" brings the idea of a double treatment and a cause – effect relation between the two pathological pattern (quite rare, instead, in the clinical practice).
Together with difficulties in the definition, DD brings few more problems. The diagnostic process of such patients is often difficult and requires long observations as well as constant revision of the conclusions from the doctor side. A correct diagnostic assessment is absolutely vital in order to have the right prognosis and plan the right treatment. When this type of patients ask to enter the treatment, their acute psychiatric syndromes are often mistaken for symptoms induced by drugs or, on the contrary, symptoms related to the addiction clearing or intoxication are mistaken for psychiatric illnesses.
Moreover, even when it is assessed, the DD syndrome is hardly ever taken into account for the treatments to come (Adams, Jendritza & Kim, 2006; Fioritti & Solomon, 2002; Hasin, Samet, Nunes, Meydan, Matseoane, & Waxman, 2006; Manzato & Fea, 2004; European Monitoring Centre for Drugs and Drug Addictions, 2004; Torres, 2008).
As a consequence, the treatment on such patients is quite complex. Compared to patients with one single condition the co-presence of two or more disorders is the cause of the higher rate of relapses and more problems in the medical field, in the psychological and toxicological sector as well as in the social one.
With this type of patients recovery is longer, social disability is severe and rehabilitation is longer and more complex (Bellack, Bennett, Gearon, Brown & Yang, 2006; Brunette & Mueser, 2006; Fioritti & Solomon, 2002; Manzato & Fea, 2004; Torres, 2008).
The Mental Health Department (MHD), the Public Drug Addiction Services (PDAS) and Therapeutic Communities (TC) are not well connected and operate in separated fields while DD syndrome requires overlapping actions and a "dialogue" between psychiatry and a field from which it has been long separated (Bellio, 2005; Cicogni, 2004; Fiorin & Citron, 2005; Fioritti & Solomon, 2002).
Professionals who take in charge this type of patients often operates in very complex and disheartening scenarios, where failure and relapses are quite common. Quite often the

