TREATMENT OF THE NARCOTIC ADDICT

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1. THE TREATMENT OF DRUG ADDICTS AS VOLUNTARY OUTPATIENTS: A PROGRESS REPORT

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THIS is a report on the first year of a research project undertaken to study the problems arising from the treatment of drug addicts outside of a hospital setting. Such a research seemed useful in view of the lack of extended experience with such a procedure, and the unwillingness of both private practitioners and community facilities to receive drug addict patients.

Reports from the United States Public Health Service hospitals specializing in the treatment of narcotic addiction show a relatively high rate of recidivism and a relatively low rate of successful cures.[1] Under conditions of hospital confinement, the relief of patients from physical dependency on narcotics has become routine, but the treatment of the psychological and emotional factors associated with the drug habit has proven more difficult. Treatment is frequently undertaken under court orders and, even in the case of voluntary commitments, requires a serious dislocation in the life of the patient, who must travel great distances from home and remain confined in an institutional environment with a drug addict population. Though receiving medical attention for his physical requirements he is often not provided with an opportunity to undergo intensive individual psychotherapy.

Opinion about the effectiveness of psychotherapy for the treatment of drug addiction is exceedingly pessimistic. Earlier reports have suggested that

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[1] Michael J. Pescor, *Follow-Up Study of Treated Narcotic Drug Addicts*, Publ. Hlth Rep., Suppl. No. 170, 1–18, 1943; and *Prognosis in Drug Addiction*, Am. J. Psychiatry, 97: 1419–1433, 1941.

the drug addict is not a suitable candidate for psychoanalysis.[2] It is also frequently said that drug addicts can best be treated in an institutional setting after physical withdrawal from the drug has been accomplished.[3]

In 1951 and 1952, outpatient clinics for the treatment of drug addicts were opened at Provident Hospital in Chicago, Northwestern University Medical School, and at the University of Illinois Neuropsychiatric Institute.[4] Scattered reports of individual treatment on an outpatient basis have appeared in the literature, and successful experiences by some analysts in private practice have been reported.[5] Emerging from these new experiences is a picture of the drug addict that differs considerably from the popular stereotype.[6] Several basic questions have been opened that require further examination.

The present research addresses itself to several specific questions: 1) Can drug addicts be treated on an ambulatory outpatient basis or must they be institutionalized in order to be treated? 2) Can drug addicts be treated on the same basis as other patients in private practice and community clinics? 3) Can drug addicts be treated psychotherapeutically while still using drugs? 4) Are any special hazards involved in treating drug-addicted patients? 5) Will drug addicts present themselves for treatment voluntarily if afforded the opportunity? 6) Should present community resources be opened to drug addicts, as they are to other disturbed persons? 7) Can drug addicts be treated by psychoanalytically trained psychotherapists?

Description of the Project

The Narcotic Addiction Research Project staff consisted of 30 professionally trained psychotherapists: 7 psychiatrists, 11 psychologists, and 12 social workers. Their minimum qualifications included a graduate degree, four years of postgraduate training and experience in the treatment of emotionally disturbed individuals, a background in psychoanalysis, and a personal analysis.

Intake procedure. Each prospective patient voluntarily telephoned the project's intake psychiatrist for an intake interview, and had an initial interview with the intake psychiatrist. The data obtained during the initial inter-

[2] Otto Fenichel, *Psychoanalytic Theory of Neurosis* (New York: Norton, 1945), pp. 375–380.

[3] Abraham Wikler, *Clinical Aspects of Diagnosis and Treatment of Addictions*, Bull. Menninger Clin., 15: 160, 1951; H. F. Fraser and James A. Grider, *Treatment of Drug Addiction*, Am. J. Medicine, 14: 571, 1953.

[4] Benjamin Boshes, Lee G. Sewall, and Mary Koga, *Management of the Narcotic Addict in an Outpatient Clinic*, Am. J. Psychiatry, 113: 158–162, 1956; also the Annual Reports of the Clinics.

[5] Robert A. Savitt, *Extramural Psychoanalytic Treatment of a Case of Narcotic Addiction*, J. Am. Psychoanal. Ass., 2: 494–502, 1954.

[6] Marie Nyswander, *The Drug Addict as a Patient* (New York: Grune & Stratton, 1956), *passim;* Charles Winick, *Narcotics Addiction and Its Treatment*, Law and Contemporary Problems, 22: 29–30, 1957.

view included the following: name, age, sex, marital status, source of referral, occupation, education, name of drug used, status of addiction, previous addiction history, duration of addiction, and chief complaint.

