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New Strategy Against

Addiction

by LILLIAN POMPIAN

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How the Medical Counseling Clinics of Chicago are bringing their patients back to useful citizenship after they are withdrawn from narcotics.

New Strategy Against DRUG Addiction

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TWO years ago an attractive 32-year-old woman entered the office of a new clinic in Chicago. A drug addict, she had had physical withdrawal several times, but each time she'd returned to drugs for emotional reasons. Now, unemployed and separated from her husband, she'd been resorting to prostitution to make enough money for the growing amounts of heroin she needed. Her desperate desire to overcome her drug habit and change her way of living had brought her to the clinic.

Reared in a small, rural community, in a stern, restrictive family, she had married in the hope of emancipating herself. But her marriage to an inadequate, delinquent husband was unhappy with physical abuse and frequent desertions. She had been introduced to narcotics through her husband and his friends, mostly to belong to the crowd, but later she couldn't overcome her craving for them.

Following a complete diagnosis that included physical, laboratory and psychological tests, Mrs. G. was

assigned to a psychiatrist. The tests showed that although she was an intelligent young woman, Mrs. G. had an unbearably painful impression of herself as an unattractive, inferior person, unworthy of the respect of others. This underlying feeling, along with personal and circumstantial problems, had contributed to her susceptibility to drugs.

In three months the psychiatrist helped her gain new insight into her feelings and behavior, encouraged her to attend business school and to secure an office job. This developed her self-confidence to such an extent that she no longer needed to depend on drugs for fleeting and illusory relief. She is still employed by the same company, has had several promotions, and has become a productive part of her community.

Mrs. G. is only one of 900 drug addicts who have passed through the unique Medical Counseling Clinics of Chicago, the first of their kind in the world, with a new approach to the problem of drug addiction. Founded in 1951 as a result of dynamic action by Dr. Leonidas H. Berry and an aroused community, the clinics stirred world-wide interest when they were discussed at the World Health Conference in Geneva, Switzerland. Detroit, Dayton, Philadelphia and other cities in the United States sent representatives to study methods being used in the clinics, as did Vancouver and many other cities in Canada.

Financed in 1951 by an act of the Illinois legislature, the clinics have three outpatient branches—at Provident Hospital, at Northwestern University and at the University of Illinois. Though the branches are autonomous and differ slightly in their method of handling patients, their general concept of the drug addict is the same.

"We insist that the drug addict is an emotionally sick person—that drug addiction is an illness with some physical manifestations, but primarily a personality disorder," said Dr. Walter A. Adams, psychiatrist and director of the Provident Clinic. "We find that our addicts have emotional tensions which grow out of frustrations. The normal individual would solve this by seeing a doctor or by some normal activity. These people turn to the drug."

Through their physical effects drugs temporarily relieve addicts of their fears, frustrations and other discomforts. They are made less aware of their basic inadequacies. An unrealistic sense of security is temporarily attained.

In the past the emphasis in the treatment of drug addicts has been on the physical aspect of their illness. At the United States Public Health Hospital in Lexington, which now also specializes in the rehabilitation of drug addicts, patients formerly received only withdrawal treatment and physical care. Yet it has been estimated that four out of five of these people returned to the use of drugs three to five months after the best institutional care. Proponents of the Medical Counseling Clinics feel that getting the addict off the drug physically is not the important feature in cure.

A few patients can be shifted to another drug. For instance, if they take heroin, they can be shifted to methodone and then the methodone is withdrawn. There is less suffering before the addict is off it. "But," said Dr. Adams, "the great trouble is that if we have not reached the emotional problem, they go back on the drug, usually when somebody has made them angry or disappointed them."

Drug addiction is defined as a state in which a person has lost the power of self-control with reference to a drug and eventually hurts himself or society through its use. There are usually three stages in drug addiction: the development of tolerance, physical dependence and habituation.

If a person uses a drug for some time he develops a tolerance so that he must have larger amounts to get the same effect he had when he took less. Dependence is expressed in physical changes in the body, in the metabolism and the way the organs work. If he stops taking the drug at this point he is sick and in pain. Finally, there is the habituation which amounts to psychic dependence.