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therapeutic relationship with the patient is damaged, due to the abuse of drugs as well as to the psychopathological disorder (Connors, DiClemente, Dermen, Kadden, Carroll & Frone, 2000; Drake, 2006; Drake, Mercer-McFadden, Mueser, McHugo & Bond, 1998; Drake, Mueser & Brunette, 2007; Fiorin & Citron, 2005; Fioritti & Solomon, 2002; Manzato & Fea, 2004; Mosti & Clerici, 2003; European Monitoring Centre for Drugs and Drug Addictions 2004; Tact, Murphy, Musser & Remington, 2004; Warwar, Links, Greenberg & Bergman, 2008).
The clinical pattern to be managed is the sum of BDP and SUDS.
BDP is a very acute "borderline" condition, where emotional instability, mood, personality and self-image disorders make it difficult to distinguish between psychosis and neurosis.
Among borderline disorders, BDP is well distinguished because it requires frequent actions of containment and crisis solutions from the services. The patient has little control on emotions which disturb his relationships and his self-identity, causing a condition of impulsiveness (Lieb, Zanarini, Schmahl, Linehan & Bohus, 2004; Stone, 2000; Stone, 2005).
BDP is often associated to drug and alcohol use. In DSM IV-TR (American Psychiatric Association, 2002) the pathological use of drugs goes under the name of SUDS (Substance Use Disorders).
There are different theories about the relation between BDP and SUDS as to underline that the use of drugs is a way to fill the sense of "emptiness" this type of patients feel inside (Correale, Alonzi, Carnevali, Di Giuseppe & Giacchetti, 2001) and/or that drug abuse calms the emotional chaos and a behaviour almost unbearable (Linehan, 1993a, 1993b; Liotti, 2001).
Patients with BDP and SUDS are increasing in number (Trull, Sher, Minks-Brown, Durbin & Burr, 2000; European Monitoring Centre for Drug and Drug Abuse, 2004), a finding confirmed by the number of patients taken in charge by PDAS and TC in Italy (Fioritti & Solomon, 2002; Mosti & Clerici, 2003).
In the current literature we find two main position about the patient's management:
One states that BDP and SUDS are recognizable by ambivalent-personality disorder and aggressiveness (self-harm and suicide), by multiple addiction and a high rate of relapses and dropout. The therapeutic relationship is consequently quite unstable and motivation to the treatment is low (American Psychiaric Association, 2001; Chiesa, Drahorad & Longo, 2000; Compton, Cottler, Jacobs, Ben-Abdallah & Spitznagel, 2003; Fioritti & Solomon, 2002; Gunderson, Daversa, Grilo, McGlashan, Zanarini & Shea, 2006; Haro, Mateu, Martinez-Raga, Valderrama, Castellano & Cervera, 2004; Martinez-Raga, Marshall, Keaney, Ball, & Strang, 2002; Robins & Chapman, 2004; Ross, Dermatis, Levounis & Galanter, 2003; Senis, 2005; Skinstad & Swain, 2001; Zanarini, Frankenburg, Hennen, Reich & Silk, 2004).
According to that, BDP and SUDS patients need a special treatment (Ball, 1998; Ball, Richardson, Connolly, Bujosa & O' Neall, 2005**;** Bellack et al., 2006; Bornovalova & Daughters, 2007**;** Dimeff & Linehan, 2008**;** Linehan, 1993a, 1993b; Linehan, Dimeff, Reynolds, Comtois, Welch, Heagerty & Kivlahan, 2002; Liotti, 2001**;** Manzato & Fea, 2004; Mosti & Clerici, 2003; Pasudetti, Callegari, Bacchin & Fiorin, 2005; Trinciarelli, Damiani & Zane, 2004).
The second position, on the other hand, states that BDP and SUDS patients do not present particular problems during the treatment and therefore do not need a special treatment (Ralevski, Ball, Nich, Limoncelli & Petraski, 2007; Van den Bosch, Koeter, Stijnet, Verheul & Van den Brink, 2005; Van den Bosch, Verheul, Schippers & van den Brink, 2002; Verheul, van den Bosch, Koeter, de Ridder, Stijnen & van den Brink, 2003).

Aims

On the basis of the difficulties emerged from the literature, this study aims at analyzing the various approaches to the care of patients with BDP and SUDS, focusing on the following areas of research:
- Diagnosis procedures;
- Definition of the substances mostly used by patients suffering from BDP and SUDS;
- Patient's perception of the substances;

- Main take in charge strategies and therapeutic planning employed in the treatment;
- Specific problems in the thetapeutic relationship and difficulties encountered by the professionals.

Methods:

Participants: 15 subjects, of whom 8 people are working at a PDAS and 7 people working in a TC.
Instrument: A semi-structured research interview, recorded, transcribed and then analyzed by means of a computer assisted content analysis (software Atlas.ti), based on Grounded Theory.
The interview has gathered data in the following areas:
1. Diagnostic information and assessment instruments employed.
2. Motivations for substance use, the perception of the therapist and the statements of the patient.
3. Patient's take in charge and possible differences when BPD and SUDS.
4. Problems related to the treatment, the therapeutic relationship, relapses and drop-outs.
5. Problems encountered by the therapists when taking in charge BDP and SUDS patients.

Outcomes:

Here below are the topics arising from the interview, divided into macro areas:

Diagnosis:

It emerges that the diagnostic assessment is a long and complex process, often revised by the therapist. All the interviews, except one (a TC operator), has reported a diagnostic assessment of the patients before entering the service. Most PDAS operators, who have been interviewed has declared the use of diagnostic assessments (MMPI in specific), together with the clinical interview.
It is also observed that PDAS don't have a single assessment, but keep monitoring the patients after they have been taken into care:

There isn't just one admission assessment, patients are periodically monitored by our staff (PDAS 5, 7)[1].