If the patient indicated a desire for psychotherapy, he was given the opportunity to get in touch with one of the participating psychotherapists. The patient was responsible for arranging all further treatment interviews. Fees for treatment were decided by the patient and his therapist on the basis of ability to pay. No patient was refused treatment for purely economic reasons. There were no criteria of patient exclusion, and all patients who called were given an appointment for an intake interview.

Seventy persons made an initial telephone contact with the intake psychiatrist in the 10-month period from September 1955 to July 1956. The

TABLE 1. SOURCES FROM WHICH PATIENTS WERE REFERRED TO THE PROJECT

Source	*Number of Patients*
USPHS (unofficially)	18
Physicians	14
Social agencies	13
Narcotics Anonymous	12
Enforcement agencies	7
Hospitals	4
Unknown	2
Total	70

sample consisted of 51 males and 19 females, ranging in age from 18 to 58 years. The median age was 26. Twenty-seven were married; 33 were single; 4 were divorced; and the marital status of 6 was not recorded.

Patients were referred to the project from a wide variety of community sources as indicated in Table 1.

Forty-eight patients reported an active addiction status at the time they were interviewed. At the time of their initial contact with the project, 18 stated that they had not been taking drugs for periods ranging from three days up to one year. No data were available on the addiction status of 4 patients. Fifty-seven reported that heroin was their drug of choice, but some were addicted to barbiturates, Demerol, and other substances. (See Table 2.)

Disposition of patients. Of the original 70 intake appointments made as a result of the first telephone contacts with the project, 62 (88.5%) were kept. Two patients who failed to keep their first appointments telephoned for a second one. Thus 64 patients were actually seen for an intake interview. Of

TABLE 2. DRUG OF CHOICE AS REPORTED BY PATIENTS

Drug	*Number of Patients*
Heroin	57
Demerol	4
Barbiturates	2
Benzedrine	2
Dolophine	1
Unknown	4
Total	70

the remaining 6, one telephoned and canceled his appointment, while 5 did not contact the project again. (See Table 3.)

Nine patients declined psychotherapy. One only wanted advice on how to remain off drugs. Another declined because "I don't want to be here. I don't want to be cured." One declined because he was "going away for the summer. My father told me to come." Four patients came with the expectation of obtaining drugs for withdrawal and did not wish psychotherapy. Two patients preferred to attempt withdrawal by themselves, without psychotherapy.

Eight patients were referred to facilities outside the project. One Benzedrine patient was on parole from a state hospital and returned to the hospital. One barbiturate addict already in treatment with a private physician was referred back to the physician, who received instructions for withdrawal. Four patients requested referral to a hospital for withdrawal treatment. One patient in treatment with a community social agency was referred back to the agency, with appropriate instructions. One patient was

TABLE 3. DISPOSITION OF PATIENTS

Disposition	*Number of Patients*
Did not appear for intake interview	6
Declined psychotherapy	9
Referred to other facilities	7
Borderline intelligence (not suitable)	1
Did not contact therapist	10
Did not keep appointment with therapist	1
Contacted therapist but declined treatment	1
Effected initial interview with therapist	35
Total	70

regarded as unsuitable for psychotherapy because of borderline intelligence.

Forty-seven patients indicated a willingness to undergo psychotherapy, but ten of these did not contact the psychotherapist to whom they were referred. One patient telephoned the therapist to whom he had been referred but declined to make an appointment for treatment. Another patient made an appointment with a therapist but did not keep it. Thirty-five patients effected an initial contact with their assigned psychotherapists.

Results of Treatment

Duration of psychotherapy. Of the 35 patients who met with a psychotherapist at least once, 13 (37%) were in treatment at the close of the project's first year. More than half of the 22 who dropped out did so within one month,

TABLE 4. NUMBER OF MONTHS DROPOUT PATIENTS REMAINED IN TREATMENT

Duration of Treatment	*Number of Patients*	*Average Number of Visits*
One month	12	4
Two months	4	10
Three months	2	17
Four months	1	20
Five months	1	33
Six months	2	15
Median: 1 month	Total: 22	Median: 8 visits

and the remainder within six months. (See Table 4.) The initial dropout rate was high, but it decreased with time (cf. Tables 4 and 5).