Drug addiction occurs in men and women of all ages, in any race, in slum dwellers and in professional families. But there is always a quirk somewhere in the family relationship. Many addicts are from homes broken through divorce, separation or death. They are unwanted, insecure and lacking in status. The same typical home instabilities are peculiar to nonnarcotic delinquents. The only generalization to be made about these families is that they are of the types which produce maladjustment.

Even where the parents are still living together, their relationship is often poor. There may be habitual bickering. Often the father plays a domineering, controlling role, with the mother in open or subtle conflict with him, enlisting the children on her side. Or the father may be weak and ineffectual, held in disregard or contempt.

"With young people, taking drugs is often a device for getting attention or for being part of a group, even if it is an antisocial group," said Dr. Lee Sewall, formerly of the Northwestern University branch of the clinics. One such case was that of a young man who came to the clinic at the suggestion of a friend who was also coming. An only child from a middle-class family in a residential community, he had completed two years of college. Though his parents provided well for him, they gave him little love or personal attention. As a result he grew up feeling inadequate and insecure.

In high school he began to associate with boys who considered it smart and daring to take drugs. Being part of this group gave him status and recognition. Before he knew it, he was "hooked."

When he came to the clinic, he'd had withdrawal but was struggling with his emotional need for narcotics and felt in danger of relapsing. Through visits to the clinic for about eight months he gradually began to feel he could get along without drugs. After a few tries he was able to secure the kind of job he wanted and find new friends and new interests. He learned that satisfaction and recognition can be gained without such a destructive device as drugs.

For years drug addiction was treated as a police and lower courts problem, since most addicts were eventually reduced to crime to pay for drugs. Dr. Berry had long felt that drug addiction was a "symptom of psychological tension"—that it had "organic aspects, social aspects and psychological aspects." Associated with Provident Hospital, in a neighborhood where many of the addicts are, Dr. Berry was one of the first to sound the alarm of the epidemic spread of drug addiction among teen-agers and young adults in the city.

He found that no adequate treatment had been de-

veloped for nonhospitalized drug addicts. Clinics that had simply dished out drugs had failed. The treatment obviously wasn't enough as shown by the high relapse rate.

Dr. Berry drew up a plan for a new type of clinic that would treat the total human being, not just the part of him that was addicted to drugs. He invited other doctors including psychiatrists, judges, police officials, social and welfare workers to a meeting where they could discuss and criticize his plan. At subsequent meetings the crime prevention bureau and medical officers of Lexington Hospital teamed up with the original group to offer suggestions and advice. Called the "Berry Plan" by newspapers, the idea gained impetus, until a committee was formed under the auspices of the Cook County Physicians' Association to sponsor in the state legislature a plan of "Medical Counseling Clinics" for narcotic addicts. The result was a law establishing three outpatient clinics and appropriating funds for the program.

The clinics are not designed to treat those actively using narcotics. Such people are referred to Lexington, and assured of assistance when they leave the hospital. The primary intent of the clinics is to carry out more effectively rehabilitation of people who have had withdrawal treatment in hospitals, penal institutions and elsewhere. The program is aimed at reducing the relapse rate after institutional care.

The name Medical Counseling Clinics was chosen instead of Narcotic Clinics or Dope Clinics so addicts would feel they were losing their identity among other sick people. Some patients come in voluntarily, referred by physicians or social and welfare agencies, others come at the instance of courts, parents or friends. Many are forced in by difficult economic conditions. The clinics' own clientele are often their greatest boosters. An interesting development has been the considerable number of self-referred patients.

After a patient is admitted to the clinic, he has a complete checkup. Physical and laboratory examinations are given as routine, and the patient is treated for any medical problem. He has the services of psychiatric social workers, psychologists and psychiatrists along with vocational guidance. At the Northwestern branch a psychiatrist treats the patient directly. At Provident the patient is assigned to a psychiatric social worker who stays with the case and periodically presents his findings to a psychiatrist in a staff meeting. The feeling at Provident is that the patient will establish a relationship with his caseworker and learn to trust him.