This intake interview seems to be more relevant when carried out within a TC, even if, in some cases, the structure makes it more like a motivational interview than a clinical one.
TC have a variety of evaluation tools for the patients and some clearly refer to the report sent by the service approaching the patient first:

We have intake interviews with each person who want to start our recovery program. Such phase represents a kind of filter: during the interview the operator begins to know the patient and collect information about him/her and he detects psychopathological elements in the personality. Patients also come with a report from the PDAS referring them (TC 7, 6).

Substances used:

11 interviews out of 15 (6 PDAS and 5 TC) show multiple addiction among patients.
Within PDAS the use of heroin is prevailing, though such aspect could be influenced by the access procedure to this kind of service which has been addressing more and more people with such problems through the year:

[1] For each quotation it is reported the group of participants (PDAS or TC), the reference number of the interviewed participant and the line of the quotation).

"The substance mostly used is heroin, though that could be influenced by the access procedure to this kind of service, mainly addressing this type of patients" (PDAS 8, 10).

TC present a wider range of patients who, besides heroin also use cocaine.

….certainly cocaine, which itself, affect social life: increases aggressi
veness, causes psychic alterations…The problem is growing fast, we're planning to start a specific program for these people taking cocaine (TC 6, 9).

Motivations for the substance use

The substance is mainly used as a "self-therapy", to fill the sensation of inner "emptiness" as well as to calm the emotional ups and downs, to enhance sensations and also to be able to face problems concerning relationships, in such a way that the use shows a shift through the years:

… in the 70's , people were aware of their "malaise" and substances were used as sedatives. From the 90's on people have felt a sort of restlessness but thought that as a normal condition in life, in other words they're not aware of their "malaise" and are in pursuit of a well being condition through strong emotions (TC 6, 11).

Most PDAS operators report that the answer they are frequently given is "fill a sensation of emptiness".

They are characterized by a constant restlessness. They are people in search of inner peace and deceive themselves, believing they can find it by annihilating their sensations. They tend to sedate sensations because too strong to bear (PDAS 2, 12).

….This sort of patients are troubled, restless and they feel a constant need to fill the sense of inner "emptiness" and the drug is a way to relieve that (PDAS 4, 12).

The motivations patients give are hardly ever clear. They loose awareness of them, especially after a prolonged use of substances (PDAS 7, 16).

Operators also refer about "incidental causes" that seem to have caused the "need" for the drug.

They usually talk about unfortunate events as the family, unsuitable friends or unpleasant life experiences (PDAS 1, 14).

Some operators in TC talk about the "exaltation of sensations".
Such findings can be explained because of the different types of patients into care in the two services. The "recreational" use of the substance along with the attempt to "solve" relational problems is also underlined.

Patients refer to use drugs among friends in 99% of cases: they talk about a " convivial" use of the substance (TC 3, 14).

These substances are used to overcome problems within a relationship. That's quite a critical aspect of borderline patients (TC 3, 12).

Among the reasons for drug abuse the participants report, we find "calming the emotional ups and downs" and "being able to face relational problems".
The reasons for the substance abuse, go from "not being aware" to incidental events, to self-healing.
The "lack of awareness" is reported by the totality of the operators working in PDAS, who usually don't have daily contacts with the patient.

On the other hand “incidental events” and “self-healing” are the reasons more often reported by operators in TC, who also state: such patients prefer to be marked as drug addicts than as psychiatric patients:

....patients mainly report the sensation of pleasure and the state of well-being given by the drug, often described as “hot substance” (TC 2, 14).
.... to them the substance works as a medication, they prefer to belong to the drug addicts group than to the psychiatric patients one (TC 7, 14).

Treatment approaches

Two types of approaches for patients treatments emerge:
An undifferentiated take in charge, more related to the single patient's case and the available resources then to the diagnosis. According to such approach, DD patients do not receive any special care as such and their treatment doesn't differ from that for other disorders. That is stated in 1/3 of the interviews, mainly in the patients’ care given in PDAS:

...Both pathological conditions are treated at the same time. The treatment is pharmacological as well as psychological, with sessions directed to the patient and to the family. “Dual diagnosis “ has a more intense treatment with more frequent sessions and more than one operator working with the patient. The therapy provides support to re-integrate the patient into the society (PDAS 6, 17).