Of the 12 patients who discontinued treatment within one month, one wanted drugs, 2 were arrested, and 9 showed such signs of poor motivation as failure to keep appointments, inability to pay fees (even 50 cents), and failure to contact the therapist. Of the 4 patients who discontinued after two months, one was withdrawn from drugs and expressed no further interest in treatment, one went to the U. S. Public Health Service Hospital at Lexington for withdrawal, and 2 were poorly motivated. Two patients who terminated in the third month entered hospitals for medical reasons. The patient who dropped out during the fourth month of treatment was arrested and sent to Lexington. After five months of treatment, one patient finally entered a hospital for withdrawal. One of the patients who discontinued psychotherapy during the sixth month voluntarily went to Lexington for withdrawal; the other was so poorly motivated that he visited his therapist only four times in the six months. (See Table 6.) Four patients of this

group were motivated sufficiently either to undertake voluntary withdrawal at home or to hospitalize themselves for that purpose.

Effect of psychotherapy upon drug addiction status. The first year of the Narcotic Addiction Research Project was primarily concerned with determining whether or not addicts would voluntarily apply for psychotherapy, whether they would stay in treatment, and what special problems, if any, their treatment entailed. The question of whether psychotherapy was an effective treatment procedure, the analysis of psychodynamics, and the examination of therapeutic techniques were deferred until the findings of the first year provided a basis for further research hypotheses. Extensive follow-up study and the setting up of objective measures of improvement were

TABLE 5. NUMBER OF MONTHS CONTINUING PATIENTS HAVE REMAINED IN TREATMENT

Duration of Treatment	*Number of Patients*	*Average Number of Visits*
One month	0	0
Two months	1	9
Three months	0	0
Four months	3	29
Five months	1	19
Six months	0	0
Seven months	0	0
Eight months	0	0
Nine months	1	40
Ten months	1	30
Eleven months	1	88
Twelve months	5	80
Median: 10 months	Total: 13	Median: 35 visits

not practical and not within the limits of the first year's research objectives.

For the present, we shall have to be content with a summary of the available data on changes in status of addiction as reported by patients before and after contact with a psychotherapist.

Changes in addiction status occurred in both the dropout and the continuing patient groups. Tables 7 and 8 show that 16 of the 22 dropout patients acknowledged addiction during their intake interview, and 4 (25%) of these reported withdrawal or a decreased habit after contact with a psychotherapist. Of the 13 patients still in treatment, 10 acknowledged addiction in their intake interview, and all 10 have reported withdrawal or decreased habit to their psychotherapists. One patient who originally reported

TABLE 6. MANIFEST REASONS WHY PATIENTS DROPPED OUT OF TREATMENT

Reason	*Number of Patients*
Poor motivation	12
Arrested	3
Entered hospital for withdrawal	3
Hospitalized for medical reasons	2
Successful withdrawal	1
Failure to obtain drugs	1
Total	22

himself to be free of drugs began to use drugs occasionally after treatment began.

Addict patients' reports on their addiction status are perhaps best regarded with an attitude of cautious skepticism. No objective test of the status of addiction in our patients was possible. The patient's own report and the observations of the intake psychiatrist and the participating psychotherapist provided our data. On the other hand, some degree of confidence can be placed in the diagnostic ability of a psychotherapist with regard to his patient. Furthermore, the external signs of drug use in a patient soon become apparent.

The fact that 10 out of the 13 patients who are continuing in treatment reported a favorable change in their addiction status must be considered in the context of the total patient population of which they are only a small part. The 13 patients who remain with the project represent only 18.6 per cent of the 70 individuals who originally applied for treatment, and they are probably those who from the very beginning had the strongest motivation and the best prognosis.

Table 9 shows that more than 50 per cent of the 64 addicts seen by the

TABLE 7. CHANGES REPORTED IN ADDICTION STATUS OF DROPOUT PATIENTS

Intake Status	*Terminal Status*	*Number of Patients*
Off drugs	Off drugs	6
On drugs	On drugs	12
On drugs	Decreased habit	2
On drugs	Off drugs	2
Total		22

TABLE 8. CHANGES REPORTED IN THE ADDICTION STATUS OF PRESENT PATIENTS

Intake Status	*Present Status*	*Number of Patients*
Off drugs	Off drugs	2
Off drugs	Occasional use	1
On drugs	Decreased habit	2
On drugs	Off drugs	8
Total		13

project psychiatrist were, on last contact, either off drugs, in treatment, or seeking some means of withdrawal (18 of these were off drugs before they contacted the project). The lack of a control group makes it difficult to de-