"Addicts often doubt the sincerity of those who want to help," said one caseworker. "Several visits are sometimes necessary to establish a satisfactory relationship." Once this trust is established the caseworker, whether he is a psychiatrist or psychiatric social worker, tries to meet the immediate needs of the patient. Does he want a job? Need decent housing? Is a member of his family ill? The patient may not be receptive to treatment if he has problems of this sort.

As Dr. Adams said, "When the drug addict asks you for something, usually you have to go about trying to get it for him. While you are doing it, then you can say, 'What about this addiction?' But if you say, 'Remember you came here for addiction, and we will get around to getting your wife in a hospital,' then he is gone."

What a warm, personal relationship with a caseworker can do was shown in October, 1954, when four young addicts who had been cured through treatment at the Provident Clinic appeared before the Senate Subcommittee to Investigate Juvenile Delinquency as witnesses for Dr. Adams, who was asking for federal aid in establishing other clinics.

Lawson J. Ford, psychiatric social worker, had treated all four of these cases. As each one told his story,

the same vicious pattern appeared. From broken or unhappy homes, the boys had started smoking marijuana in their early teens and eventually switched to injections of heroin. As the need grew for larger quantities of narcotics, they had resorted to theft and other crimes. One of them said, "During that time I did not have my right mind because as a dope addict you lose control of your mind. You don't know what you have done. If somebody lifts you up and gives you a hand, you can make it. Mr. Ford was mighty nice to me. He wanted to find out my background and what caused me to use drugs."

When asked why he had kept coming back to the clinics, he said, "Because Mr. Ford made me feel he wanted to help me. He was interested in me. Somebody really has to get behind you and show you that you're wanted." This man has not taken drugs since January, 1953, is working in a church and taking religious instruction in the hope of becoming a minister.

A 26-year-old addict who had taken physical withdrawal at Lexington four times and relapsed each time said, "I just used to drift back to the old gang. I thought I could take a 'pop' without getting hooked but couldn't. Everyone had lost confidence in me including myself. He showed me I could take a different outlook and everybody who is against me because I was a drug addict is not necessarily so."

Another young man who had been cured said, "There are a number of addicts who want to be helped. They want to stop but don't know how. This clinic is the only one I know that gives proper time to addicts."

The staff of the clinic feels it is gauged to the special needs of the drug addict—to his special immaturities. "We are not saying that we cure all of them," Dr. Adams said, "but we get a reasonable percentage of cures."

THE work of the clinics has been recognized and widely approved by people in other fields. Recently an evaluation was made by a citizens' advisory committee—judges, doctors, psychiatrists and social and welfare agencies. Their appraisal was, "The Medical Counseling Clinics provide a needed resource in the community. A substantial number of former addicts are now off drugs, are no longer getting on police records, and are employed."

A judge of the narcotics court said, "They have had a sufficiently good result with enough cases to show what can be done."

Medical research is an important aim of the clinics. Studies of the nature and mechanism of present-day addiction and development of new techniques for reducing the rate of return to drug use are being investigated. Another point in the clinic plan is a medical prevention program. This is being directed toward school-agers and those slightly older who may be using marijuana cigarettes and occasionally stronger drugs. Ultimate control of the drugs at the distribution level is the hope of those who have observed the ravages of narcotic addiction.

IT has been reliably estimated that a drug addict costs the community $10,000 a year in drugs, in crimes committed and time spent in jail. Therefore, rehabilitation represents a financial as well as human gain.

One former addict cured at Provident wrote to his caseworker, "I sincerely hope this letter will find you in the best of health. As for myself, I couldn't be any better off. For God has put his arms around me, and you can believe me when I tell you that I am happy. You see, I was dead and now I am alive. I found that some people really do care."

Such cases make the proponents of the Medical Counseling Clinics feel that they can show a much larger proportion of redeemable victims of drug addiction among the youth of our times.

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