The second is a specific take in charge for patients with both disorders (BDP and SUDS): a treatment more related to the specific diagnosis. In such case patients receive special attention, treatment is well planned and customized and more resources are allocated (in terms of number of professionals taking care of the patient, number of sessions and various activities planned for him). This treatment pathway is carried out in the majority of cases:

The treatment pathway is established by the resources the patients finds within himself and in his environment more than by the psychopathological diagnosis. In general the service rely on a team of professionals and nursing staff who work with the patient during the therapeutic treatment. Nevertheless the presence of a psychopathology can implement the resources, in particular a psychologist Mental Health Services and TC (PDAS 7, 21).

The above treatment pathway is not exclusive of BDP and SUDS patients but includes all cases that present a co-morbidity of psychiatric disorder and substance abuse/addiction.
The services that offer a specific take in charge of patients, report pharmacological treatment along with individual psychological support and a side support called “psycho-social” including a group and family therapy.
One of the centres also reports to be available for a therapeutic follow-up after the completion of the treatment.
The work done in TC is more interlinked in comparison with PDAS and it tends to integrate the different treatment offered to the patient.
In PDAS it’s more common a clear separation between pharmacological treatment and psychiatric treatment (mainly delegated to the MHD).
When approaching such disorders in co-morbidity, the centres face many difficulties about the path to follow: they need to open a dialogue while their organization doesn’t include any networking or cooperation among themselves.
Moreover the kind of patients have changed through time and rehabilitation programs have been adjusted accordingly.

Until recently we’ve held session with the family, following a systemic approach, while now such activity has been suspended and it would now be quite hard to do because such patients often don’t have a family or, if they do, the parents are quite old and are not so keen to discuss certain issues (TC 4, 17).

Truly speaking, the distinction between the two different types of patients is less and less marked, since people suffering from drug abuse disorders only are becoming rarer… Probably that also

depends on the fact that TC have also developed good diagnosis skill…The substantial improvement obtained through the years is due to the good practise of the operators who have been able to develop very customized treatment pathways which take into account the patients inner resources and the goals to be attained (TC 7, 19).

Difficulties

The last part of the interview analyzes the main problems encountered in the treatment of BDP and SUDS patients which can be grouped in the following areas: therapeutic relationship, relapses, drop outs and operators' difficulties.
In particular the therapeutic relationship, appears to be the most complex, without substantial differences between TC and PDAS
1/3 of the operators talk about "mood swings" when referring to the patient's mood disorders, going from euphoria and restlessness to despair, rage and inward and outward aggressiveness.
They also report another typical element of BDP in the relation with others: the modality of idealization and rejection and the relation with the other goes from highly idealised to devaluation.
Relapses and drop out: the vast majority of operators working in both type of centres refer to relapses and drop out as a big obstacle to the treatment. It's quite difficult for the patient to carry on with the treatment and these facts are probably connected, since the interviews usually refer to both.
In Fig. 1 and Fig 2 are displayed the "code trees" with contents outlined by PDAS and TC operators.