TABLE 9. SUMMARY OF THE ADDICTION STATUS OF TOTAL PATIENT POPULATION AT THE TIME OF MOST RECENT CONTACT WITH THE PROJECT

Addiction Status	*Number of Patients*
Did not appear for intake interview	6
Addiction status unknown	4
On drugs	1
Off drugs	1
Declined psychotherapy	9
Unmotivated	1
Seeking drugs for withdrawal	3
Attempting withdrawal at home	2
Off drugs	3
Referred to other facilities	8
Hospitalized	5
In treatment with private physician	1
Back to referral agency	2
Did not see therapist	12
On drugs	9
Off drugs	3
Saw a therapist	35
On drugs	13
Arrested	2
Hospitalized (arrested)	1
Hospitalized (medical reasons)	2
Hospitalized (for withdrawal)	3
Off drugs	14
Total	70

termine how much improvement might have taken place if these patients had received no help, but there does seem to have been a significantly higher percentage of improvement in the group of patients who remained in treatment, as compared to the group who dropped out (see Tables 7 and 8). The reality and permanence of such improvement will have to be determined by further research.

Factors in Treatment

The drug-addicted patient. The traditional stereotype of the drug addict holds him to be a bad therapeutic risk. He is considered to be irresponsible toward treatment routines and is expected to make excessive demands, to break appointments, and to exhibit very poor motivation. These are some of the reasons for the general reluctance to treat drug addicts psychotherapeutically. Many regard addicts as potentially dangerous, criminal, and untreatable.

While our experience showed many addicts to be poorly motivated, not a single instance of hazardous or threatening behavior toward a therapist was reported. On the contrary, according to the therapists, many of the addicts in treatment did not seem to differ from other patients in terms of keeping appointments, payment of fees, responsible attitude toward treatment, motivation, and demands upon the therapist.

It is generally believed that drug addicts are not amenable to psychotherapy while under the influence of narcotics. In applying normal treatment procedures, our therapists reported no special difficulties attributable to the patient's drug status. In one case, the patient frequently appeared for her treatment sessions under the influence of narcotics, and the therapist was able to work through this behavior with the patient and to use it constructively in the treatment strategy. Addiction per se does not seem to present insurmountable problems to the therapist in the treatment hour proper, although it does result in many situational crises such as arrest, legal and job difficulties, marital discord, family interference and economic pressures.

The participating therapists were asked to give their diagnostic impressions of the 13 patients who remained in treatment. Nine were described by their therapists as exhibiting schizoid tendencies such as feelings of grandiosity and omnipotence, and a pervasive use of fantasy in dealing with reality. All 13 tended to have passive oral personalities characterized by paranoid and magical thinking. Their intelligence ranged from normal to very superior. The 10 men in this group were all employed. Two of the 3 women were housewives, and the third was a prostitute. All of these patients are currently paying for their own therapy.

The presenting problems, with one exception, dealt with areas of behavior

other than addiction: frigidity, suicidal impulses, marital discord, headaches, or hatred of father. The therapists reported that the content of the therapy sessions was more concerned with these problems than with addiction. The relationship of addiction to the other personality problems emerged as the therapeutic process continued. Patients began considering withdrawal from drugs within a period of two months after commencing therapy. The therapy appeared to have had the function of enabling the patient to cope with anxiety for which he had hitherto resorted to drugs.

All except three of the patients in this group were known to authorities for violations of law associated with their addiction, like burglary, robbery, or the possession and selling of narcotics. Of the three patients not known to community authorities, one used barbiturates and Benzedrine, one barbiturates only, and one used Demerol.

Six of the patients were married and living with their spouses; seven patients were single. None of the spouses was addicted. In all cases but one, the patients had close interpersonal ties with nonaddict friends, and maintained their contact with the addict subculture primarily to obtain drugs. Ages ranged from 21 to 55, with a median age of 28.

The behavior of the 22 patients who dropped out of therapy did not seem to differ significantly from that of those who continued, and the reasons for their discontinuing are not clear. Faulty technique, situational factors, inability to satisfy the patient's felt need for drugs or some combination of these may partly explain the termination of therapy by the members of this group.