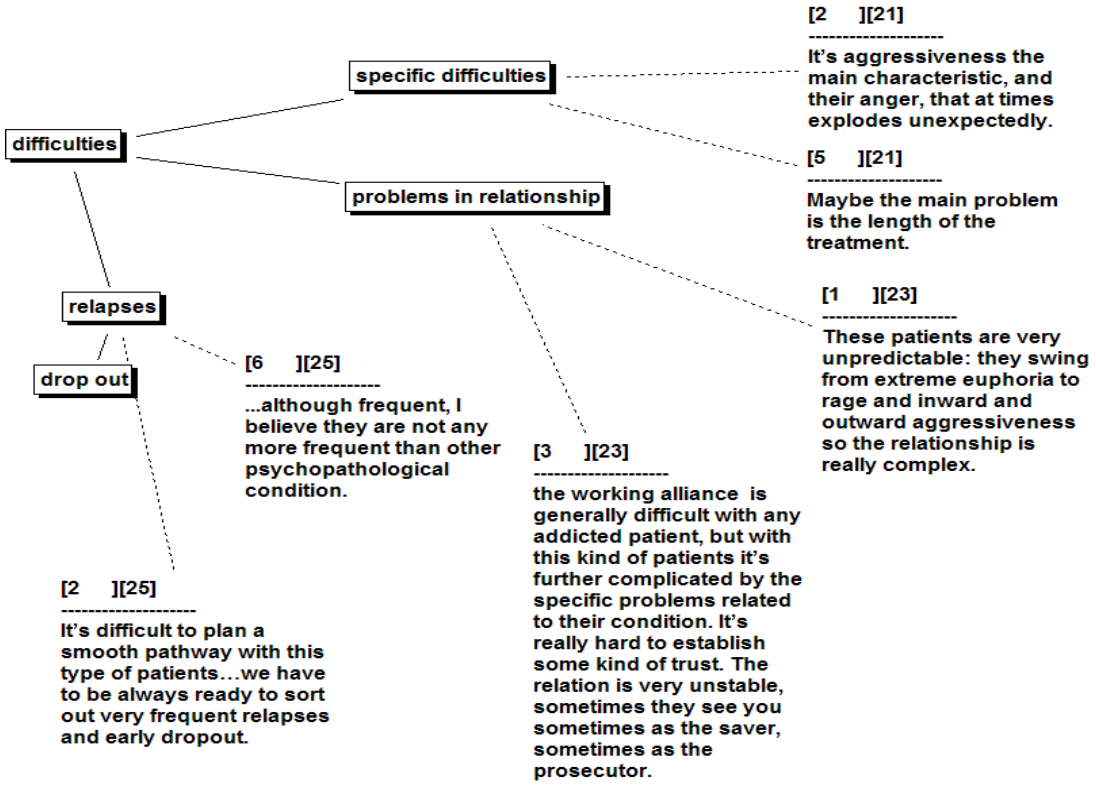

Fig. 1 – Perceived difficulties in the relationship with patients (PDAS operators)