Characteristics of the psychotherapists. The majority of the therapists who participated in the project had no previous experience with addict patients, and were generally hopeful about the outcome of psychotherapy with addicts. The few therapists who had previously treated addict patients were generally not so optimistic. As the therapists acquired more experience in the treatment of addicts, their attitudes underwent modification. They began to feel that psychotherapy might be effective only with some addicts. They felt the need for some screening device that might eliminate patients inaccessible to present psychotherapeutic techniques, but their confidence was increased by their contact with addict patients, and they will now accept addict patients in their private practice. Their original optimism has been tempered by a greater awareness of the practical and technical difficulties of treatment. Most of the therapists had expressed some anticipatory anxiety about the possibility of personal hazards involved in seeing addicts in their offices, but this anxiety has greatly diminished.

At the beginning of the project, some of the nonmedical therapists expressed concern about the management of the medical requirements of the addict. Experience showed that the medical problems arising during treat-

ment could be routinely handled by referral to outside medical or hospital resources, wherever they could be found. The pharmacological problems of addiction thus constituted no insurmountable obstacle when appropriate medical facilities were available for referral.

There was general agreement among the therapists that more detailed information and instruction on pharmacology, withdrawal symptoms, withdrawal procedures, legal problems, and community resources were absolutely necessary in order to handle the practical problems that occurred during therapy. They similarly expressed a need for frequent staff meetings at which there could be an exchange of experiences and a discussion of case material.

In the treatment of addicts, strong feelings may be provoked in therapists by the patient's use of drugs. In many cases, negativism, hostility, and hopelessness may characterize these countertransference feelings. These professional prejudices may be related in part to the prevailing animus toward drug use, and in part to previous therapeutic failures and some publicized incidents of presumed violence by drug addicts.

Though some project therapists developed ambivalent feelings toward their addict patients, they did not become unduly involved with them personally during treatment, for example, in lending money or supplying drugs. Neither rejection nor overprotection characterized their orientation toward addict patients. Undoubtedly their extensive psychoanalytic training and experience in handling other acting-out disorders enabled them to maintain professional detachment, even in the face of the extraordinary reality pressures that confront addict patients.

Therapeutic approaches. The exploratory nature of this research led to the decision to permit each therapist to treat his addict patients like his other patients and to employ his own psychotherapeutic approach. It was hoped by this laissez-faire attitude to accumulate a body of clinical material that could be used to evaluate the relative success and failure of different procedures and to learn something more specific about handling addicts in treatment.

Many different approaches and techniques were tried. One therapist required his patient to be withdrawn from drugs before accepting him for treatment. Other therapists accepted patients while they were still on drugs. Some therapists were relatively active and directive, while others were less directive. Most therapists saw their patients individually, but some introduced their patients into group psychotherapy as well. Frequency of visits varied among patients from once in two weeks to five times a week.

The data do not yet permit any generalizations on the efficacy of one approach over another with regard to the treatment of drug addicts, but they do provide a body of clinical material from which hypotheses may be drawn.

Nevertheless, our therapists did feel that some as yet undetermined modification in their therapeutic technique could yield greater success in the treatment of addict patients.

Problems of withdrawal. The majority of our patients were able to withdraw from drugs, outside of a hospital setting. With medical advice, the patients were able to employ their homes and their families for withdrawal. In a few cases Dolophine was used to mitigate the withdrawal symptoms. Most patients were instructed in the home use of hot baths, tranquilizers and barbiturates. Withdrawal in many cases was accomplished over a weekend, although in some cases this procedure failed and hospitalization was required. Several patients elected to go to Lexington rather than face withdrawal under these conditions.

In its lack of community facilities for the hospitalization of addicts, New York City is like other cities. This became a problem for the patients who needed hospitalization during the withdrawal period. As large metropolitan hospitals refused to admit addicts, it was necessary to take advantage of whatever hospital facilities could be found. This lack of available hospital facilities contributed to the difficulties attendant upon withdrawal. For example, a veteran patient who was employed regularly and was able to pay for hospitalization was refused admission by six large hospitals, despite his willingness to comply with any conditions they might impose and despite the willingness of a reputable medical specialist to cooperate with the hospital.