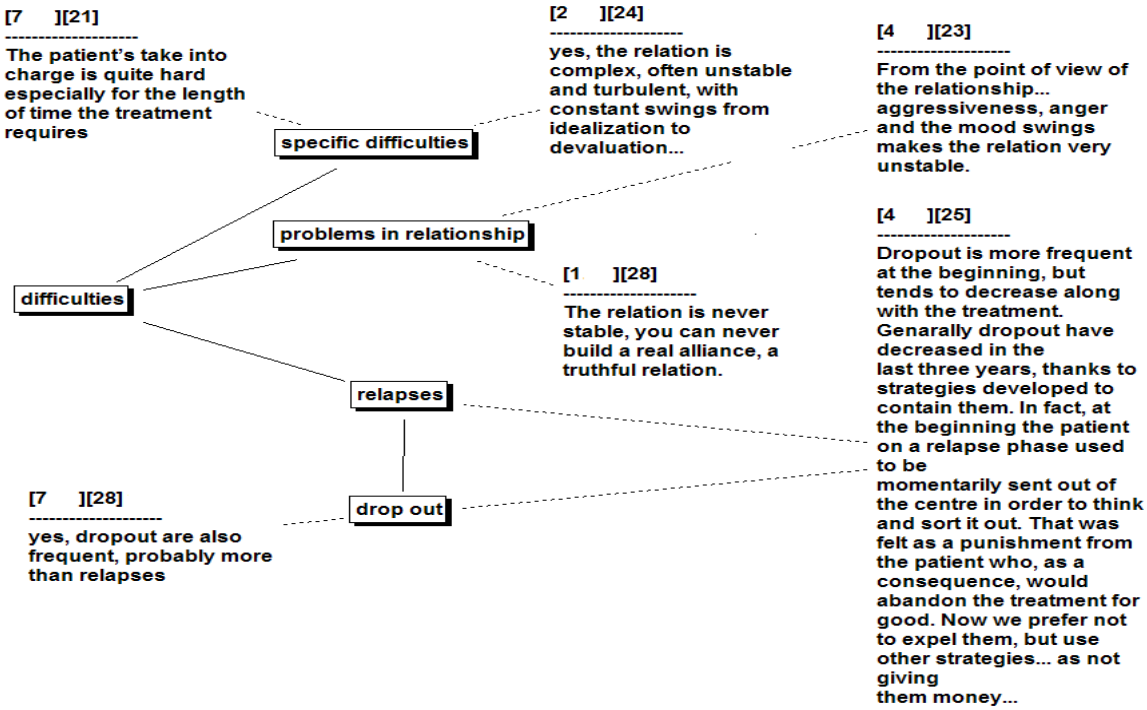

Fig. 2 – Perceived difficulties in the relationship with patients (TC operators)

Various difficulties from the operators side (Fig. 3 and Fig. 4) are highlighted in the majority of the interviews. A positive attitude of the therapist is fundamental for the treatment efficacy, but that is constantly challenged by the frequent relapses and dropout of the patient.

The answers given by the operator can be divided into three groups: a small number who declare they haven't encountered particular problems and they haven't found any differences in the treatment of BDP and SUDS patients.

About one third of the participants, both from TC and PDAS, underline a fear for failure and not being able to bring the treatment to a successful outcome.

The majority talk about de-motivation: they know about the high rate of failure, so they seem not to be so keen to take in charge of this type of patients. Such attitude is more common in TC.

Structures offering specific treatment pathways for BDP and SUDS patients seem to have more relapses and dropout compared to those offering an undifferentiated one as well as a lower level of motivation among operators. Said that, it doesn't necessarily mean that undifferentiated treatments works better: it could mean that where the pathway is specific a more accurate analysis of the problems is also carried out.

TC operators also highlight the emotional involvement of the staff working with such patients: it shows the deep relation between patient and therapist but, at the same time, it makes the work very difficult if not properly analyzed and solved.

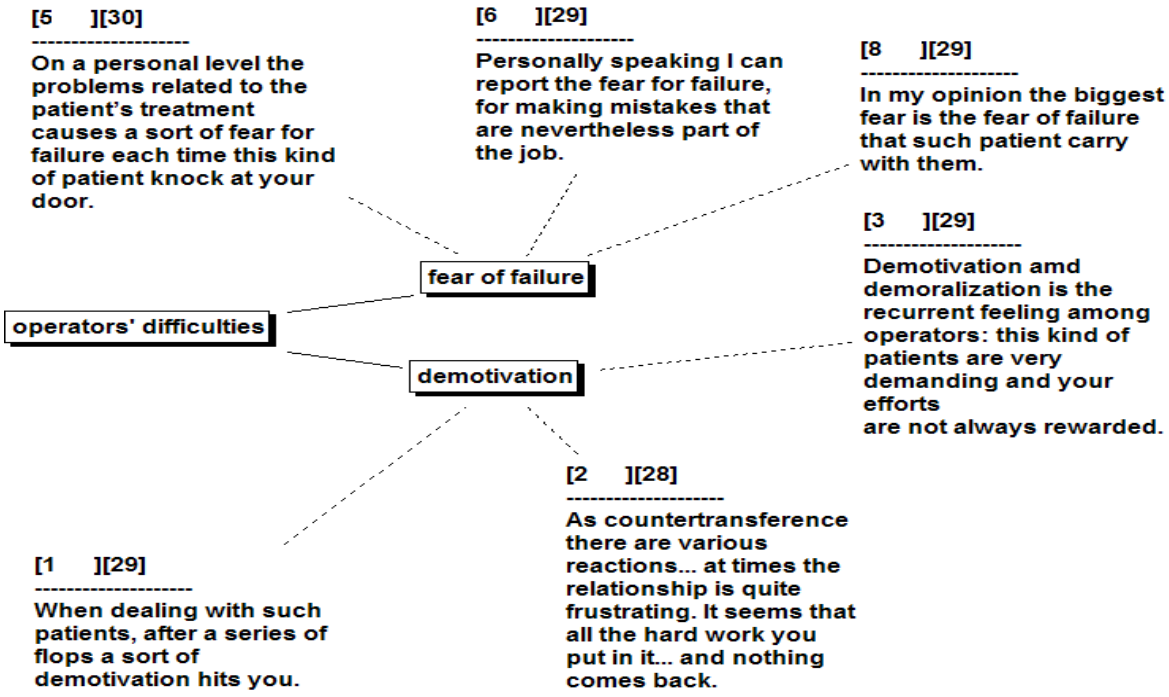

Fig. 3 – Operators' difficulties (PDAS)

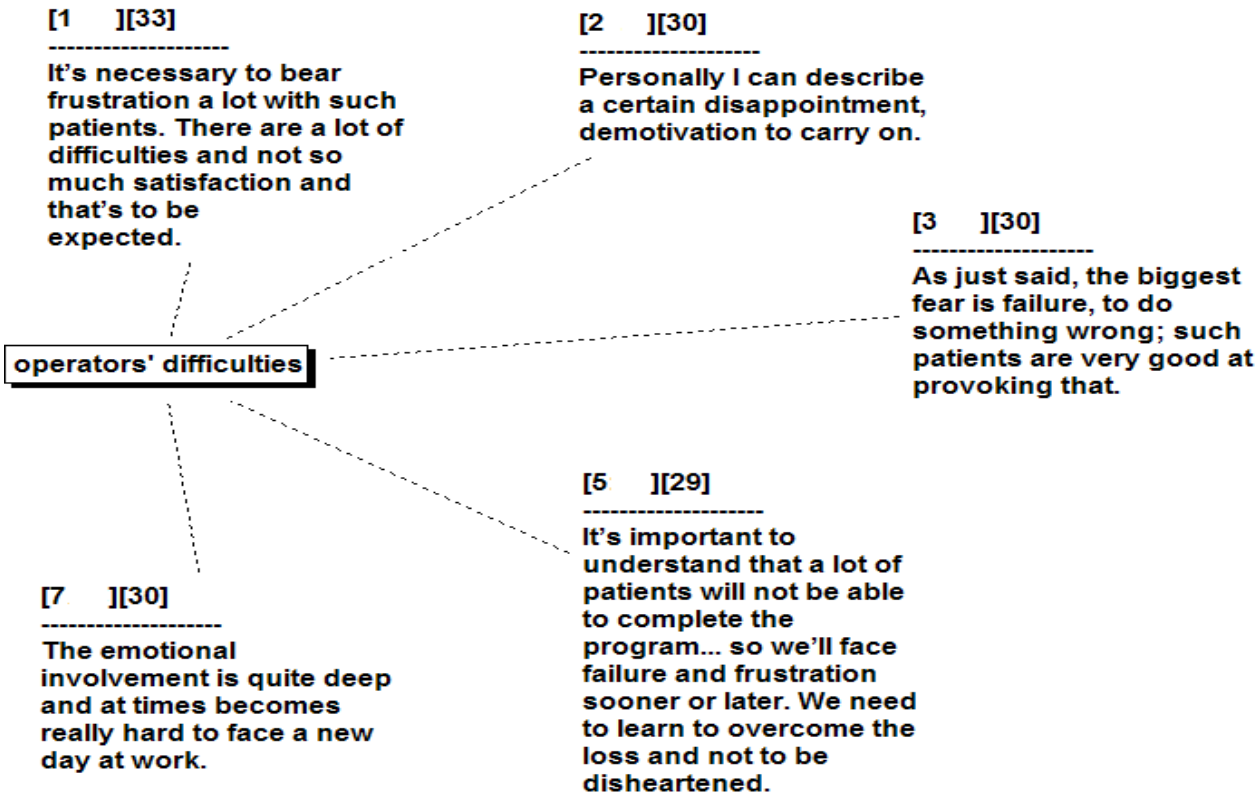

Fig. 4 – Operators' difficulties (TC)

Discussion and conclusion

According to literature (Fioritti & Solomon, 2002; Hasin et al., 2006; Manzato & Fea, 2004; European Monitoring Centre for Drugs and Drug Abuse, 2004; Torres, 2008), diagnostic assessment is extremely important for the patients' take in charge and requires various quantitative and qualitative instruments.