A number of patients applying to the project were seeking withdrawal from drugs, rather than psychotherapy. The lack of an established facility for this purpose was probably responsible for the dropout of these patients. It was also found that after psychotherapy began, many patients arrived at the decision to undertake withdrawal from drugs, and the lack of a hospital facility was an obstacle to the further course of treatment. Our therapeutic goal was the treatment of the total individual rather than his drug addiction symptom. The actual withdrawal from drugs was one step in this therapeutic process, based on the rationale that the underlying problem had to be treated or else the symptom would continue or would recur. The lack of community facilities thus tended to give an undue prominence to the withdrawal aspect of treatment.

The addict's family. The addict's family provided a constant source of interference in the therapy situation. This interference included numerous telephone calls, demands for appointments, refusal or inability to follow instructions, and overt hostility to the therapist and to therapy. Withdrawal of financial support from the patient, impugning the honesty and sexual integrity of the therapist, evicting the patient at the beginning of treatment, refusal to accept counseling or participate in any adjunct therapy, and ef-

forts to direct or coerce the therapist were typical behaviors of members of addicts' families. The mothers of the addicts figured most prominently in this interference, with the fathers conspicuous by their total lack of contact with the project.

Comment

Any number of reasons may help to explain why as many as 13 patients have remained in therapy. These include the voluntary nature of referral, the project's freedom from stereotyped community and institutional associations, and its nonpunitive and nonmoralizing philosophy. The lack of predetermined treatment or special facilities may have attracted patients. The patients' own motivations were accepted, and the staff was willing to work with them at whatever level they were willing to work. The psychoanalytic orientation of the therapists may have been important, along with the fact that the initiative for remaining in treatment rested entirely with the patient. Some undetermined selective factor may have operated to produce a small group of patients with an unusually good prognosis.

Although our ability to hold patients in treatment exceeded the expectations of some of us, a majority of the patients who applied to the project did not remain in treatment. Some of these patients may have been seeking a source of drugs rather than therapy. Others wished physical withdrawal; and some of those who declined psychotherapy might have availed themselves of hospitalization for withdrawal purposes, were such facilities available.

It is possible that some special psychotherapeutic technique is required for handling addiction. Our participating therapists had no relevant guidelines since no such technique has yet been formulated. In some cases, a confluence between the patient's needs and the therapist's behavior may have been missing. How to handle interfering parents represents another possible cause of difficulty in therapy. Reality factors like arrest and economic pressure may have caused some patients to drop out.

Psychotherapy may not be a desirable means of reaching some addicts, since they may suffer from more intractable disease processes (such as schizophrenia) which current techniques cannot readily reach. Some patients may have developed the capacity to control their addiction, without the kind of insight provided by psychotherapy, and may have merely required medical advice. Some patients may have dropped out of therapy because of the therapists' inexperience in perceiving the special behaviors of addiction and thus not being able to handle them. The lack of a functional classification of addicts and their behavior may have made it difficult for the therapist to decide what kind of treatment might be appropriate for the given patient.

It must be noted that many of the thousands of addicts in the New York area heard of the project and its services and did not contact it. Since the project received some publicity, it is clear that many addicts knew of its facilities but did not use them. Our patient population clearly represents a self-selected group.

Summary

Thirty psychoanalytically trained psychotherapists have been studying the accessibility of narcotic addicts to psychotherapy. This progress report covers the first year of the research, during which 70 addicts voluntarily contacted the project. Referrals came from a wide variety of sources within the Greater New York area. No patients were refused treatment. The great majority of the patients were heroin addicts, with some who were taking various synthetics.

A screening psychiatrist arranged an intake interview with the addict patients, after which they were referred to a participating therapist. This procedure resulted in the assignment of 47 patients for psychotherapy, of whom 35 actually effected an initial contact with a therapist. Each therapist established the specifics of treatment for the patient in accordance with whatever mode of procedure he believed appropriate.

Thirteen patients remain in treatment after one year. Their median duration of treatment is 10 months, and the median number of visits is 35. Of these 13 patients, 10 had ceased to use drugs, 2 had decreased their habit, and one took drugs occasionally.

Our tentative results suggest that some narcotic addicts may be treated on an outpatient basis by psychoanalytically trained psychotherapists who use procedures which do not differ significantly from those used in the treatment of other emotionally disturbed persons. It has been demonstrated that some drug addicts will voluntarily present themselves for psychotherapy and that they do not seem to present untoward hazards. They may be treated on an ambulatory basis while still addicted. Withdrawal for some patients can be accomplished on an ambulatory basis, although the lack of appropriate hospital facilities presents certain practical problems.