Substances are used in order to fill a sense of inner “emptiness”; such finding can be connected to the operators educational background (mostly psychodynamic).
Borderline patients seem to use not only a single substance but more at the same time. Multiple addiction becomes a fundamental piece of information when giving a prognosis and planning the treatment pathway, in particular it makes the treatment outcome less certain (Senis, 2005; Skinstad & Swain, 2001).
There are also other problems emerging: the treatment becomes difficult for its length, relapses and dropout as well as the quality of the therapeutic relationship.
The majority of the operators talk about their fear of failure and de-motivation in getting involved in this sort of treatment. In accordance with what emerges from the literature relapses and dropout are related to de-motivation in 12 interviews and that might be detrimental to the outcome (Drake, 2006; Drake et al., 1998; Drake et al., 2007; Fiorin & Citron, 2005; Fioritti & Solomon, 2002; Manzato & Fea, 2004; Mosti & Clerici, 2003).
The two variables get into a vicious circle: the therapist, already de-motivated and being aware of the hard work, start a treatment and such de-motivation increases further the chances of failure, which in turn, causes further de-motivation in the therapist. On the other hand therapists are easily affected by working with patients who are so heavily marked at a social level.
In spite of all that, a model of therapeutic planning is still to be developed. There isn’t any specific pathway but it is adjusted from a specific treatments, without any special care.
Ten cases applying specific patients treatments also report the highest rates of relapsed and dropout. As paradoxical as it seems it can be explained with a metaphor by Cicogni (2004): health structures tend to get rid of “difficult cases” as a player tend to get rid of “worthless cards”. The reason for it might lie in the fact that such patients with very specific needs, prone to relapses and hardly able to start treatments, are sent to these services where there aren’t enough resources, adequate training and the right support for the operators working in them.
Two treatment approaches are observed within the two different types of structures: PDAS and TC. In Italy the constant changing of law has caused an increasing distance between psychiatric services and drug addiction services: in fact the distinction has become about the treatment approach. PDAS work mainly with pharmacological intervention, while TC work with psychotherapy, educational and social approaches and they enhance one aspect of the approach or another. Few differences emerge from the two services.
PDAS have a more homogeneous group of users, more frequently attended by opiate abusers; a smaller variety of proposed treatments, for the most pharmacological treatments, even though combined with a psychological take in charge (not always followed by the patient) and a tendency to keep separated the addiction treatment from the psychological/psychiatric intervention, mainly given by the MHD.
TC have a more heterogeneous group of users, who consume not only heroin but also other substances, usually cocaine, or who are multiple addicts; the proposed treatment are more customized with a wider range of psychological and psycho-social intervention, a greater willingness to follow the patient even after the treatment and a kind of taking in charge paying attention to integrated interventions.
TC perceive relapses and drop out in a different way. Patients expelled from other services because too difficult to deal with are followed step by step and relapse is seen as a condition that need a stronger and more accurate treatment and not only as the cause of the expulsion from the programme.
Such approach might easily produce better outcomes than PDAS (Mosti & Clerici, 2003).
In conclusion, it is important to think about some issues:
the take in charge and the treatment pathways need to be differentiated according to the diagnosis; developing different approaches that go further the pharmacological treatment, at present the most spread; promoting integrated patient’s caring and networks PDAS and TC; helping and supporting patients for a long time, because of their psycho-social marginalization.
Operators’ need for specific training as well as psychological and methodological supervision in order to avoid burn out.

The present research shows some weaknesses, in particular regarding the specific region where it has been carried out. Although such area represent a paradigm for the services offered and for their networking, it is generally different from facilities in other regions, and so it would be interesting in the future a comparative research in other social background.

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