Discussion

Herbert A. Raskin, M.D.:* Psychotherapy comprises an essential component in the treatment of any emotionally ill person. How it relates to the care of the individual who is manifesting his emotional illness through drug addiction remains an unanswered question. Dr. Nyswander and the group in New York deserve commendation for entering an area of investigation

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that is beset with every pitfall known to the field of research. Any person trained in statistical methodology and experimental technique winces at the thought of working on a project of studying and evaluating psychotherapy. It is really virgin territory. There are virtually no precedents for studying the effects of psychotherapy in any form of mental disturbance by a control design. It is frequently stated that this is impossible because of irreducible differences between the therapist and patient, the multifactorial and intangible nature of the therapeutic process, and the like. Criteria and standardization of diagnosis, methods of evaluating improvement, and criteria for comparisons of therapeutic techniques complicate the investigation further. Even our knowledge of the psychological structure of the person addicted to drugs, and of the illnesses of which addiction is but one symptom, remains very incomplete.

The authors have indicated how their group is attempting to meet these problems of investigation. As experience is accrued, I am sure that more definitive conclusions will be forthcoming. It is interesting to note that the experience of the group in New York corresponds very closely with our own experience in Detroit.[1]

It is quite clear that the problem of narcotic addiction does not involve only the individual who is addicted. It is a problem that directly or indirectly concerns every citizen of any community where addiction exists. Any control measures *must* stem from a frame of reference of total community activity. Individual and group psychotherapy have specific roles to play in such programming, but these functions comprise a single facet in the attempt to control this problem.

We feel that the role of hospitalization in the total program is principally that of completing withdrawal from the drug and effecting a total evaluation and study of the individual patient. Each patient comprises an individual entity. With each person, a complete sociological, physical and psychological study and evaluation is required. Each particular problem of living and emotional functioning must be strictly delineated, and specific post-discharge programming must be determined and initiated prior to release from the hospital. This period of hospitalization is viewed as an interim function, the period to be that minimally required to accomplish the stated purpose. This is estimated to be 30 days.

Of paramount significance in this program is continuing care and contact following discharge from the hospital. Reliance upon voluntary efforts of the addicted person to seek help in his reintroduction into society, which is almost invariably needed, has been demonstrated to be futile.

We also have found that some narcotic addicts may be treated on an out-

[1] Herbert A. Raskin, Thomas A. Petty, and Max Warren, *A Suggested Approach to the Problem of Narcotic Addiction*, Am. J. Psychiatry, 113: 1089–1094, 1957.

patient basis by psychoanalytically trained psychotherapists who use procedures which do not differ significantly from those used in the treatment of other emotionally disturbed persons. It is in this area of activity that the work of Dr. Nyswander's group will be of inestimable value to us.

Ideally, psychotherapy should be directed toward young people with relatively well developed ego strengths who express, or are capable of expressing, overt anxiety and whose strivings and goals show good contact with reality and an awareness of social and cultural demands. This ideal, obviously, will not be met in working with the addicted population. We do not yet know the criteria by which to select patients for any particular technique of psychotherapy. It is our feeling, however, that withdrawal from the addicting drug must precede the establishment of a therapeutic relationship. Ignoring a status of active addiction would seem to imply to the patient condonement by the therapist. It is a severe handicap if any question exists that the aim of therapy is anything other than living without drugs. The person and his illness, rather than the symptom, remain the focus of therapy. The question has also arisen as to whether psychotherapy can be accomplished on a compulsory basis. It has been our experience that this comprises no serious deterrent to the conduct of therapy. As a matter of fact, many of the individuals addicted to drugs seem to welcome this. Initially, at least, compulsory therapy seems to serve the same purpose accomplished by drug use.

The incapacities of personal functioning of the addicted person dictate community provision of therapeutic and rehabilitative aids through strongly enforced legal channels. In Michigan, we have two channels available, the long existent Probate Code with commitment procedures identical to those for any mental illness, and the recently enacted Ryan Act directed specifically at narcotic addicts. Recent conferences have indicated a probable greater effectiveness in using the probate procedure.

Narcotic addiction is a serious problem that directly affects every citizen of any community in which it exists, and meeting this problem becomes the direct responsibility of these same citizens. Any and all communal forces that reflect in any way on increased effectiveness of social and community integration have a specific role to play. Such a program requires total community organization and total community action.